

**Nigam Harsh ; Jain Raveena ; Congestive Heart Failure ; Homoeopathic Heritage ; September, 2017 ; ISSN : 9070-6038**

**CONGESTIVE HEART FAILURE (CHF)**

**Authors**

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He is a regular contributor to Homoeopathic Heritage and Author of Lectures on Homoeopathic Case Management; Miasma, A Road Less Travelled both published by B. Jain Publishers. His aim is to establish Homoeopathy on its scientific merit and make it integrated with orthodox medicine in such a way that the Scope and Limitation of Homoeopathy are well defined.

**Dr. Raveena Jain**, B.H.M.S. from Pt. Jawahar Lal Nehru State Homoeopathic Medical College works as clinician in charge Rheumatology OPD at Dr. Nigam's Homoeopathic Healthcare at Kanpur.

**Abstract**

Congestive heart failure is a chronic progressive condition which affects the pumping of heart muscles. It is a clinical condition which results in pulmonary vascular congestion and reduced cardiac output.<sup>1</sup>

About 23 million people worldwide have heart failure. About half of these with CHF die within five years after being diagnosed. Almost 1.4 million people with CHF are under 60 years of age. CHF affects people of all ages from children and young adults to the middle-aged and the elderly. The incidence of CHF is equally frequent in men and women. Heart Failure contributes to approximately 2,87,000 deaths a year. These data vary widely depending upon the exact diagnosis and response to particular therapy that play a role in patient's survival.<sup>1</sup>Based on disease specific estimates of prevalence and incidence rates of heart failure in India range from 1.3 to 4.6 million.<sup>2</sup>

**Keywords** : Congestive Heart Failure; CHF ; Homoeopathy

**Heart failure - Basic Concepts**

This is a syndrome of fluid retention causing dyspnoea on exertion or on lying flat (Orthopnea) and edema due to insufficient cardiac output. It may complicate many different heart diseases.

A common mistake is to fail to look for the cause. As venous pressure rises, there is pulmonary and peripheral congestion - hence the term congestive cardiac failure (CCF).

Common risk factors for the development of Congestive Heart Failure are Age, Hypertension, Diabetes Mellitus, Physical inactivity, Obesity, Smoking, Metabolic syndrome, Family history of heart failure, Enlargement of left ventricle, Excessive consumption of alcohol, Coronary Artery Disease, High Cholesterol and Triglycerides and Prior heart attack.

**Classification** of CHF is in two ways

I. High-output, low-output and fluid overload

II. Left or right ventricular failure (RVF or LVF)

**A. High-output failure** The heart's output is normal or increased due to increased needs. Failure occurs when cardiac output fails to meet needs. It will occur with normal heart, but even earlier if there is heart disease.

**Cause:** Heart disease with Anemia, Pregnancy, Hyperthyroidism, Paget's disease, A-V malformation, beriberi.

**Consequences:** Initially features of RVF; later LVF become evident.

**B. Low-output failure** The heart output is inadequate (e.g. ejection fraction < 35%).

**Cause:**

**Excessive preload:** eg mitral regurgitation or fluid overload. Fluid overload may cause LVF in a normal heart if renal excretion is impaired or big volumes are involved. It is easily caused if there is simultaneous compromise of cardiac function and in the elderly.

**Chronic excessive afterload:** Eg Aortic stenosis, hypertension

**Pump failure is due to: *Heart muscle disease:*** Ischaemic heart disease;

Cardiomyopathy. ***Restricted filling:*** Constrictive pericarditis, tamponade, Restrictive cardiomyopathy. ***Inadequate heart rate:*** Beta-blockers, heart block, post MI.

### **Right ventricular failure**

This causes peripheral oedema, abdominal discomfort, nausea, fatigue and wasting (often weight gain). **Signs** Raised JVP, Hepatomegaly, Pitting Edema and Ascites.

**Left ventricular failure** is dominated by pulmonary oedema. The symptoms are exertional dyspnoea, orthopnoea, paroxysmal nocturnal dyspnoea, wheeze (cardiac asthma), cough ( $\pm$  pink froth), haemoptysis, fatigue. The **signs** are tachypnoea, tachycardia, inspiratory basal crackles, pulsus alternans (alternating large and small pulse pressures), cardiomegaly, cyanosis and pleural effusion. Peak expiratory flow rate maybe low, but if it is < 150L/min, suspect COPD or asthma.

### **Investigations**

**Chest X-Ray** shows prominent upper lobe veins (upper lobe diversion), diffuse patchy lung shadows often basal but sometimes perihilar "bat's wings" or occasionally unilateral (if nursed

on one side), or nodular (especially if pre-existing COPD), fluid in the fissures, pleural effusion, cardiomegaly, kerley B lines peri-bronchial cuffing.

**ECG** may elucidate cause (look for evidence of infraction, ischaemia or ventricular hypertrophy).

**Echocardiograph** is the key diagnostic test and, ideally, it should be advised whenever the diagnosis or cause of heart failure is uncertain which is often.

**CLINICAL STAGING OF CHF**

**Table 1: AHA/ACC heart failure staging compared with NYHA classification scheme<sup>2</sup>**

<b>AHA/ACC STAGE</b>	<b>EXAMPLES</b>	<b>NYHA CLASSIFICATION</b>
<b>STAGE A</b> Patients at high risk for heart failure but without structural heart disease or symptoms of heart failure	Hypertension, diabetes mellitus, obesity, CAD (Post MI or revascularization), peripheral vascular disease, CVA, family history, exposure to cardiac toxins)	-
<b>STAGE B</b> Patients with structural heart disease but without signs and symptoms of heart failure	Prior MI, left ventricular hypertrophy or reduced LVEF, asymptomatic valvular disease	-
<b>STAGE C</b> Patients with structural heart disease with prior or current symptoms of heart failure	Known structural heart disease and dyspnoea, fatigue, reduced exercise intolerance	I – IV
<b>STAGE D</b> Patients with refractory heart failure requiring specialized interventions	Marked symptoms at rest despite maximal medical therapy, with recurrent hospitalizations	III – IV

**Table 2: New York Heart Association Functional Classification of Heart Disease<sup>3</sup>**

<b>Class</b>	<b>Functional Description</b>
I	Asymptomatic except during severe exertion
II	Symptomatic with moderate activity
III	Symptomatic with minimal activity
IV	Symptomatic at rest

## **HOMOEOPATHIC APPROACH**<sup>4,5,11,15</sup>

### **HEART FAILURE: LONG-TERM MANAGEMENT**

- Treat cause if possible, e.g. valve lesion, or hypoxia in cor pulmonale.
- Treat exacerbating factors (anemia, thyroid disease, infection, BP)
- Restrict salt and alcohol intake (if the latter is excessive).
- Maintain optimal weight and good nutrition
- Stop smoking.
- **Try to avoid NSAIDs-** They cause fluid retention and may interact with diuretics and ACE inhibitors to cause chronic renal failure.

### **HOMOEOPATHIC VIEW**

Heart failure is a true chronic disease. It is a chronic miasmatic disease.<sup>4</sup> The dominant miasm is Psoro-Sycotic. It is a one-sided chronic miasmatic disease and stage 4 end stage disease.<sup>5</sup>

### **THERAPEUTIC STRATEGY**<sup>5,6,7,8,15</sup>

For such kind of cases, best suited strategy is “Layered Prescribing”. Layered prescribing is a method based on the assumption that certain patients have distinct levels of disease, which require separate prescriptions to be given in appropriate sequence in order to bring about a complete and lasting cure.

### **TREATMENT PLAN**<sup>5</sup>

We have elaborated different therapeutic approach as per different stages of CHF (See Table 3)

**Table 3:**

<b>CHF AHA/ACC CLASSIFICATION</b>	<b>STAGE A</b>	<b>STAGE B</b>	<b>STAGE C</b>	<b>STAGE D</b>
	Patients at high risk of heart failure but without structural heart disease or symptoms of heart failure	Patients with structural heart disease but without signs and symptoms of heart failure	Patients with structural heart disease with prior or current symptoms of heart failure	Patients with refractory heart failure requiring specialized interventions
<b>HOMOEOPATHIC DISEASE CLASSIFICATION</b>	<b>STAGE 1</b> Chronic miasmatic disease : Malaise	<b>STAGE 2</b> Chronic miasmatic disease : Functional disease	<b>STAGE 3</b> Chronic miasmatic disease : Organic disease	<b>STAGE 4</b> Chronic miasmatic disease : End stage multi-systemic disease
<b>STRATEGY</b>	Classical prescribing (based on totality that is the sum and the essence of symptoms).	Prescribing based on fundamental shift of symptoms. Followed by classical prescribing.	Organ remedies and drainage treatments. Clinical prescribing. Layered prescribing.	Local disease. Organ remedies and drainage treatments.
<b>AIM</b>	Cure	Cure	Initial reversal of pathology, then cure	Palliation.
<b>SUGGESTED POTENCY</b>	High/Medium	High/LM	Low/Medium/LM	Low

**TREATMENT PLAN IN MODERN SETTINGS**<sup>5</sup>

The aim is balance between facilitation by Homoeopathy and decompensation caused by Antipathy/Allopathy. That is how Homoeopathic management is integrated with orthodox management. This is not easy and much consideration is required such as:

**a. A Heavily medicated patient**

1. Single dose should be avoided and it is better to use
  - Split single dose
  - Multiple doses (LM Potency)
2. Give small remedies before giving constitutional remedy.

**b. If current orthodox medicine is producing side effects:**

1. Consider drainage: Review case after two weeks, if nothing happens then shift to specifics.
2. Specifics/organ remedies to detoxify and tone up the organ or system before giving a deeper organ remedy given as mother tincture or 1x to 6x.
3. Therapeutic/Fundamental prescription.

Emphasis is placed on clinical diagnosis focusing on a group of remedies with known affinity to a system or a clinical condition (whole person is not taken in account) yet the case is taken completely, considering locality, etiology, modality, sensation and concomitant. The aim is to select a simillimum which corrects the disturbance prevailing in an organ/tissue/system.

This usually results in the use of a medium or a small remedy.

4. After the therapeutic fundamental prescription
  - No response = Think of blocks to cure
  - Response = Think of withdrawal of orthodox medicine if medically justified.

## **ILLUSTRATIVE CARDIAC CASES**

### **Case 1:**

In January, 2000 Mr. G.N.G. Male, 65 years presented with Dyspnoea, Ascites, Pedal edema. He was suffering from a failing heart, he was having Cardiomegaly with Hypertension and Albuminuria. He was discharged from SGPGI with diagnosis of DCMP(LV function was only 10%) and medication of Digoxin and Lasix, since he was not responding and doctor's advised that nothing more could be done he wanted to know whether Homoeopathy could help him. His heart was dilated, face bluish and congested, ankles swollen, with a trace of albumin in urine, He seemed very tired, collapsed and done up. He could not lie because of breathlessness. He was hot and thirstless with scanty urination. An extremely proud man, reserve and silent in nature. He was very difficult to handle as he was restless and hurried. He had warts on his face.

He was given **Quebracho Q & Senega Q** with nebuliser for respiratory distress. As drainage **Convallaria Q and Iberis Q** were used, **Apis 6** then **Apis 30** were used at frequent interval.

For three months he led a very quiet life just moving from bed to couch, But with medication he started responding well. His Ascities went down, Pedal edema disappeared, Dyspnoea was better he could lie down now and sleep. Then he developed cough for which was given **Laurocerasus Q** with which he responded well.

After five months I felt his vitality had grown to such an extent that I give him **Thuja 1 M**. He was reserved and silent type with aggravation from warm & wet, perspiration sweet smelling, desire for raw onion, predominant sycotic miasm characterized his present state, not to forget warts. The progress was almost startling after Thuja. He became energetic went back to his work and social engagements within two month of intercurrent treatment with Thuja 1 M, although his warts grew in number.

Two years passed since he first came to me, he is fine, has no dyspnoea and uses his nebuliser occasionally. His dilatation disappeared and his BP came to normal. He regained his old vigor. Remember he was given a bleak prognosis by orthodox doctors but his DCMP has been corrected, which means his cardiac failure has been arrested and reversed and his dilated and abnormal heart has constricted to normal size with markedly improved cardiac function. The patient lived till 2013 and was treated in later years by me for BPH and he passed away because of Cardiac arrest at the age of 78 years.

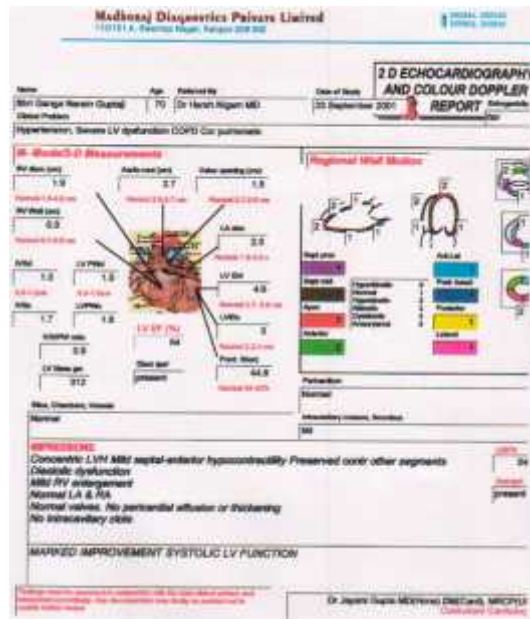
Let's compare his ECHO findings before and after one year of Homoeopathic treatment. (See Table 4)

**Table 4:**

<b>Cardiac Parameters</b>	<b>Normal Range</b>	<b>13 December 2000</b>	<b>23 September 2001</b>
<b>Right Ventricle dimension</b>	0.7-2.6 cm	5.2 cm	1.9 cm
<b>Left Atria</b>	1.9-4.0 cm	3.9 cm	2.5 cm
<b>Left Ventricular end Diastolic Dimension</b>	3.7-5.6 cm	7.0 cm	4.6 cm
<b>Left Ventricular end Systolic Dimension</b>	2.2-4.0 cm	6.0 cm	3.0 cm
<b>LVEF</b>	60 +/- 6%	10%	54%
		Grossly enlarged left and right ventricles with severe	Concentric LVH. Mild septal-anterior Hypocontractility.

		hypokinesia. Global Hypocontractility. <b>LVEF 10%.</b> <b>Bilateral ventricle enlargement</b>	Preserved other Segments. <b>LVEF 54%.</b> <b>Mild RV.</b> enlargement. Normal LV,LA,RA
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## INVESTIGATIONS



### Case 2:

**Mrs. N.R**, 47 years presented with heaviness and oppression in the chest region, along with the sensation of coldness in the region of chest. She also complained of weakness, tiredness and sleeplessness with soft pulse. There was the general aggravation of all complaints on waking in the morning. The patient was chilly and had the general aggravation from cold. The patient had general depression. She was hypertensive and diabetic for past 10 years.

The investigations were done and her Echocardiography reports showed Left Ventricular Hypertrophy and global hypokinesia and the ejection fraction was 32% on 11-02-2009. On the basis of totality of her symptoms, she was prescribed Kali Carbonicum 200. The investigations were repeated in May 2009 and her Echocardiography report showed an increase in ejection fraction which was 41% and left ventricle became normal in size. There was significant improvement in oppression and coldness in the region of heart and there was a feeling of



general well being. In March 2010 again her Echocardiography was done and it showed normal left ventricular size and an ejection fraction of 40%. During that period she was symptomatically alright. Again after about an year in February 2011 Echocardiography was done and according to that there was no LVH and the ejection fraction increased to 52% and there was no mitral regurgitation. (See table 5)

**Table 5**

<b>ECHO REPORT</b>	<b>SUMMARY OF FINDINGS AND ECHOCARDIOGRAPHIC DIAGNOSIS</b>
<b>11-02-2009</b>	Left Ventricle is dilated with global hypokinesia, <b>Ejection fraction=32%</b> , Trivial Mitral Regurgitation. No LV clot. Other parameters within normal range. <b>IMPRESSION</b> : Dilated Cardiomyopathy
<b>09-05-2009</b>	Left Ventricle is normal in size, Global hypokinesia of left ventricle, <b>Ejection fraction=41%</b> . No mitral regurgitation. Other parameters are within normal range.
<b>06-03-2010</b>	Left ventricle is normal in size. No LVH. Global hypokinesia of LVH. <b>Ejection fraction=40%</b> . No mitral regurgitation. Other parameters are within normal range.
<b>26-02-2011</b>	Left Ventricle is normal in size. No LVH. No RWMA. Mild Global Hypokinesia. <b>Ejection fraction=52%</b> . No mitral regurgitation. Other parameters are within normal range
<b>08-06-2017</b>	Left Ventricle is enlarge with hypertrophied wall. No trivial MR present. RV dimensions are normal. <b>Ejection fraction=60%</b> . No RWMA. No LA/LV clot. No diastolic LV present. <b>IMPRESSION</b> : Left Ventricular Hypertrophy

She was treated with layered prescribing approach. Her prescribed medicines are tabulated. During her treatment, she not only improved substantially in cardiac function but many of her other organ pathologies completely recovered (See table 6)

**CONCOMITANT CURE OF OTHER PATHOLOGIES IN SAME PATIENT WITH HOMOEOPATHY**

**UTERUS** : at the commencement of the treatment she had two **intramural subserosal leiomyomas**, and bulky cervix with few **nabothian cysts**, largest one with echoes possibly due to **chronic cervicitis** as on USG report of 21-11-2010. During treatment there remained only one

fibroid with nabothian cyst of cervix on USG dated 05-04-2012. Another USG report done on 07-05-2013 revealed only bulky uterus and cervix with nabothian cysts of cervix, fibroid got disappeared. USG report done on 09-09-2014 showed no abnormality in uterus and cervix. There was no fibroid, the size of uterus and cervix were normal, there was no evidence of nabothian cysts in cervix. (See table 6)

**BREAST** : In 2009 she was having fibroadenoma in both breasts bigger one seen on left side which was also cured under treatment. Sonomammography report done on 14-09-2016 showed hypoechoic soft tissue lesions in left breast, probably dilated ducts. (See table 6)

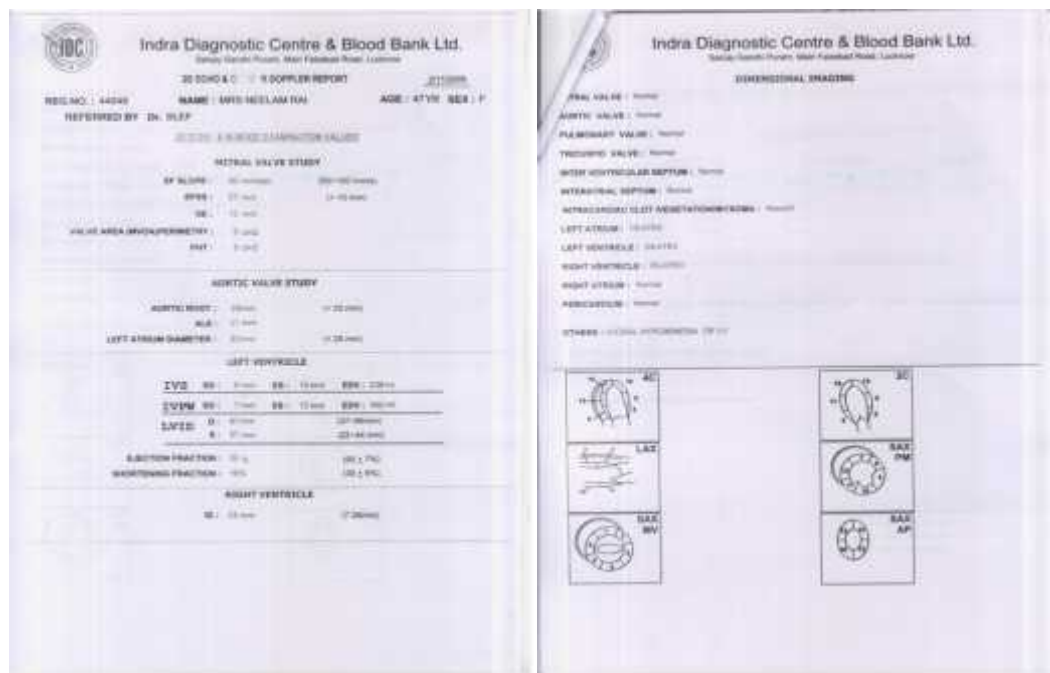
**LIVER AND SPLEEN** : During her course of treatment, she also suffered from fatty degeneration of Liver and enlargement of spleen, which also got cured during treatment. (See table 6)

<b>DATE</b>	<b>USG ABDOMEN REPORTS</b>
<b>21-11-2010</b>	Intramural and Subserosal Leiomyomas.Bilateral normal appearing Ovaries with a small Follicular cyst on Left side.Bulky Cervix with few Nabothian cysts.
<b>05-04-2012</b>	Fibroid Uterus with Nabothian cyst of Cervix.
<b>06-12-2012</b>	Grade 1 Fatty Infiltration of Liver.Mild Splenomegaly.Fibroid Uterus with mildly enlarged and cystic Left Ovary.
<b>07-05-2013</b>	Grade 2 Fatty Infiltration of Liver.Bulky Uterus and Cervix with Nabothian cysts of Cervix.
<b>09-09-2014</b>	Grade 2 Fatty Infiltration of Liver.
<b>14-07-2016</b>	Normal Ultrasound.
	<b>SONOMAMMOGRAPHY REPORTS</b>
<b>22-07-2009</b>	Well defined homogeneous lobulated masses in both breast bigger one seen on the left side S/O Fibroadenomas with normal axilla study.
<b>14-02-2010</b>	Well defined homogeneous lobulated masses in both breasts bigger one seen on the left side S/O of Fibroadenomas with small cysts in the left breast at 6'O Clock periareolar area with normal axilla study.
<b>24-04-2011</b>	Bilateral soft tissue lesions (Fibroadenomas) with small cystic lesion in left upper quadrant.
<b>06-04-2012</b>	Bilateral fibroadenomas

09-09-2014	Small hypoechoic lesions in both breasts, 11 mm and 5 mm..Fibroadenomas
14-09-2016	Hypoechoic soft tissue lesions left breast...Dilated ducts.

**Table 6**

**11-02-2009**



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**COLOR FLOW MAPS**

HEALTHY MITRAL REGURGITATION, NO AORTIC REGURGITATION, NO TRICUSPID REGURGITATION

**DOPPLER STUDY**

	VELOCITY (cm/s)	FLOW (ml/min)	GRADIENT (mmHg)
<b>MITRAL FLOW</b>			
E	120 cm/s	Normal	10
A	80 cm/s	Normal	10
<b>AORTIC FLOW</b>	120 cm/s	Normal	10
<b>TRICUSPID FLOW</b>	120 cm/s	Normal	10
<b>PULMONARY FLOW</b>	120 cm/s	Normal	10

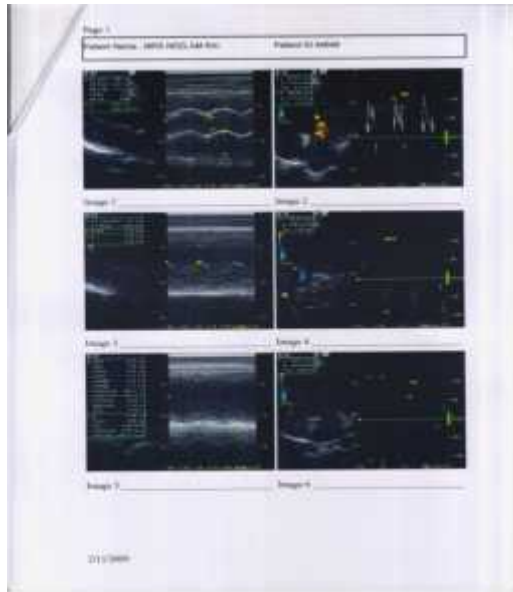
**SUMMARY OF PHYSICAL AND ECHOCARDIOGRAPHIC FINDINGS**

LVOT CLAVIC WITH NORMAL AORTIC REGURGITATION, ED, NORMAL MITRAL REGURGITATION, NO TRICUSPID

LVOT REGURGITATION WITH NORMAL AORTIC

REGURGITATION: SLIGHT ECHOCARDIOGRAPHY

DR. SUDHAKAR REDDY  
 MD (General)  
 MR (Cardiology)



09-05-2009

**Indra Diagnostic Centre & Blood Bank Ltd.**  
 20/20, Gandhi Park, Main Post Road, Lutterworth

**DIMENSIONAL IMAGING**

MITRAL VALVE: Normal  
 AORTIC VALVE: Normal  
 PULMONARY VALVE: Normal  
 TRICUSPID VALVE: Normal  
 INTER VENTRICULAR SEPTUM: Normal  
 INTRAVENTRICULAR SEPTUM: Normal  
 INTRACARDIAC CLOT/VEGETATION/EMBOLUS: Absent

LEFT ATRIUM: Normal  
 LEFT VENTRICLE: Normal  
 RIGHT VENTRICLE: Normal  
 RIGHT ATRIUM: Normal  
 PERICARDIUM: Normal

CHamber (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12)

**Indra Diagnostic Centre & Blood Bank Ltd.**  
 20/20, Gandhi Park, Main Post Road, Lutterworth

**2D ECHO & C - R DOPPLER REPORT**

REG. NO.: 22542      NAME: NEELAM RAJ      AGE: 47YR      SEX: F

REFERRED BY: DR. SELF

**2D ECHO & M-MODE EXAMINATION VALUES**

**MITRAL VALVE STUDY**

EF SLOPE:	42 mm/sec	(30-60 mm/sec)
SPD:	4 cm	(1-15 cm)
CD:	15 cm	
VALVE AREA (MVA) (PISA):	0.5 cm <sup>2</sup>	
PAV:	0.5 cm <sup>2</sup>	

**AORTIC VALVE STUDY**

AORTIC ROOT:	25mm	(1-25 mm)
ALA:	22 mm	
LEFT ATRIUM DIAMETER:	27 mm	(1-28 mm)

**LEFT VENTRICLE**

IVD	ED: 80mm	ES: 10mm	EDV: 110ml
IIVM	CD: 7mm	ES: 12mm	EDV: 47ml
LVID	D: 40mm	ES: 17-20mm	
R:	35mm	22-45mm	

**EJECTION FRACTION: 41%**      (50-75%)  
**SHORTENING FRACTION: 20%**      (30-60%)

**RIGHT VENTRICLE**

D:	19 mm	(7-28 mm)
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**COLOUR FLOW MAPPING**  
NO MITRAL REGURGITATION, NO TRICUSPID REGURGITATION

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**DOPPLER STUDY**


	VELOCITY (cm/s)	FLOW PATTERN	GRADIENT
<b>MITRAL FLOW</b>	E: 50 cm/s A: 34 cm/s	Normal	5/8
<b>AORTIC FLOW</b>	50 cm/s	Normal	1/4
<b>TRICUSPID FLOW</b>	47 cm/s	Normal	1/4
<b>PULMONARY FLOW</b>	55 cm/s	Normal	5/8

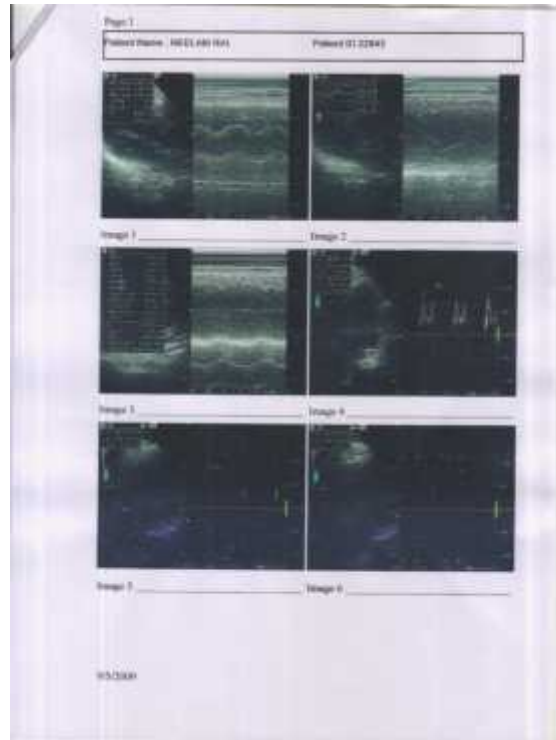
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**SUMMARY OF FINDINGS AND ECHOCARDIOGRAPHIC DIAGNOSIS**

L.V. IS NORMAL IN SIZE, GLOBAL HYPOKINESIS OF L.V. EJECTION FRACTION = 47%, NO MITRAL REGURGITATION.

**OTHER PARAMETERS WITHIN NORMAL RANGE**

  
 DR. ANURITA CHAKRABORTY  
 M.D. (Medicine)  
 S.M. (Cardiology)



06-03-2010

**Indra Diagnostic Centre & Blood Bank Ltd.**  
Shree Swathi Park, Main Road, Kottur, Ludhiana

**2D ECHO & C.D. DOPPLER REPORT**

REG. NO.: 43555      NAME: NEELAM RAJ      AGE: 45YR      SEX: F  
 REFERRED BY: Dr. SCLF

**2D ECHO & M-MODE EXAMINATION VALUES**

**MITRAL VALVE STUDY**

EF slope	65 mm/min	200-100 mm/min
EFSD	7 mm	(+ 12 mm)
DC	12 mm	
VALVE AREA (MVA) (PERICUTY)	7 cm <sup>2</sup>	
MRP	0 cm <sup>2</sup>	

**AORTIC VALVE STUDY**

AORTIC ROOT	30mm	(+ 25 mm)
ALB	17 mm	
LEFT ATRIUM DIAMETER	42 mm	(+ 25 mm)

**LEFT VENTRICLE**

IVS ED	8 mm	BB: 11 mm	BBW: 128 mm
LVW ED	7 mm	BB: 10 mm	BBW: 83 mm
LVESD	51 mm	BB: 57 mm	BBW: 120 mm
ES	28 mm	BB: 22 mm	BBW: 100 mm

**EJECTION FRACTION**: 47%      (50 ± 7%)  
**SHORTENING FRACTION**: 20%      (20 ± 5%)

**RIGHT VENTRICLE**

RV	18 mm	(+ 10 mm)
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**DIMENSIONAL MEASUREMENTS**

MITRAL VALVE: Normal  
 AORTIC VALVE: Normal  
 PULMONARY VALVE: Normal  
 TRICUSPID VALVE: Normal  
 INTER VENTRICULAR SEPTUM: Normal  
 INTER ATRIAL SEPTUM: Normal  
 INTER ATRIAL SEPTAL VEGETATION/VEGIBLA: Normal  
 LEFT ATRIUM: Normal  
 LEFT VENTRICLE: Normal  
 RIGHT VENTRICLE: Normal  
 RIGHT ATRIUM: Normal  
 PERICARDIUM: Normal

**OTHERS**: GLOBAL HYPOKINESIS OF LV



AC



LAX



SAX PL



SAX AP

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**COLOUR FLOW MAPPING**

**DOPLER STUDY**

	VELOCITY (CM/S)	ACCELERATION (CM/S <sup>2</sup> )	GRADIENT (CM/S)
<b>MITRAL FLOW</b>			
E1: 20 cm/s			
A: 22 cm/s	Normal		0.8
<b>AORTIC FLOW</b>	40 cm/s	Normal	0.8
<b>DESCENDING FLOW</b>	40 cm/s	Normal	0.8
<b>ASCENDING FLOW</b>	40 cm/s	Normal	0.8

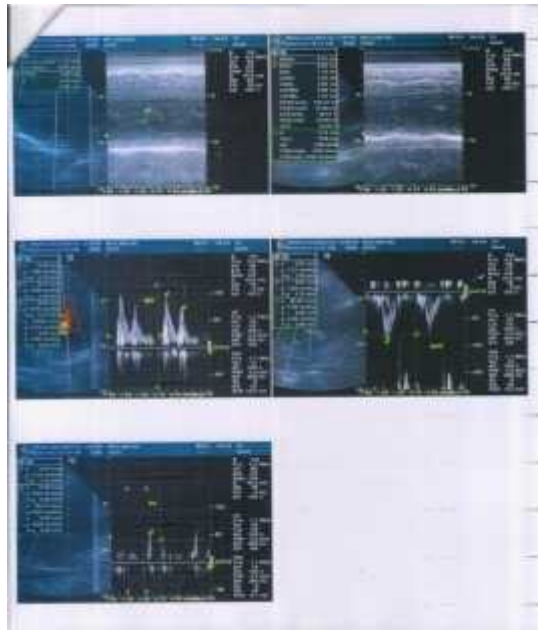
**SUMMARY OF FINDINGS AND RECOMMENDATIONS:**

L.V. NORMAL IN SIZE. NO LVH.

Normal dimensions of LV. Ejection fraction - 60%. No mitral regurgitation.

OTHER PARAMETERS WITHIN NORMAL RANGE.

*[Signature]*  
 DR. MANISH KUMAR  
 MD (General)  
 DR. Lucknow



**26-02-2011**

**Indra Diagnostic Centre & Blood Bank Ltd.**  
 10/10, Gandhi Park, 10th Floor, Road, Lucknow

**3D ECHO & COLOR DOPPLER REPORT**

REG. NO. / CODE: NAME: NEELAM SINGH AGE: 45 YR SEX: F

REFERRED BY: Dr. SELF

**3D ECHO & M-MODE EXAMINATION VALUES**

**MITRAL VALVE STUDY**

EF SLOPE	75 degrees	(60-100 degrees)
EPDS	0 mm	(0-10 mm)
DE	10 mm	
VALVE AREA (PROXIMAL/ANTERIOR)	4 cm <sup>2</sup>	
PMV	0 cm <sup>2</sup>	

**AORTIC VALVE STUDY**

AORTIC CUSP	12 mm	(8-24 mm)
ALV	10 mm	(10-20 mm)
LEFT ATRIAL DIAMETER	35 mm	(30-45 mm)

**LEFT VENTRICLE**

EYS	40 mm	ES	40 mm	END	35 mm
ZVPM	55	SS	52 mm	SSK	50 mm
LVZD	51	51	50-60 mm	52-60 mm	
	51 mm		52-60 mm		

**BURTON FRACTION** 75%      **SHOWNING FRACTION** 20%

**RIGHT VENTRICLE**

RV	35 mm	(20-40 mm)
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 10/10, Gandhi Park, 10th Floor, Road, Lucknow

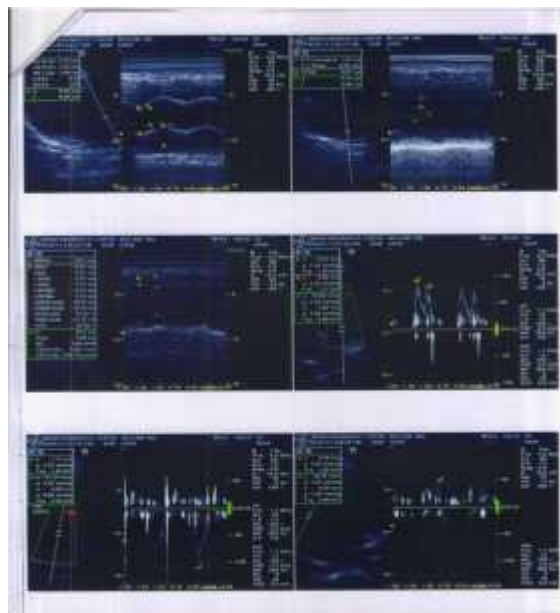
**DIMENSIONAL IMAGING**

MITRAL VALVE: Normal  
 AORTIC VALVE: Normal  
 PULMONARY VALVE: Normal  
 TRICUSPID VALVE: Normal  
 INTER VENTRICULAR SEPTUM: Normal  
 INTER ATRIAL SEPTUM: Normal  
 INTRACARDIAC CLOT / THROMBOSIS: Normal  
 LEFT ATRIUM: Normal  
 LEFT VENTRICLE: Normal  
 RIGHT VENTRICLE: Normal  
 RIGHT ATRIUM: Normal  
 PERICARDIUM: Normal

OTHERS: MULTIFOCAL HYPERTENSIVE CHANGES

*[Signature]*  
 Dr. Manish Kumar

The figure shows six schematic diagrams of cardiac cross-sections. 1C and 2C are long-axis views. LAX is a long-axis view. SAX PM, SAX MV, and SAX AP are short-axis views at different levels.



**PRESCRIBED MEDICINES**

The medicines prescribed during her treatment according to the functional shift of symptoms presented by the patient and observed by us are mentioned in tabulated form. Let’s take a look at the medicines prescribed. No high potencies were alternated with each other. On the day of taking high potencies, low dilutions mother tinctures were not given.

**Table 7**

<b><u>Prescriptions</u></b>	<b><u>Homoeopathic Potency in Pills</u></b>	<b><u>Homoeopathic Tinctures In Low Dilution</u></b>
<b>First Prescription</b>	Kali-carb 10M	Arnica, Acid-phos, Cactus-g
<b>Second Prescription</b>	Kali-carb 10M	Arnica, Acid-phos, Cactus-g
<b>Third Prescription</b>	Lachesis 10M	Arnica, Acid-phos, Cactus-g
<b>Fourth Prescription</b>	Kali-carb 10M	Arnica, Acid-phos, Cactus-g
<b>Fifth Prescription</b>	Kali-carb 10M	Arnica, Acid-phos, Cactus-g
<b>Sixth Prescription</b>	Lachesis 10M	Arnica, Cactus-g, Fraxinus-am
<b>Seventh Prescription</b>	Rhus-tox 10M	Arnica, Cactus-g, Fraxinus-am

	Ferrum-met 10M	
<b>Eighth Prescription</b>	Rhus-tox 10M Ferrum-met 10M	Lycopus-virg, Crataegus, Fraxinus-am
<b>Ninth Prescription</b>	Rhus-tox 10M Ferrum-met 10M	Lycopus-virg, Crataegus, Fraxinus-am
<b>Tenth Prescription</b>	Pulsatilla 10M Ferrum-met 10M	Crataegus, Phytolacca-dec
<b>Eleventh Prescription</b>	Lachesis 10M Conium 10M	Acid-phos, Phytolacca-dec
<b>Twelfth Prescription</b>	Lachesis 10M Conium 10M	Acid-phos, Phytolacca-dec
<b>Thirteenth Prescription</b>	Lachesis 10M Conium 10M	Acid-phos, Phytolacca-dec
<b>Fourteenth Prescription</b>	Lycopodium 10M	Lycopus-virg, Crataegus

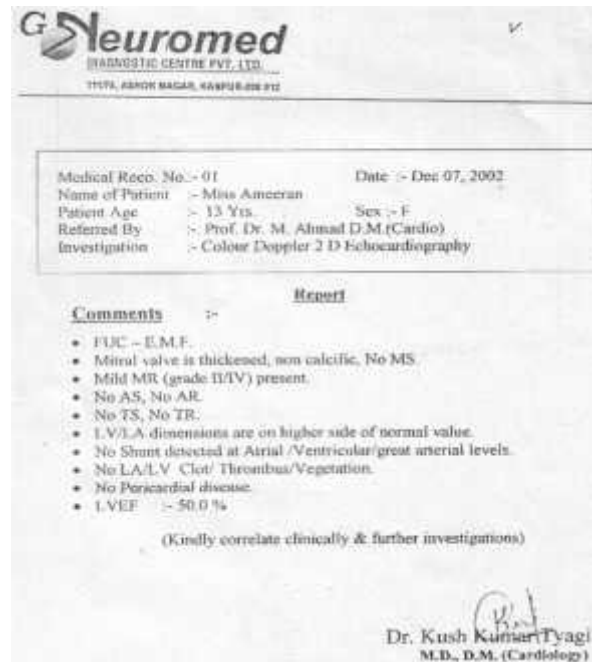
### Case 3

#### A case of Cardiomegaly

A baby, F/12 years, a case of EFE and enlarged globally hypocontractile left ventricle, with severe impairment of systolic function. **LVEF was 28%** as on 07-12-2002. She was also suffering from convulsions. The growth of the patient was also hampered and intelligent quotient was on the lower side. On the basis of symptom similarity, she was prescribed **Bufo 6** followed by **200** and **1M** and **Convallaria majalis Q** (chosen because CHF + ENDOCARDITIS) in drop doses, which resulted in improvement in the convulsions and general well being. There was general improvement in the growth.

After about an year and half, her Echocardiography was repeated, which showed no endocardial thickening. The LV/LA dimensions were on higher side of normal. The **LVEF was 50%**. (See table 8)





**Table 8**

DATE	ECHOCARDIOGRAPHY REPORTS
08/05/2001	Enlarged globally hypocontractile left ventricle with severe impairment of systolic function. Endocardial and strands compatible with EFE. LVEF 28%.
07/12/2002	LV/LA dimensions are on higher side of normal. No endocardial thickening. LVEF 50%.

**Case 4**

**Mr. S.K.S**, 56 years/M, a case of Diabetes Mellitus since 3-4 years presented to us with itching eruptions on scalp with itching on face which was aggravated from warmth and warm baths. He also suffered from Myocardial Infarction on 30-09-2016. The Echocardiography done on 02-10-2016, the ejection fraction was 30%. After sometime the echocardiography report was repeated on 02-06-2017, the ejection fraction increased to 40% to 45%. (See Table 9)

**02-10-2016**



02-06-2017



Table 9

DATE	ECHOCARDIOGRAPHY REPORT
02-10-16	Akinetic mid anterior septum apex, mid IVS and mid anterior wall, LVEF=30%. Normal cardiac chamber dimension. Trace MR. Trace TR. DRA=A>E. No intra cardiac Clot/ Vegetation/PE

<b>02-06-17</b>	Akinetic mid anterior septum and Apex, LVEF 40-45%. Normal cardiac chamber dimension. Trace MR. Trace TR. DRA=A>E. No intra cardiac Clot/Vegetation/PE
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## **MANAGEMENT OF CONGESTIVE HEART FAILURE WITH HOMOEOPATHY**<sup>9,10</sup>

### **Some Important Remedies**

**HEART FAILURE** - Adon.v., Adren., Agaricin., Alcohol., AmyL, Ant. t., Atrop., Caffeine., Camphorated oil, Coeamie., Conv., Crat., Digitaline., Dig., Ether., Glon., Oxygen inhalation., Sacchar. Off, Saline infusion., Serum ang., Spart., Stroph., Strych.s., Ver.a.

**DYSPNOEA (cardiac)** - Acon. fer., Acon., Adon. v., Adren., Am. c., Apis., Am., Ars., Ars. iod., Aur. m., Cact., Calc. ars., Carbo. v., Chin. ars., Cim., Collins., Conv., Dig., Glon., Iberis., Kali-n., Kal., Lach., Laur., Lycop., Magnol., Naja., Ox. ac., Op., Quebracho., Spig., Spong., Stroph., Strych. ars., Sumb., Viscum., See Respiratory System.

**DEGENERATION, fatty** - Adon., aest., Adon. v., Am., Ars. iod., Ars., Aur., Bar. c., Caps., Coff., Crotal., Cupr., Cim., Crat., Cupr.ac., Fucus., Kali. c., Kali feroc, Kal., Phos. ac., Phos., Physost., Phyt., Sacchar. of, Stroph., Strych. ars., strychn. p., Vanad

**DILATATION** - Adon. v., Am c., Ars. iod., Ars., Bar. c., Chlorof Cact., Cim., Conv., Crat, Dig., Gels., Iberis., Laur., Lil., Lyc., Nux., Naja., Phaseol., Phos., Physost., Plumb., Prun. sp., Spart. s., Spig., Stroph., Tab., Ver. v., See Debility, muscular.

**HYPERTROPHY** - Acon., Amyl-nitr., Arn., Ars., Asper., Aur., Bell., Brom., Cact., Caffeine, Caust., Cerreus., Conv., Crat., Dig., Glon., Iberis., Iod., Kal., Kali carb., Kalm., Lith., Lil. t., Lycop., Naja., Natr. m., Nux., Phos., Phyt., Plumb., Rhus. t., Spig., Spong., Stroph., Strych. ars., Ver. v., Viscum. Hypertrophy uncomplicated, of athletes - Am., Brom., caust., Rhus. t.

## **FREQUENTLY USED LOW POTENCY HOMOEOPATHIC MEDICINES IN CHF**<sup>9,10,11,12,13,14,16</sup>

### **Defining Key Words**

1. **ARDS**= Acute Respiratory Distress Syndrome.
2. **CHF**= Congestive Heart Failure
3. **CKD**= Chronic Kidney Disease
4. **CAD** = Coronary Artery Disease
5. **HTN**= Hypertension
6. **LVH**= Left Ventricular Hypertrophy
7. **LVF**= Left Ventricular Failure
8. **RVH**= Right Ventricular Failure
9. **T2DM**= Type 2 Diabetes Mellitus
10. **VHD**= Valvular Heart Disease

### **Defining Key Syndromes**

1. **Features of venous engorgement**  
Dyspnoea; edema; dropsy; Anasarca; Oligo or Anuria; Hepatomegaly; White pasty stools
2. **Features of cardiac dyspnoea**  
Breathlessness; Dyspnoea on lying (Orthopnea); Cough with or without hemoptysis; Cyanosis; Clubbing.
3. **Features of gastric irritability**  
Indigestion; Heartburn; Flatulence; Abdominal discomfort; Constipation or Diarrhea
4. **Features of Cardiac Irritability** Rapid heart action. Precordial pain with constriction, tenderness around the region of the Heart. Pulse, weak, irregular, intermittent, tremulous, rapid. Palpitation from nervous irritation, with oppression around heart.

#### **1. ADONIS VERNALIS**

##### **CHF + CKD +/- ALBUMINURIA\_+/- EDEMA;DROPSY;ASCITES**

- RVF Predominant with features of venous engorgement
- Low vitality, with weak heart and slow, weak pulse.
- Precordial pain, palpitation, and dyspnoea. Marked venous engorgement.

#### **2. APOCYNUM CANNABINUM**

##### **CHF + VENOUS ENGORGEMENT + EDEMA; DROPSY; ASCITES + GASTRIC IRRITABILITY + THIRST +/- CKD**

- RVF Predominant.
- This is one of our most efficient remedies, in Ascites, Anasarca and Hydrothorax, and urinary troubles especially suppression and strangury. (Cardiac or Renal)
- The dropsy is characterized by great thirst and gastric irritability.
- Mitral and Tricuspid regurgitation.

- Ascites with Watery stools. Sense of oppression about the epigastrium and chest
- Modalities: Worse, cold weather; cold drinks; uncovering.

### **3. CONVALLARIA MAJALIS**

#### **CHF + VENOUS ENGORGEMENT + DILATATION OF HEART**

- RVF Predominant with Dilation of Heart with features of Venous Engorgement.
- A heart remedy. Increases energy of hearts action, renders it more regular. Of use when ventricles are over-distended and dilatation begins, and when there is an absence of compensatory hypertrophy, and when venous state is marked.
- Endocarditis with extreme dyspnoea.
- *Sensation as if heart ceased beating, then starting very suddenly.*
- Palpitation from the least exertion.
- Tobacco heart, especially when due to cigarettes..
- Angina pectoris. Extremely rapid and irregular pulse.
- Modalities: Better, in open air. Worse in warm room.

### **4. CRATAEGUS**

#### **CHF + INSOMNIA**

#### **HTN + T2DM + CAD + INSOMNIA + TYPE A Personality**

#### **CHF + DYSPEPSIA + NERVOUS PROSTRATION**

- A cardio-tonic. No influence on the endocardium.
- Myocarditis. Failing compensation. Irregularity of heart. Insomnia of aortic sufferers; anemia; edema; cutaneous chilliness. High arterial tension. Is a sedative in cross, irritable patients with cardiac symptoms.
- Chronic heart disease, with extreme weakness. Very feeble and irregular heart action. General anasarca.
- *Arteriosclerosis. Said to have a solvent power upon crustaceous and calcareous deposits in arteries.*
- Modalities : Worse, in warm room. Better, fresh air, quiet and rest.

### **5. IBERIS AMARA**

#### **CHF + DILATION/ HYPERTROPHY + CARDIAC DYSPNOEA + NO DROPSY**

#### **PALPITATION + VERTIGO + CHOKING IN THROAT**

- LVF Predominant with Dilation of Heart or due to Hypertrophy of heart with features of Cardiac Dyspnoea.
- State of nervous excitement. Has marked action upon the heart. Possesses great efficacy in cardiac diseases.

- Violent palpitation *induced by slightest exertion, or by laughing, or coughing. Darting pains through heart. Cardiac dyspnoea. Tachycardia.*
- Influenza Heart
- Modalities: Worse, lying down; on left side; motion; exertion; warm room.

## **6. LAUROCERASUS**

**CHF + DILATION/ HYPERTROPHY + CARDIAC DYSPNOEA + CYANOSIS +/- HEMOPTYSIS**

**CHF + VHD**

- Spasmodic tickling cough, especially in cardiac patients, is often magically influenced by this drug.
- *Lack of reaction*, especially in chest and heart affections.
- *Drinks rolls audibly through esophagus and intestines.*

## **7. QUEBRACHO/ASPIDOSPERMA**

**CHF + CYANOSIS**

**ARDS + CYANOSIS**

- The digitalis of the lungs. (Hale). It stimulates respiratory centers and increases oxygen in the blood.
- “Want of breath” during exertion is the guiding symptom.
- *Cardiac asthma*: Due to Acute Pulmonary Embolism or Pulmonary Stenosis.

## **8. LYCOPUS VIRGINICUS**

**CHF + VHD + HYPERTHYROIDISM +/- CYANOSIS +/- HEMORRHOID**

**CHF + VHD + CARDIAC DYSPNOEA**

- LVF Predominant with features of Cardiac Dyspnoea
- A heart remedy, and of use in exophthalmic goiter and hemorrhoidal bleeding. Indicated in diseases with tumultuous action of the heart and more or less pain. Hemoptysis due to valvular heart disease.
- Tobacco Heart, Rapid heart action of smokers. Precordial pain; constriction, tenderness, pulse, weak, irregular, intermittent, tremulous, rapid.
- Cyanosis. Hearts action tumultuous and forcible. Palpitation from nervous irritation, with oppression around heart. Cardiac dyspnoea.

## **9. RAUWOLFIA SERPENTINA**

## HTN + CAD + INSOMNIA

- In high blood pressure without marked atheromatous changes in the vessels.
- It also acts as a sedative.

## 10. SPARTIUM SCOPARIUM

### CHF + HTN + CKD + NERVOUS IRRITABILITY + GASTRIC IRRITABILITY

### CHF + CRF +/- ALBUMINUREA\_+/- EDEMA; DROPSY; ASCITES

- RVF Predominant with Dilation of Heart with features of Venous Engorgement
- Tobacco Heart
- Angina pectoris. Irregular action disturbed rhythm due to gas, etc., feeble in nervous hysterical patients.
- Myocardial degeneration, falling compensation, cannot lie down. Here it produces much comfort. Has specific action upon the kidneys, enabling them to eliminate and relieve the distress upon the heart. It weakens the cardiac contraction. The total amount of urine is increased. The drug has therefore diuretic properties and is useful in dropsy.

## 11. STROPHANTHUS HISPIDUS

### HTN + CHF + FLATULENCE + DEPRESSION

### CHF + GASTRIC IRRITABILITY + CARDIAC DROPSY

### CHF + LVH due to VHD

- RVF Predominant with features of Venous Engorgement
- May be used with advantage to tone the heart, and run off dropsical accumulations. In small doses for weak heart ; It feels enlarged. In mitral regurgitation, where edema and dropsy have supervened.
- Strophanthus occasions no gastric distress, has no cumulative effects, is a greater diuretic, and is safer for the aged, as it does not affect the vaso-motors.
- After the long use of stimulants; *irritable heart* of tobacco smokers. Arteriosclerosis; rigid arteries of aged. Restores tone to a *brittle* tissue, especially of the heart muscle and the valves. Especially useful in falling compensation dependent upon fatty heart.
- Anemia with palpitation and breathlessness.
- Pulse quickened. Hearts action weak, rapid, irregular, due to muscular *debility*; and *insufficiency*. Cardiac pain.

## 12. SUMBUL-FERULA SUMBUL

## **CHF + DYSPNOEA + HYSTERICAL/ NERVOUS SYMPTOMS**

### **HTN + LVF + CAD**

- LVF Predominant with Hypertrophy of heart with features of Cardiac Dyspnoea.
- Has many hysterical and nervous symptoms, and is of use in neuralgic affections and anomalous, functional, cardiac disorders.
- At issue remedy for sclerosed arteries.
- Nervous palpitation. Neuralgia around left breast and left hypochondriac region. Cardiac asthma. Aching in left arm, heavy, numb and weary. Loses breath on any exertion. Pulse irregular.
- Modalities- Worse, active exercise; left side.

### **13. VISCUM ALBUM**

### **CHF + LVH due to VHD + DYSPNOEA + HYPOTENSION**

- LVF Predominant with Hypertrophy of heart with features of Cardiac Dyspnoea.
- Hypertensive albuminuria. Valvular disease, with disturbances in sexual sphere.
- Hypertrophy with valvular insufficiency; pulse small and weak; unable to rest in a reclining position.
- Palpitation during coitus. Low tension. Failing compensation, dyspnoea worse lying on left side.
- Weight and oppression of heart; as if a hand were squeezing it; tickling sensation about heart.
- Modalities- Worse, winter, cold, stormy weather; in bed; lying on left side.

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