case studies using

THE BÖNNINGHAUSEN REPERTORY

Therapeutic Pocketbook Method

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Summary

Expanding on our earlier introductory comments within this Journal,(1) we herein demonstrate the application of Bönninghausen's unique *repertorial method* both *wholly* & *solely* encapsulated within his *Therapeutisches Taschenbuch* (TT),(2) utilising our English language TT republication, *The Bönninghausen Repertory* (TBR),(3) with case examples successfully treated using TBR alone, thereby highlighting its simplicity, accuracy, and depth of therapeutic scope.

Using TBR

The exclusive application of TBR(4) in my own practice for over four years,(5) coupled with our more recent examination of Bönninghausen's earlier repertories,(6) have together provided valuable insight towards the most efficient application of this method in the clinical situation. Whilst it is not possible (nor is it my purpose) within these few pages, to thoroughly examine and discuss the method and its effective application using our TBR,(7) the following case studies(8) are nevertheless offered as a follow up to my earlier article,(9) as examples of the case analysis, the use of TBR, and the effectiveness of the method in the treatment of chronic cases.

Terminology

Presenting (main) complaint: That complaint(10) which is the most bothersome and/or for which the patient seeks treatment. Sometimes, the patient seeks treatment for a less significant complaint, simply because they believe their other complaints are not able to be helped, or they are unaware of the gravity or urgency of other discernible signs, and the practitioner must determine which complaint in each case is to be considered as the focus of treatment.

Concomitant complaint: All other complaints co-existing with the presenting complaint. Concomitant complaints may be seen in syndromal relationship to the presenting complaint. In a chronic case which develops over a longer term, the concomitant complaints may even pre-date the main or presenting complaint for which the patient seeks treatment.(11) Their connection to the main illness may be established without doubt when a single remedy covers both the main and the concomitant complaints.(12) Concomitant symptoms wherever present, must be considered for a case to be regarded complete.

As far as is possible, a *complaint* (collection of presenting or concomitant symptoms) must be defined by its specific *location*, and *modalities* (which must themselves be characteristic (consistent)).

Cases

1. *Plantar wart*

   MD, 31 years, female, full-time mum. Presented with a single very large and very deep plantar wart on her left sole, in the region of the ball of the foot (between digits 2-3) which had been growing slowly over the previous 6-7months. Surgery was advised but without promise of either success (high incidence of recurrence after surgical excision), or that no neural deficit would result from the surgery in such a sensitive, nerve rich region.

   Symptoms: Plantar wart, around 2cm diameter, with a very thick core and very sensitive to pressure. The wart looked more like a very thickened stratum corneum without visible roots, and the centre was particularly thick and hard (hyperkeratotic). The wart was at times painful *per se*, a sharp pain, which was particularly exacerbated if standing on the part, especially on a hard surface (a rock, etc). Generally feels unwell in hot weather, or if becomes overheated (through exertion etc.) No other ascertainable symptoms. Rubrics:

   TBR358 Foot, Sole + TBR1908 Skin, Warts, Horny + TBR1916 Warts, Stitching
   TBR2668 *Aggr*. Walking, on cobble-stone (stone pavement, uneven surface)
   TBR2099 *Aggr*. Warm air, + TBR2104 *Aggr*. Warm, heated, becoming

   Whilst the concomitant complaint modalities relating to a general feeling of being "unwell" were not necessary for the homœopathic diagnosis (remedy selection) in this case, they have been included to demonstrate the depth of coverage of this remedy for the whole process of illness in this case. Hahnemann's MMP (*Materia Medica Pura*) confirms our choice with the following clear descriptions:

Ant-c.CK/CD386 "Great sensitiveness of the soles of the feet to walking, especially on stone pavements…"
Ant-c.CK/CD387 "Large horny places on the skin of the sole of the foot, near the beginning of the toes, paining like corns, and always returning after being cut out."
Ant-c.CK/CD409 "He feels ill in the heat of the sun and the warm air, even with light motion and work."

Indeed, there could be no better description for this patient's plantar wart, and quickly revealed by using the TBR to simply combine the characteristic components which precisely define the complaint.

Rx: Ant-c 30 (L) b.d.(13) Three weeks later she reported a marked improvement in the pains - she can now stand on that foot without discomfort (even on hard surfaces), also able to walk normally, and for long periods without difficulty. No stitching pains per se. On examination, the "wart" measured around half its original size, and the central core was slowly exfoliating to reveal a softer base. *Rx: Ant-c 30 (L) b.d.*

4 weeks later: almost no visible "wart" – just an area of hardened skin. Still some pain if standing on hard surface (esp. on a rock etc.). *Rx: Ant-c 30 (L) b.d. to continue*
4 weeks later: Hard centre of old wart area fell off. Now the area is flatter, and smaller. No real pain - just some discomfort experienced after prolonged standing - not even painful if walks over a rock. Very happy with results. *Rx: Ant-c 30 (L) b.d. to continue.* Patient was discharged 1 month later and has not returned.

2. *Remittent Cough*

C.T., 3 years, female. Presented 13 March 2002 with history of remittent cough since a severe attack of acute bronchitis 2 years earlier which was associated with violent cough ending only after vomiting. The (now dry) cough, which is associated with heat all over body, comes in episodes which increase in violence, yet even between episodes, she is never quite free of cough. She is particularly worse during the winter months and sleeps with head elevated which helps settle the cough. Pitiful when sick. Rubrics taken:

TBR736 Cough, expectoration, without + TBR1404 Generals, Spasms
TBR2111 *Aggr*. Winter + TBR2453 *Aggr*. Lying with head low

These rubrics sufficiently defined the remedy for this case. *Rx: Puls.30 (L) o.m.*

03 April 02: For first 4 days of taking medicine, coughed up lots of green mucous. Since then, has had no cough. No fever. Looks well. Lungs clear on examination. *Rx: Puls. 30 (L) o.m. to continue*.
24 April 02: Remains well. No signs of a any problems. Parents very happy. *Rx: Puls 30 (L) o.m. to continue.*

Note the rubric TBR1404 (Generals, Spasms) refers to spasmodic (episodic) phenomena, not simply to muscle spasms (which may be found under the section on *muscles*). Whilst there were other features which could have also added to the repertorial consideration (eg., TBR2658 *amel*. after Vomiting; TBR2353 *aggr*. during Heat [concomitant to the cough episode]), the rubrics selected pointed out the main contenders, which could easily be further distinguished without repertorial aid. It is best to remember that the repertory, any repertory, is merely an aid, and the final selection must be based upon the data of provings.

3. *Recurrent Cough*

L.C, 8 years, male. Presented 6 June 2002 with history of recurrent coughs, which would come each winter. At 12 months of age, was diagnosed with asthma (parents stopped all inhalors over 2 years ago). Condition begins with cough at night, and usually persist all winter. Other symptoms: epistaxis for no reason, since last few years; poor comprehension – at times, can't even seem to understand a simple question such as "where are you going", or "where is your jacket" – seems confused and as if his brain just doesn't function. He is very embarrassed about this, especially at school where he is doing poorly. Rubrics:

TBR2111 *Aggr*. Winter (PM) + TBR143 Epistaxis (CC) + TBR1069 Comprehension difficult (CC)

Note: The aim in each case is to use the least possible number of rubrics, since the repertory is only used as a pointer to the materia medica, which may then be consulted for the remedy selection. These three rubrics provided me with sufficient direction, being sufficiently familiar with the respiratory symptoms of this remedy in Hahnemann's MMP, to make my selection quickly. *Rx: Rhus-t. 30 (L) o.m.*

05 July 02: Cough much better. No epistaxis. Comprehension seems better also. New symptom: Pain in penis after urination. *Rx: Rhus-t 30 (L) o.m. to continue.*

02 August 02: No cough. No epistaxis. Comprehension great. *Rx: Rhus-t 30 (L) 1 dose every 2nd day.*

I treat the whole family, and the parents recently reported (April 2003) this child remains cough free and comprehension remarkable, even the teachers have commented. No other symptoms.

Notes:

1. In this case that the individuality of this case was sufficiently distinguished by the presenting symptom modality coupled with two concomitant complaints. It is, as Bönninghausen stated, most often that the *combination* of characteristic (though individually not sufficiently distinguishing) symptoms of a case, which itself provides the necessary distinction. The separation of areas affected (respiration, nose, mind), in this single case provided a sort of triangulation to zero in on its specific remedy, without the necessity for finer detail being explored in each particular area.

2. Whilst the new symptom reported at the second consultation fitted well the symptoms of Rhus., (*Rhus*.MMP465 "Great smarting on the front part of the urethra, continuing during and after micturition… ", MMP466 "…smarting in the urethra, during and after micturition."), nonetheless, it was not disturbing enough (to the patient) to warrant a change in the prescription. It is not uncommon to observe such minor new symptoms appear during the course of treatment in chronic cases, however, they are often transient, and will disappear without further attention. Only when they persist and now significantly affect the patient do they demand our attention.

4. Impetigo

S.S-L., 11 years, female. Presented April 2002 with a diagnosis of impetigo which had begun 6 weeks earlier as a single lesion at left corner of mouth, thought to be a cold sore. But gradually lesions appeared in various places over the body. Lesions were themselves striking – with large (2-3cm) main eruptions surrounded by a circle of smaller vesicles at its perimeter. The other striking feature was that only the left side was affected – left arm, left leg, left corner of mouth, even left side of trunk – a few lesions approached but stayed to the left side of her navel. Rubrics taken:

TBR1964 Ulcers, blisters around, with + TBR1185 Sides, Left.

Rx: Lach. 0/1 t.d. down to b.d. (with improvement). Mother reported back 5 days later with "great improvement" – no new lesions, old lesions drying and getting smaller. Skin completely clear after 2 weeks. Still no recurrence after three months.

It is uncommon for to require or depend upon "sides" in a case of illness, since symptoms must appear somewhere; but a particular side, or locality, may indeed be considered significant when, in a fully developed disorder, it remains the consistent focal point. This case was clear in that the lesions approached, but did not cross the midline, even though the condition had ample opportunity to do so over the previous 6 week period of its existence. Note also that the exact description of the eruption was instrumental in defining the nature of the illness for the sake of reaching a homœopathic diagnosis (remedy selection).

5. Chronic sinusitis

MM, 39 years, female, horticulturist: Presented in November 1998 with recurrent sinusitis for many years, with 'searing' pains in, and puffy swelling of the cheeks, with a feeling of fullness (congestion) in the face, and accompanied by some yellowish/greenish nasal catarrh. The facial pains would, at their worst, extend into the teeth, were worse on the left side, and < lying on that (painful) side (which increased the fullness sensation and puffiness in the cheek lain upon). The pains were typically *aggr*. noise, light, strong odours (even of coffee), heat, but especially reproducible by a *loss of sleep*, to the point that she would leave an engagement or function early, in order to ensure a sufficient length of sleep.

She had a history of migraines (still quite frequent at presentation) since the age of 8 years, and extensive diagnostic investigations were clear. The pain often was focused behind one (usually the left) eye, and was preceded by black floaters (*muscae volitantes*). Also in the history, 2 years earlier, she had an endometrial ablation due to *very frequent and profuse menstrual flow* (with clots), accompanied by lower back pains and swelling of the vagina & vulva region. The rubrics taken for the case were:

TBR716 Coryza, obstructed
TBR2459 Aggr. Lying painful side
TBR 2599 Aggr. Sleep, loss of

These above rubrics combined to cover the presenting (main) complaint. Hahnemann's MMP provided the confirmation necessary for the prescription in such a persistent and inveterate illness:

MMP635-646 (coryza)
MMP186-219 (teeth & jaw pains)
MMP103,107,110 (swelling of cheeks)
MMP1095-7 (persistent nasal obstruction)
MMP147 (floaters in field of vision)
MMP602 (swelling of the vagina)

Rx: Nux-v. 30 (liquid) b.d. She reported back by telephone 2 weeks later, that she had some aggravation initially, but after 2-3 days her sinusitis (fullness in the head and face, etc.) had completely vanished within 3 days. She cancelled her follow-up appointment.

July 2000, she again consults me, but this time for her migraines, which have gradually become more uncomfortable - no return of her sinusitis (head feels completely clear). On examining the symptoms of her migraines, they were unchanged from her previous record, the worst modality being the *loss of sleep*. She also complains about her weight-gain over the past few months, due to the fact that she has had an uncontrollable desire to eat, and usually junk food.

Apart from the symptoms already covered by *Nux vomica*, the profuse menstrual flow (TBR645) and the voracious appetite (TBR376) are well covered by the original prescription. The following symptoms from MMP are noteworthy for this case:

MMP25 "In the morning, headache as if he had not slept enough"
MMP43 "Aching pain in the forehead, as if he had not slept enough"
MMP44 "Aching pain over the left eye"
MMP45 "Aching pain over the right orbit…when he lies on the right side, …going off when he lies on the opposite side"
MMP604-610 (Menses too frequent)

Rx: Nux-v. 30 (liquid) o.m. Returned 8 September 2000 reporting "I feel very well". She has had only 4 migraines since beginning the remedy, and each time it was triggered by late night functions (which she has frequented more often, due to the improvement in her condition). Her sleep quality is better – waking without that dull head. Also, a long-term easy tendency to gagging (on brushing teeth, unpleasant odours, etc) has markedly diminished.

6. Chronic palmar dermatitis

JE, 50 years, female, bank teller. Presented 25 October 2000 with dermatitis, affecting the hypothenar eminences and extending to the palmar surface of both hands. The affected areas were marked by hard desquamations (hard flakes of skin) which had to be picked-off, exposing a painfully raw surface beneath. Patient linked the onset of this condition with the onset of her menopause (3 years earlier). Other symptoms:

Sinusitis: frequent and severe, at worst times with strong pains extending over the face
Feeling of 'lightness' in the legs at night in bed (almost every night)

This case was fairly straightforward. The *presenting complaint* was identified in the location, TBR329 Palm, and nature of the complaint clearly described under TBR1775 Eruptions, Hard. The combination of concomitants was equally defining: TBR716 Obstructed coryza + TBR1311 Lightness feeling in the limbs. Even though there were no striking modalities, the combination of other (lesser) characteristics proved sufficient to identify the remedy for this case. *Rx: Spig. 30 (L) o.m.*

November: Hands improved, the patient reporting that there was less peeling and less need to pick at the hard flakes. No return of the lightness sensation in her legs. Interestingly, her ankles, which were constantly swollen since the age of 14 years (which she had not mentioned to me before), and for which she had been on diuretics (*Moduretic*) all that time, have also improved. *Rx: Spig. 30 (L) o.m.*

December: Hands much better - still peeling, but look much smoother and flakes of skin are not so hard. Feeling much better in herself. Ankles still less swollen. No sinusitis. *Rx: Spig. 30 (L) o.m.*

This case continues to do well on infrequent doses of *Spigelia*, with intercurrent *Pulsatilla* when a change of symptoms demanded it (anxiety + weepiness + concordances (14) to *Spigelia*).

7. Aggressive psychosis

S.T., 14 years, female: Presented 10 August 2001 with severe emotional disorder which seemed to date back to her having been "bashed" 12 months earlier (also coincided with menarche, and relationship breakup). Symptoms have become worse over the past 6 weeks or so, and no menses since 2 months. Becomes depressed, angry, suicidal. Feels as if "crazy" – talks aloud to herself and hears voices; becomes threatening with lots of foul language ("fuck", "cunt", "shit" etc.), and very aggressive, striking out in anger – wants to hurt people and break things. Not scared of anyone any more – certainly not of any authority. This girl was now feared by her friends at school, and the parents were at a loss to know what to do, and psychiatry had not improved things. Rubrics taken:

TBR1054 Maliciousness + TBR1040 Audaciousness + TBR1074 Insanity (madness in general; *Psychoses*)
TBR642 Menses, suppressed (amenorrhœa)

As the repertory confirmed, this case evidenced a clear picture of a *Veratrum album* psychosis. Rx: Verat. 30 (L) o.m.

01 Sept. 01: Better in general – not so "wild"; not so "rude" or "vulgar". Not hearing any voices, and is now not carrying on conversations with herself. *Rx: Verat. 30 (L) o.m. to continue.*
29 Sept. 01: Had been O.K., but had a "breakdown" and went backwards again. *Rx: Verat. 200 (L) o.m.*
03 Nov. 01: All going well – no dramas. *Rx: Verat. 200 (L) o.m. to continue.*
01 Dec. 01: All fine. Feeling and doing really well. Doesn't feel that wildness nor the need to hurt anyone. Wants to be good and do the right thing. *Rx: Verat. 200 (L) one dose every 2nd day.* This dosage schedule was explained to the father as a precursor to complete withdrawal from treatment by the time the medicine was used up, but to contact me should symptoms begin to recur. I have not been contacted.

In his MMP preamble to *Veratrum album*, Hahnemann states: "Physicians have no notion of the power possessed by this drug to promote a cure of almost one third of the insane in lunatic asylums… because they know not the peculiar kind of insanity in which to employ it…" *Note* the concomitant amenorrhœa was also useful in confirming the remedy selection.

Concluding remarks

As with any repertory, an understanding of the precise meaning of rubric terms is the key to its most effective and efficient use, and this is particularly the case with this repertory whose rubrics are very summarised representations of the materia medica and generally broader in their scope than with other works. Whilst some cases require 5 or 6 rubrics to adequately define their scope, most often only 3 or 4 rubrics (or less) are sufficient.

This fundamental process of understanding rubrics requires a careful and methodical reference to the source materia medicæ (provings) in their original language, and whilst slow and difficult, our own work in this regard over the past few years has not only proved invaluable for our clinical work, but sadly, revealed the many and repeated errors of both omission and comprehension, based partly on a lack of care, and partly on assumptions with regard to meaning by translators without due reference to original sources for an accurate and contextual clarification.(15)

Lastly, these few cases show that the repertorial method of Bönninghausen, through its representative TBR, is applicable to chronic inveterate illness as well as to acute.(16) In fact, this method lends itself more particularly to the treatment of multi-system chronic disorders,(17) where a consideration of the (precisely defined) complaints in their combination is most often required for the homœopathic diagnosis, for which purpose this repertory, from concept to construct, provides a unique and unsurpassed mechanism.

notes

1 AJHM. Vol. 96, No. 2., Summer 2003.

2 Bönninghausen's TT first appeared in 1846 (Münster), being quickly followed by its English translation *Therapeutic Pocketbook* (TPB) completed in the same year. Refer earlier article for the various English language editions.

3 G.Dimitriadis (Ed.): The Bönninghausen Repertory – Therapeutic Pocketbook Method, Hahnemann Institute Sydney, June 2000.

4 To avoid any confusion, it must be stated that the recent "Bönninghausen Repertory" computer programme produced (within a 5-month period) for the *Radar* platform (without reference to the provings for clarification of rubrics), and whose name too closely resembles that of our own work, bares no relation to our TBR (which required 5 years of work for its completion).

5 We had been trialing our TBR manuscript in practice for over 18 months prior to publication.

6 *Systematisch-alphabetisches Repertorium der Homöopathischen Arzneien. Erster Theil, enthaltend die antipsorischen, antisyphilitischen und antisykotischen Arzneien* [Systematic Alphabetic Repertory of Antipsoric Remedies…{SRA}], 1st ed. 1832; 2nd ed. 1833; *Systematisch-alphabetisches Repertorium der Homöopathischen Arzneien. Zweiter Theil, enthaltend die (sogenannten) nicht-antipsorischen Arzneien* [Systematic Alphabetic Repertory of the (so-called) Non-Antipsoric Remedies {SRN}], 1835. Our group at the Hahnemann Institute in Sydney are now examining Bönninghausen's TFR work, to locate errors of typography, language, duplication, omission, etc., for the purpose of republication of a single work: *The First Repertory* (TFR).

7 Refer TBR Introduction on *How to Use this Repertory* for a more detailed account of the method.

8 These cases were amongst those presented at seminars on the Bönninghausen method in Sydney, Auckland, and Wellington.

9 The concepts outlined in that article should be kept in mind by the reader when studying these cases, in particular with regard to the concept of a complete symptom and precisely defined complaint.

10 To remind the reader of my previous article, by 'complaint' I mean a collection of symptom components (sensation/finding, location, modality/ies) which together render the symptom complete (complaint; identifiable condition).

11 Suffice it here to say that disease is best understood as a process (not simply an event) which develops, less or more rapidly, over time and may influence various systems and organs. In chronic disorders, the final pressing symptoms for which a patient presents may indeed be simply the end result of a long and convoluted process of disorder expressing itself through series of symptoms, some of which may have disappeared, either spontaneously or with the help of relieving medications etc., but which nonetheless reflected the single process of disorder.

12 When a single remedy which covers both the presenting complaint and the concomitants can not be found, then the presenting complaint usually forms the focus of treatment. The only exceptions will be when the presenting symptoms are ill-defined (incomplete), and/or the concomitants so strongly distinguished as to their singular character, that the remedy may be then decided on them alone.

13 For many years now, after having carefully studied the writings of Hahnemann on the matter, I have adopted a particular approach wherein both *Centesimal* and *50 Millesimal* ('0/' or 'Q') potencies are given in the same manner, without presumption of potency-based effect variance. Only in this way can we then attribute any differences to potency alone. This has provided some important conclusions for my own practice, but this is not the place to expand on that topic.

For dispensation purposes, I label my liquid preparations (centesimal potencies) with the suffix (L), in order, firstly, to distinguish it from the so-called 'radionically prepared potencies', and secondly, to indicate they are not precisely the potency from the manufacturing pharmacy (say, 30 centesimal), but rather, the solution of two globules into a specific amount of liquid, succussed prior to administration.

14 This most helpful chapter on the concordances developed by Bönninghausen, is as simple to use as it is brilliant in its conception and utility. Whilst this is not the place to expand on the matter, that it has been too often completely misunderstood can be evidenced by A.H. Okie, in his 1847 English language TPB, was so ignorant as to have omitted it, brazenly stating "As this is a subject upon which, at the present, we have but little experience, and as the author's concordances seemed to offer nothing new or of a really practical nature upon this subject, I have omitted it…"). But, as I have myself discovered and shown at my seminars, it is not too difficult a task to comprehend

the construct and application of this chapter (even though Bönninghausen did not leave any particular direction in this regard), and the results speak for themselves.

15 Our work on the TFR of Bönninghausen has been even more revealing in this regard, and has uncovered unexpected mistakes of past (even well-known) authors which must, at all cost, be avoided in any future work. It is our intention to present our findings with the republication of the TFR. It is to be noted that these errors have not only been reproduced within republications of old works, but are being added-to by present day translators who not only fail, but consider it unnecessary, to consult the original sources before deciding on meaning. Specific examples from familiar modern works may form the subject of another article.

16 It is simply an error to assume that the method is suited mostly or only to the acute or one-sided diseases.

17 My own practice and that of my close colleagues see mostly such chronic cases (including so-called ‘mind’ disorders). Because our system of therapy is not covered by our ‘Medicare’ national health scheme, patients usually seek our help as a last resort, after having been elsewhere (usually to many physicians and medical specialists). These patients often have a long history of treatment (allopathic, including herbal, naturopathic, chiropractic, etc.), dietary, and other changes in an effort to get better, and our experience even in these cases shows not only the effectiveness of the well selected homœopathic remedy (over and above the patient’s other medications), but also the simplicity and speed of prescribing using TBR.

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