



Homeopathic/Isopathic Meridian Therapy

Primary Chronic Polyarthritis (PCP)

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Etiology and Pathogenesis

Primary chronic polyarthritis, or rheumatoid arthritis, is a systemic illness, which proceeds either continuously or with episodic attacks; it is considered to arise on a familial basis. According to orthodox medicine, its etiology and pathogenesis are unknown. Professor Enderlein's view is that long term abnormal bacterial flora and congestive conditions should probably be considered as significant factors in the disease's origins. The widespread view of PCP as an autoimmune disease does not say much, since it doesn't address factors and causes.

Rheumatism factors as Anti-IgG antibodies have been confirmed in about 80% of PCP cases. Most cases of juvenile rheumatoid arthritis, and patients in the first 4-8 months after onset of the disease, are serologically negative. The disease usually appears between the ages of 30 and 50, attacking women 3 to 5 times more frequently than men which points to endocrinological factors in the disease's origin. Climate seems also to have a considerable influence, since there are more cases of it in cold, wet regions.

Clinical Characteristics

Onset of the disease is not usually acute; instead, it insinuates itself slowly, with general symptoms such as fatigue, lack of appetite, weight loss, paresthesia, puffy fingers, circulatory disorders, pain in the basal and medial joints of the fingers and toes (symmetric on both extremities) and morning joint stiffness. The ailment then

migrates from the finger joints via the wrist joints and elbows up to the shoulder, or from the toes via the ankles and knees to the hip joints. Inflammatory attacks in the preliminary stages of the disease in the form of joint effusions accompanied by reddening, overheating and motion and pressure pains in the joint regions often remit spontaneously.

Course of Illness of PCP

In the disease's advanced stages, the inflammatory attacks deform joints in various ways and degrees of severity. The disease can take one of three courses:

1. Exudative arthritis with periarticular edema and impaired mobility due to swelling of the soft tissue
2. Fibrous arthritis with impaired mobility due to capsule atrophy and rubbing sounds due to proliferative synovitis
3. Bony ankylosis with impaired mobility due to total joint stiffness, in which the joint space is hardly visible in an X-ray.

X-ray Findings

There are often no changes visible in X-rays in the early stages of the disease.

The first findings are slight initial blurring of the joint surface image, narrowing of the joint space; later on, gradual destruction of spongy bony parts, osteolysis, mutilations and osteoporosis on up to dystrophy. In the later stages, there is no visible joint space, and subluxations, luxations, ankylose

and synostoses make their appearance.

Laboratory findings

BSR is noticeably higher, especially in the initial stages and during acute episodes. There is a demonstrable increase in gamma globulin (and, in acute cases, in alpha globulin as well). The chronic stage frequently exhibits hypoalbuminemia as well as hyper-gamma-globulinemia. Other findings include - besides the aforementioned rheumatic factors - positive CRP, low serum iron level, anemia, elevated serum copper level, increase in plasma fibrinogen and, usually, leukocytosis during acute phases.

Special Forms of PCP

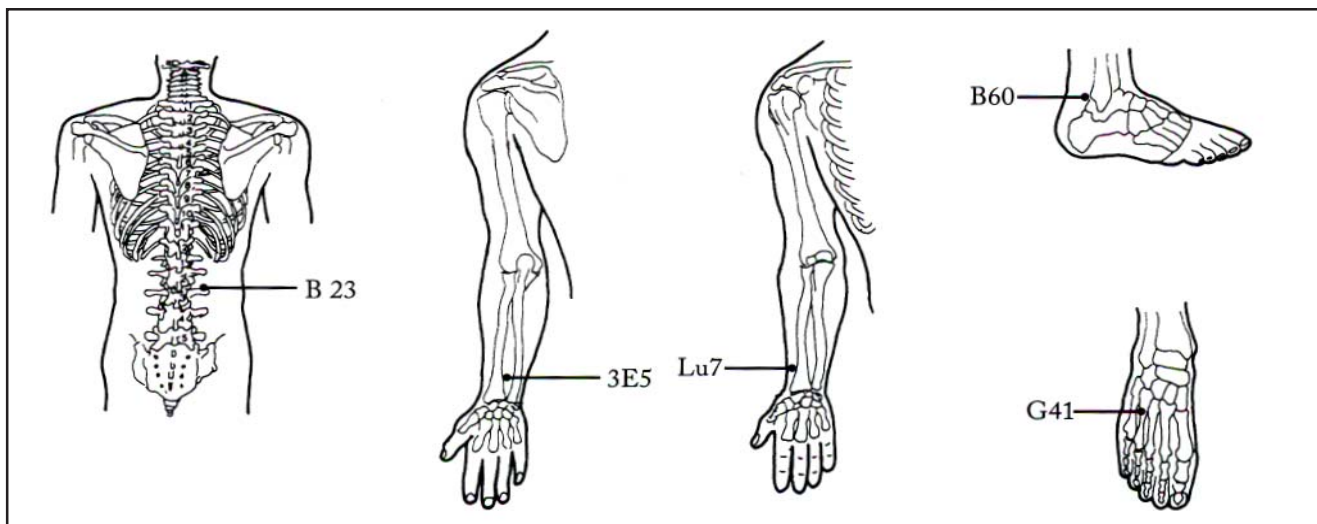
Special forms of PCP include: Still's syndrome (juvenile chronic polyarthritis), Felty's syndrome (chronic seropositive polyarthritis with splenomegaly, leukopenia and yellowish-brown skin pigmentation), Sjogren's syndrome (seropositive PCP with keratoconjunctivitis sicca and xerostomia), psoriasis-arthritis (joint ailments don't appear until years after the onset of chronic psoriasis).

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Therapizing PCP

A. Injections in the following acupuncture points with:

Bacillus subtilis 6X (1 amp.) + *Mucor racemosus* 6X (1 amp.) + lactic acid (1 amp.)

ABBR.	DESIGNATION	LOCALIZATION
B23	Shen Shu, transport point to kidney	2 fingerbreadths laterally from the vertebral spinous process of the 2nd lumbar vertebra
B60	Kun Lun, Tibetan mountain name	In the hollow between the outer malleolus and the achilles tendon
3E 5	Wai Guan, Outer Pass	2 cun proximal to the carpal transverse fold of the back of the hand between radius and ulna
Lu7	Lie Que, Bottleneck	At the styloid process of the radius, 1.5 cun above the wrist fold
G41	Zu Lin, Tear Descent	In the proximal angle between metatarsal bones IV and V

Recommended therapy: slowly inject 0.2-0.5 ml SC in each point twice weekly.

Note: one may sometimes note some reddening at the injection site after SC injection of *Bacillus subtilis*, but this will fade quickly on its own.

B. Autologous blood treatment

The injections are administered at five-day intervals, SC initially, then IM.

1st injection: 0.2 ml AB + 1 amp. Drosera/Echinacea angustifolia/juglans complex SC

2nd injection: 0.3 ml AB + 1 amp. Drosera/Echinacea angustifolia/juglans complex SC

3rd injection: 0.5 ml AB + 1 amp. Drosera/Echinacea angustifolia/juglans complex SC

4th injection: 1.0 ml AB + 1 amp. Drosera/Echinacea angustifolia/juglans complex SC

5th injection: 1.5 ml AB + 1 amp. Drosera/Echinacea angustifolia/juglans complex SC

6th injection: 2.0 ml AB + 1 amp. Drosera/Echinacea angustifolia/juglans complex SC

It is not necessary to increase the amount of autologous blood any more than this. The patient's reactive state determines how long the injections are to be continued.

C. Additional medicinal therapy

Zincum gluconicum 3X dilute drops, take 5 drops 1-3 times daily.

Aspergillus niger 3X suppository, insert 1 suppository once daily before going to bed.

Bacillus firmus 4X and *Mycoacterium phlei* 4X ampules, alternate 1 ampule every 3-4 weeks IM.