

THE EFFICACY OF FOLLICULINUM IN THE
TREATMENT OF
PREMENSTRUAL TENSION

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THE EFFICACY OF FOLLICULINUM IN THE TREATMENT
OF
PREMENSTRUAL TENSION

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I, Karen Andrea Kirtland, do hereby declare that this research
dissertation is my own work and has not been presented for any
other diploma or another Technikon or University.

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DEDICATION

To my parents for their endless love, support, guidance and
patience.

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ABSTRACT

The purpose of this investigation was to evaluate the effect of Folliculinum 15CH on a patient experiencing premenstrual tension, with reference to the patients perception of the treatment, in order to determine how effective Homoeopathy is in the treatment of premenstrual tension. A sample of 31 patients was conveniently selected from the greater Durban area, and from this sample 16 patients were treated with Homoeopathic medication and the remaining 15 patients received placebo treatment. Patients were screened using a series of delimitations. The patients participating in the research project were then asked to sign a consent form.

An extensive case history was performed on each patient at the first consultation. The following information concerning the symptoms was obtained from the patient: whether the symptoms occurred in the second half of the menstrual cycle, increased in severity as the cycle progressed, were relieved at the onset of menstruation, were absent in the post-menstruum, and whether the symptoms were present for two or more consecutive cycles. The case was reassessed at each subsequent visit over the following six months. At each consultation the patient was informed as to how to take their medication and they were given questionnaires to complete regarding their perception of the treatment.

The study was conducted using the double blind protocol having a neutral pharmacist dispense the medication/placebo to the patients.

The hypothesis was tested using the Mann-Whitney U test, it is an excellent alternative to the t-test and it does not have the restrictive assumptions and requirements associated with the t-tests (Siegel 1956). On performing the Mann-Whitney U tests utilising observations obtained from the questionnaires i.e. Questionnaire One was the Moos Menstrual Distress questionnaire and Questionnaire Two was the Premenstrual Assessment Form, it was seen that there was a statistically significant difference in the following symptoms for the treated group: Muscle stiffness in questionnaire one ($P=0,056$), loneliness in questionnaire one ($P=0,022$), nausea and vomiting in questionnaire two ($P=0,03$), swollen breasts in questionnaire two ($P=0,018$), irritability in questionnaire one ($P=0,014$), mood swings in questionnaire one ($P=0,05$), and depression in questionnaire two ($P=0,03$). Several symptoms appeared to improve but the results were not statistically significant: Skin disorders in questionnaire two ($P=0,08$), loneliness in questionnaire two ($P=0,08$), cramps in questionnaire one ($P=0,075$), swollen breasts in questionnaire one ($P=0,071$), irritability in questionnaire two ($P=0,084$).

This would indicate that the perception by the patient to the treatment was influenced by the homoeopathic medication. The placebo group acted as a control. When testing the hypothesis further, the fourth and sixth sets of observations of both the treated and placebo groups were compared and the following results were obtained: of the treated group 89% improved, 4% remained unchanged and 7% worsened of the symptoms discussed and this is inversely proportional to the placebo group namely 7% improved, 4% remained unchanged and 89% worsened.

UITTREKSEL

Die doel van die ondersoek was om die effek van Folliculinum 15CH te bepaal by pasiënte wat ly aan premenstruale spanning, met spesiale verwysing na die pasiënt se persepsie van die behandeling, met die doel om die effektiwiteit van Homeopatie as behandelingsmetode te bepaal. 'n Groep van 31 pasiënte vanuit die groter Durban gebied is met 'n gerieflikheidsmetode geselekteer. Van hierdie groep is 16 pasiënte met homeopatiese medikasie behandel en die orige 15 pasiënte het 'n placebo behandeling ontvang. Die pasiënte was almal gekeur deur gebruik te maak van 'n aantal uitsluitings en 'n toestemmingsvorm is deur almal onderteken.

Gedurende die eerste konsultasie is 'n uitgebreide gevallestudie afgeneem om vas te stel of die simptome wat gedurende die tweede helfte van die menstruale siklus voorkom, toeneem met verloop van die siklus, verlig met die aanvang van die siklus, verdwyn in die post-menstruale periode en of die simptome teenwoordig was vir twee of meer opeenvolgende siklusse. Die geval is met elke daaropvolgende besoek geevalueer vir ses maande. Gedurende elke besoek is die pasiënt ingelig omtrent die gebruik van die medikasie en 'n vraelys aangaande die pasiënt se persepsie van die behandeling is ingevul.

In hierdie studie is gebruik gemaak van 'n dubbelblinde protokol asook 'n neutrale apteker wat die medikasie voorsien het aan die pasiënte.

Die hipotese was getoets deur gebruik te maak van die Mann-Whitney U toets. Dit is 'n goeie alternatief vir die t-toets aangesien dit nie die beperkende aannames en vereistes van die t-toets het nie (Siegel 1956).

Nadat die Mann-Whitney U toets op die vraelyste data uit gevoer was, soos die Moos Menstruale Spanning vraelys wat vraelys een is en Premenstruele Evaluasie Vorm wat vraelys twee was, is daar statisties beduidende verskille gevind in die behandelde groep van die volgende simptome: Spierstyfheid in vraelys een ($P=0,056$), alleenheid in vraelys een ($P=0,022$), naarheid en braking in vraelys twee ($P=0,03$), geswelde borste in vraelys twee ($P=0,018$), liggeraaktheid in vraelys een ($P=0,014$), buierigheid in vraelys ($P=0,05$) en depressie in vraelys twee ($P=0,03$).

Verskeie simptome het verlig alhoewel dit nie statisties beduidend was nie soos: Velkwale in vraelys twee ($P=0,08$), alleenheid in vraelys twee ($P=0,08$), krampe in vraelys een ($P=0,075$), geswelde borste in vraelys een ($P=0,071$) en liggeraaktheid in vraelys twee ($P=0,08$).

Die resultate toon dat die persepsie van die behandeling wel beïnvloed is deur homeopatiese medikasie. Die placebo groep is as kontrole gebruik. Die hipotese is verder getoets deur die vierde en sesde observasies van beide groepe met mekaar te vergelyk en die volgende resultate is gevind: van die simptome onder bespreking het 89% van die behandelde groep verbeter, 4% het onveranderd gebly en 7% het versleg. Die omgekeerde het in die placebo groep plaasgevind naamlik: 7% het verbeter, 4% het onveranderd gebly en 89% het versleg.

Uit die resultate dit is duidelik dat homeopatie 'n statisties beduidende verskil gemaak het in die pasiënt se persepsie van die behandeling en beheer van die simptome.

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TABLE OF ABBREVIATIONS

<u>ABBREVIATION</u>	<u>FULL WORD</u>
Tx	Treatment
Plc	Placebo
PMT	Premenstrual tension
Q1	Questionnaire one
Q2	Questionnaire two
M1	Muscle stiffness Q1
S2	Skin disorders Q2
L1	Loneliness Q1
L2	Loneliness Q2
C1	Cramps Q1
N2	Nausea and vomiting Q2
B1	Swollen breasts Q1
B2	Swollen breasts Q2
I1	Irritability Q1
I2	Irritability Q2
X1	Mood swings Q1
D2	Depression Q2

INTRODUCTION

Premenstrual ailments are some of the most common disorders suffered by women today and medical science has not yet come up with a perfect solution to this unpleasant condition (Dalton 1984; Keyes 1988). This problem is compounded by the fact that many a doctor claims that premenstrual ailments are all in the mind (Dalton 1984).

Premenstrual ailments are real just ask any women who suffers from one or more of these distressing symptoms, which may present as a mild discomfort to a severe condition. Some women contend with these symptoms for their entire lives, unaware of alternative treatment for this condition.

There are over 100 symptoms which have been identified as premenstrual ailments. They fall into three categories; physical, behavioural and psychological. The most recorded are; bloatedness, including weight gain, breast tenderness, swelling, headaches, depression, anxiety and irritability (Rubinow et al 1986; Dalton 1984).

As yet the cause of Premenstrual Tension has not been identified, let alone a cure, even with extensive research that is being carried out throughout the world.

Despite this common condition orthodox treatment has been palliative, by treating the symptoms in order to alleviate the discomforts experienced approximately 10 days prior to each period. The Natural approach (PMS Advisory Service), a treatment programme extensively used, appears to have found a solution to this disorder. The treatment programme, prepared especially by gynaecologists, combines life style, nutrition and essential vitamins and mineral supplements to ensure maximum relief.

Recurrence or occurrence of this condition adversely affects relationships at home and negatively affects productivity and work efficiency, thus taking its toll and a relief needs to be sort.

In general one can say the "majority of the modern medicines are given for a definite physiological effect on some organ or function of the body...and... most modern drugging, in short is aimed at individual annoying symptoms and makes no attempt to back the constitutional cause of the disease" (Hubbard 1965:168-173) while the "effective use of Homoeotherapeutics requires the physician to know the patient - spiritually, physically and psychologically" (Baker 1990:6-11).

Unfortunately past research on Homoeopathic treatment of premenstrual tension is not extensive but articles by practising homoeopaths (Martinez 1990) produced clinical observations that indicate that Folliculinum does have an effect on symptoms present during premenstrual tension. Folliculinum will be given to a patient after a concise medical and Homoeopathic case history has been taken. The potency of 15CH was selected on the success that Martinez (1990) had. The medicine will address the physical symptoms and attempt to alleviate them i.e breast engorgement, fluid retention, headaches and so on. Then it will address the mental and emotional symptoms relating to this condition i.e sadness, anxiety, depression, social isolation, decreased efficiency and so on.

Solving the symptoms of Premenstrual Tension will bring about welcomed relief to all women that are experiencing these distressing symptoms, thus enabling women to go about their daily

routine free from decreased productivity, decreased personal relationships and with decreased efficiency.

Relief through Homoeopathic research will hopefully allow a woman to consider alternative treatment, knowing that they may obtain relief from such a despairing condition, and Homoeopathy will be recognised as a means of treatment for Premenstrual Tension.

Due to the relatively low cost and easy implementation, Homoeopathy is definitely the most feasible solution in the treatment of premenstrual tension.

It is also extremely cost effective in the long run. It is through this research project on premenstrual tension that a firm contribution can be made to finding a solution for alleviating premenstrual ailments, so that women can lead lives free from any of the presenting symptoms relating to premenstrual tension.

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CHAPTER ONE: THE PROBLEM AND ITS SETTING

1.1 THE PROBLEM STATEMENT

The purpose of this investigation is to evaluate the effect of Folliculinum 15 CH on a patient experiencing premenstrual tension, with reference to the patients perception of the treatment, in order to determine how effective Homoeopathy is in the treatment of premenstrual tension.

1.2 THE HYPOTHESIS

It is hypothesized that there is a statistically significant improvement in the patient's experiencing premenstrual tension, with reference to the patient's perception of the treatment .

1.3

DELIMITATIONS

This study will not accept any subject who is undergoing any other form of treatment for Premenstrual Tension.

No other treatment other than Homoeopathic treatment will be administered.

This study will not attempt to investigate the mechanism of action of Folliculinum.

1.4

ASSUMPTIONS

The patient participating in this study will not take any other medication for the treatment of premenstrual tension other than the Homoeopathic medicine prescribed. It is assumed that the patient will take the medicine as prescribed.

It is assumed that the prescribed medicine will be prepared as defined in the Homoeopathic Pharmacopoeia.

1.5

DEFINITION

PREMENSTRUAL TENSION: A condition of nervousness, irritability, emotional disturbances, headaches, and/or depression affecting some women for up to about ten days before menstruation. The condition is associated with the accumulation of salt and water in tissues. It usually disappears soon after menstruation begins.

FOLLICULIN: Folliculin is a natural hormone secreted by the ovaries; it is estimated biologically, the RAT unit being the smallest quantity of Folliculin required to produce vaginal signs of oestrus in castrated female rats; 140g by subcutaneous injection, at three hourly intervals (Allen and Doisy's test). It is a crystalline compound, white, insoluble in water, the bases unit being the RAT unit, which is international. The first soluble attenuation is the fourth Hahnemannian centesimal (Julian 1979:231).

CHAPTER TWO: REVIEW OF THE RELATED LITERATURE

2.1 OVERVIEW

Premenstrual ailments are some of the most common disorders suffered by women today. Although extensive research is still being done, medical science has not yet come up with the perfect solution.

This literature review will cover as much as possible on premenstrual tension as a subject on its own. Due to its complexities one must know as much as possible, about it before an alternative solution can be proposed.

The following information will be discussed, the definition and causes of premenstrual tension, the typical clinical picture, differential diagnosis, as well as how to diagnose the condition, and how modern medicine treats this complex condition.

Premenstrual Tension is a diverse topic on its own, which needs to be explained and expanded upon before combining it with Homoeopathy. The topic at hand is Homoeopathy and once again, the definition of Homoeopathy will be given, as well as the history of Homoeopathy, the underlying principles and a general but brief description on the practice and art form of the field.

Finally the most important part of this literature review which without the above mentioned parts could not come about, is the interaction of Homoeopathy and Premenstrual Tension. The easiest and most easily understood method I could use was to compare traditional orthodox treatment with that of Homoeopathic treatment, indicating how one differs from the other by stating facts and as many references as possible to show you which treatment is most effective. The homoeopathic picture of Folliculinum will also be included.

2.2 PREMENSTRUAL TENSION

2.2.1 DEFINITIONS AND CLASSIFICATIONS

The definition of Premenstrual Tension (Merck Manual 1987:907), the standard medical dictionary, is: "a condition characterized by nervousness, irritability, emotional instability, depression, headaches, generalized oedema, and mastalgia that occurs during the 7-10 days before menstruation and disappears a few hours after the onset of menstrual flow. There is a gain of weight due to fluid retention..."

In more simpler terms, as put by Collins Paperback English Dictionary (1981) "Premenstrual Tension is nervous tension that may be experienced as a result of hormonal changes in the days before a menstrual period."

The Bantam Medical Dictionary (1982) defines Premenstrual tension as a " condition of nervousness, irritability, emotional disturbances, and\or depression affecting women up to 10 days before menstruation. The condition is associated with accumulation of salt and water in tissues. It usually disappears soon after menstruation begins." Frank, an American Gynaecologist, first defined the syndrome in 1931, his description still stands as a graphic and vivid statement: "The group of women to whom I refer especially complain of feeling indescribable tension from 7-10 days preceding menstruation which, in most instances, continues until the time that the menstrual flow occurs. The patient complains of unrest , irritability "like jumping out of their skin" and a desire to find relief by foolish and ill considered actions. Their personal suffering is intense and manifests itself in many reckless and sometimes reprehensible actions. Not only do they realise their own suffering, but they feel conscious stricken toward their husbands and families, knowing well that they are unbearable in their attitude and reaction within an hour or two after the onset of menstrual flow complete relief from both physical and mental tension occurs."

Dalton (1984) defines premenstrual tension as " the recurrence of symptoms in the premenstruum with absence of symptoms in the postmenstruum."

Magos and Studd (1984) have provided a working definition of premenstrual tension as "distressing, physical, psychological and behavioural symptoms not caused by organic disease which regularly occurs during the same phase of the menstrual (ovarian) cycle and which significantly regresses or disappears during the remainder of the cycle."

Premenstrual ailments are divided into two or sometimes three classifications depending on the source of reference. The first two classifications are physical symptoms and psychological symptoms, the third classification is behavioural symptoms, which is often grouped with psychological symptoms (Dalton 1984).

Physical symptoms according to Watson and Studd (1992) include abdominal bloating, breast tenderness, weight gain, headaches, hot flushes and backache.

The commonest psychological symptoms experienced during premenstrual tension are tension which is recognised as having 3 components: depression, irritability, lethargy and changeable moods also are included in this category. Watson and Studd (1992) state that the psychological symptoms of premenstrual tension include "tension, irritability, tiredness, mood swings, with decreased libido and increased or perverted appetite."

Behavioural changes may include agrophobia, decreased work performance, loss of concentration, absenteeism from work and avoidance of social activities, accidents, criminal behaviour and attempted suicide, which occur more frequently during the premenstrual phase of the menstrual cycle (Watson and Studd 1992).

The most useful classification according to Mims Disease Index (1993-1994) is in terms of severity rather than the type of symptoms i.e

- 1).Mild: Symptoms signal the onset of menstruation. No medical advice sought or needed.
- 2).Moderate: Symptoms are annoying and cause concern but are not sufficient to interfere with functional at home or work. Medical advice is sought in about one\third of cases.
- 3).Severe: Symptoms are such that functions at home or work are disrupted. Medical advice is usually sought-sometimes by the husband or family or employer on behalf of the patient.

2.2.2

AETIOLOGY

Needing to know the cause and pathophysiology will enable us to obtain a greater understanding of the condition and the enable us to find a solution to this common distressing syndrome.

According to all literature read, the aetiology of premenstrual tension is unknown (Dalton, 1984; Mercks Manual, 1987; Keyes, 1988; Wickes, 1988; Chihal, 1990 and Hsia and Long 1990), to name only a few. According to Cecil Textbook of Medicine (Wynngaarden and Smith, 1988) there are numerous theories about the aetiology of premenstrual tension:

An alteration in the ratio of oestrogen to progesterone in the luteal phase.

Alteration in the alpha-melanocyte stimulating hormone or beta-endorphin activity.

Alteration in monoamine neurotransmitters, alteration in prolactin activity.

Increases in the vasopressin secretion.

Alteration in mineralocorticoid secretions.

Alteration in prostaglandins.

Endogenous allergies to steroids (especially progesterone).

Reactive hypoglycaemia and many others.

Dalton (1984) popularised the possibility that premenstrual tension is caused by an imbalance between oestrogen and progesterone during the late luteal phase of the menstrual cycle. Early studies showed progesterone was deficient in the luteal phase in PMT patients.

Rubinow et al. (1986) showed that there was no difference in follicle-stimulating hormone, luteinizing hormone, sex hormone binding globulin, dihydrotestosterone, prolactin, or cortisol between treated and untreated patients.

Chihal (1990:463) also discusses at a central opioid abnormality may be the cause of premenstrual tension. Several opioid-like substances are found in the central nervous system and these endogenous opioids can be affected by levels of sex steroids. The level of beta endorphin increases in the peripheral blood during the luteal phase of the menstrual cycle and presumably the blood levels also reflect an increase in central endorphin. Premenstrual tension could be an opiate withdrawal syndrome. Another proposed theory is abnormal production of prostaglandins that may be responsible for the modulation of catecholamine and beta-endorphin production in the central nervous system. Several studies have shown abnormal prostaglandin precursors in the serum of PMT patients compared to controls. Brush et al. (1900) demonstrated levels of cis-linoleic acid and decreased levels of gamma-linoleic acid. This defective saturation could lead to decrease production of prostaglandin E. This supports the use of evening oil of primrose, because it contains large amounts of gamma-linoleic acid, in the treatment of premenstrual tension. Chihal (1990) states that nutritional deficiencies contribute to the cause of premenstrual tension and that treatment plans for control of PMT contains some dietary suggestions. Many PMT sufferers report "cravings" for a specific food i.e. chocolate, salt , sweets and so on.

Abraham (1983) showed that women with PMT consumed more refined sugar, salt and dietary products than controls. He also suggested that they consumed less B vitamins, zinc, and manganese. He also revealed low red cell magnesium levels in PMT sufferers. Premenstrual sufferers do benefit from good nutrition but there is a lack of evidence that nutritional disorders are the primary cause of premenstrual tension.

2.2.3

CLINICAL PICTURE

Premenstrual complaints are exceedingly diverse. At least 150 different symptoms have been attributed to the premenstrual syndrome (Keyes 1988).

Careful observations of the clinical manifestations of premenstrual complaints are important from a number of perspectives. Both clinical investigations and attempts at treatment need to take account of the particular symptoms experienced by each individual (Keyes et al 1988).

Dalton (1984) cited cases of premenstrual tension beginning around menarche (or even before) and reaching severe levels during adolescence. At the opposite end of the reproductive years, it has been speculated that premenstrual symptoms may worsen for some women during menopause and that some cyclic symptoms may persist for up to two years after menopause (Keyes 1988).

The signs and symptoms of premenstrual tension characteristically occur 10 days to 2 weeks before menses and stops at the onset of menstruation (Tatford 1986).

The most common symptoms of premenstrual tension have been well characterized by Rubinow et al. (1986)

AFFECTIVE

Sadness

Anxiety

Anger

Irritability

Labile Mood

PAIN

Headaches

Mastalgia

Musculoskeletal

AUTONOMIC

Nausea

Palpitations

Sweating

"Hot flashes"

FLUID BALANCE

Bloating

Weight gain

Oliguria

Oedema

COGNITIVE

Decrease concentration

Indecision

Paranoia

"Rejection sensitive"

Suicidal ideation

NEUROVEGETATIVE

Insomnia\Hypersomnia

Anorexia\Food cravings

Fatigue\Lethargy

DERMATOLOGIC

Acne

Greasy\Dry Hair

BEHAVIOURAL

Decreased Motivation

Poor Impulse Control

Decreased Efficiency

Social Isolation

The disorder significantly lowers the quality of life of affected women at home, work and their social lives (Mims Disease Index 1993-1994).

2.2.4 DIFFERENTIAL DIAGNOSIS

The presence of premenstrual symptoms is not in itself definitive evidence of premenstrual tension for the innumerable symptoms can be found in men, children and postmenopausal women i.e. fatigue, abdominal bloating, nausea, dizziness, etc. Dalton (1984) has stated only the common differential diagnoses as seen in a busy premenstrual clinic, and they occur in females between the age of 16-45, and the symptoms occur 14 days before the onset of menstruation. The symptoms will be considered in the order in which they present -that is, at interview, general examination, vaginal examination and on completion of a menstrual chart.

Presenting symptoms:

If the presenting symptoms also occur in the postmenstruum, even to only a mild to moderate extent, then the patient is suffering from menstrual distress and the cause of her symptoms need s further investigation.

Depression may be due to an endogenous depression or anxiety due to neurosis; both conditions require further psychiatric evaluation.

Lethargy may require the exclusion of hypothyroidism by thyroid function tests, and hypokalaemia due to excessive diuretic intake, which can be confirmed by electrolyte estimation.

Bloatedness may be a manifestation of idiopathic oedema resulting from prolonged dieting, excessive diuretics and self imposed fluctuation of sodium and carbohydrate intake.

Breast tenderness and engorgement may result from hyperprolactinaemia which can be confirmed by prolactin estimation.

Headaches and migraine may be caused by specific allergies or prolonged intervals between food.

Asthma may result from allergies, either inhaled or ingested. A common one seen in the premenstrual syndrome clinic is due to sensitivity to aspirin taken to alleviate some other premenstrual symptom such as backache.

Food cravings and compulsive eating may be a manifestation of excessive dieting or bulimia in one who has previously suffered anorexia nervosa.

Physical examination

Hyperandrogenism may occur among disturbed and violent adolescence, who regularly shave their faces and wear jeans and long sleeves so that the evidence of hirsutism is not suspected. Evidence of male hair distribution on the abdomen and buttocks, together with raised testosterone and androstendione levels confirm the diagnosis.

Hypertension may account for headaches and anxiety.

Galactorrhoea may be evidence of hyperprolactinaemia, which requires further investigation into a microadenoma of the pituitary.

Vaginal examination

Pain on moving the uterus may be due to pelvic inflammatory disease, endometriosis or constipation. In pelvic inflammatory disease there may be evidence of a vaginal discharge, suprapubic pain, bilateral adnexal tenderness and sometimes a history of low - grade pyrexia. In endometriosis there may be a bulky uterus and a history of dyspareunia and infertility. Constipation will be apparent on vaginal examination with pain over the rectum and loaded faeces in the pouch of Douglas.

Menstrual charts

When the patient returns with their menstrual chart completed for at least two months, three types of patterns are discernible.

1. Premenstrual syndrome in which symptoms are grouped in the premenstruum with an absence of symptoms for a minimum of seven days in the postmenstruum.
2. Dysmenorrhoea in which the symptoms are limited to menstruation and are absent in the premenstruum and postmenstruum. In spasmodic dysmenorrhoea the symptoms are usually of pain, backache, and possibly vomiting and fainting.
3. Menstrual distress with symptoms occurring spasmodically throughout the cycle, but most marked in the paramenstruum.

It is, of course, possible to have premenstrual syndrome present at the same time as some other disease and so cause an exacerbation of the symptoms in the premenstruum. However, it is important to recognise what proportion of symptoms are attributed to premenstrual syndrome and what proportion to the other disease (Dalton 1984).

According to the Mims Disease Index (1993-1994) it simply states that the differential diagnosis must find " other causes of fluid retention - renal or adrenal.

Other causes of breast swelling or pain e.g. mammary dysplasia.

Thyroid disorder (hyper -or hypoactivity).

Polycystic ovary syndrome (Premenstrual syndrome may be part of the presentation if there is an oestrogen excess).

Psychiatric disorders (depression, mania).

2.2.2

DIAGNOSIS

According to Dalton (1984) for the diagnosis of premenstrual tension to be made the following requirements need to be met:

1. Symptoms occur exclusively during the second half of the menstrual cycle.
2. Symptoms increase in severity as the cycle progresses.

3. Symptoms must be relieved by the onset of full menstrual flow.

4. There must be an absence of symptoms in the postmenstruum.

5. Symptoms have to be present for at least two consecutive cycles.

Dalton (1984) and Keyes (1988) both recommend that a correct diagnosis depends on the accurate recording of symptoms day by day, together with a precise recording of the dates of menstruation and state that variation in the length of cycles need to be considered (i.e. 28-31 days or longer). Dalton (1984) favours the use of menstrual or frequency charts and states the simplicity of the recording encourages cooperation of the patient. The patient is asked to mark with an "m" on the appropriate square on the chart each day of menstruation. The patient is then asked to mark on the chart the days when the symptoms are present. Appropriate symbols may be used by each women but must explain what the denotations signify to the researcher.

Keyes (1988), also encourages this technique but encourages a comprehensive case history and physical examination, calender evaluation, differential diagnosis, and diagnosis followed by the appropriate treatment. Various methods of diagnosis have been devised by numerous researchers all basically including the same techniques in order to obtain success.

The Moos Menstrual Distress Questionnaire (Jonker 1992) asks the women to rate on a six-point scale the severity of 47 symptoms, the severity scale ranges from 'no experience' to 'disturbing experience'.

The Premenstrual Assessment Form was devised by Halbreicht et al. (1985) and describes 95 symptoms that may be experienced by the patient premenstrually and the severity scale ranges from "not applicable" to "extreme change" in symptoms during treatment.

2.2.6

ALLOPATHIC TREATMENT

According to Wickes (1988); Keyes (1988); Hsia and Long (1990); Robinson and Garfinkel (1990); the most effective treatment of premenstrual tension is a conservative one including accurate diagnosis, stress control, sensible levels of diet and exercise, perhaps the use of alprazolam in the premenstrual period.

Wickes (1988) and Chihal (1990) also recommend the use of vitamin supplementation, diuretics, prostaglandin inhibitors, antihypertensives and antimania medication, Bromocriptine, Danazol, prostaglandin precursors, oral contraceptives, gonadotropin releasing hormone antagonists and progesterone supplementation or therapy. Robinson and Garfinkel (1990) claim that progesterone has proven ineffective in the treatment of premenstrual tension and recommend the use of mefenamic acid and evening oil of primrose although such an approach has been proven useful in practice but it is still unproven theoretically.

The Merck Manual (1987), a standard medical dictionary, states that the treatment of premenstrual tension involves a combination of symptomatic relief and correction of the theoretic causes. If the symptoms are mild , no treatment or a mild analgesic eg. aspirin 600mg. Fluid retention may be relieved by limiting salt intake and giving a diuretic during the last 10 days of the menstrual cycle or 24-36 hours before the expected onset of the symptoms. A tranquillizer together with reassurance and counselling will reduce the irritability and emotional discomfort. Family support is also useful. Hormonal manipulation is less useful than would be expected from the theoretic aetiology. According to Watson and Studd (1992) treatment of premenstrual tension is best governed by the patient's assessment of the severity of symptoms.

Dietary advice is recommended, exercise and modification of lifestyle may also be beneficial. Patient's with severe symptoms may need treatment by suppression of ovulation. Ablation of the menstrual cycle by pregnancy, hysterectomy and bilateral oophorectomy will certainly work. Cycle suppression by luteinizing hormone releasing hormone analogues and Danazol have some value but there are potential problems with osteoporosis and virilization with detrimental lipid changes. Oral contraceptives will prevent ovulation and only appears to be successful occasionally. The most effective method of suppressing ovulation is to use percutaneous oestrogen in a dose adequate to suppress ovulation.

The Johnson and Johnson PMS advisory service provide a treatment called " the natural approach " and conclusive medical research has proven its success. This approach reported an 84% success rate in patients treated in St Thomas Hospital, London. Goddard and Jakubowitz and Dewhurst achieved an 86% success rate. The "natural approach" treatment programme includes:

1. Dietary suggestions
2. Useful information on weight control when necessary.
3. Recommendations for essential lifestyle changes.
4. Psychological therapy to help cope with modern stress and tension.

5. A description of essential nutrient supplements that you should take to overcome your bodies vitamin and mineral deficiencies. (PMS Advisory Pamphlet 1984)

Patients should be informed that at present there is no one therapy that has been effective in all women.

2.3 HOMOEOPATHY

2.3.1 DEFINITIONS

What is Homoeopathy? This question is a broad one, and hence its answer cannot be limited. To say that Homoeopathy is based upon the Law of Similars is but the bounding of a cone by describing its base and leaving its apex undiscovered and projecting into space; this answer is unsatisfactory. Some say that Homoeopathy is involved in mysticism and the "unexplained."

The Wholistic Practioner (Twentyman 1988 4:5-10) states the definition of Homoeopathy as " Homoeopathy: a discipline of healing arts, a science concerned with the cause, diagnosis, treatment and prevention of the disease by administering in small doses medicines made from mineral, animal and plant resources which would produce in healthy persons symptoms similar to those they are designed to removed."

Simply put by Jouanny (1991):" Homoeopathy is a therapeutic method which clinically applies the Law of Similars and which uses medicinal substances in weak or infinitesimal doses."

Homoeopathy is a science of healing based upon the Law of Similars as a law of selection. To select under this law, one must be acquainted with the parts and counterparts, positives and negatives - similars -that his conclusions may be made by exclusion, that he may demonstrate to himself as well that remedies are not indicated, as that the one similar only can conform to the disease at hand; appropriate, because it of all the known medicines is most like unto the disease to be cured (Gypser 1987).

1.3.2

THE HISTORY,THE FOUNDER AND UNDERLYING PRINCIPLES

According to Jouanny (1991:11-22), the basis or origins of Homoeopathy are rooted as far back as twenty-five centuries ago in a well established and more than well respected school of thought and medicine, that being Hippocrates, ironically the founder of allopathic medicine. Even as far back as that, Hahnemann's (who I will expand on later) principle " Similia Similibus Curentor " more easily understood as:" The same things which cause the disease, cure it " was observed and acknowledged and was also in Hippocrates language, stated as " The strangury which is not, cures the strangury which is ",strangury being the term for cystitis, by

Hippocrates which was cured by small doses of Cantharis which in tincture or in the original form causes cystitis (Jouanny 1991:12).

In centuries that followed, many other doctors made similar observations but could not draw a practical conclusion.

The break through came about when a German physician , chemist and toxicologist, around about 1790, Christian Samuel Hahnemann, who was well acquainted with the Hippocratic School of thought and its observations. He himself clinically became aware of remedies that caused a particular condition to also cure it, this is he followed the hypothesis by carrying out experiments on, himself firstly and later on healthy people around him, constantly noticing that substances causing certain signs and symptoms in healthy individuals mimicked those seen in unhealthy or diseased patients- this form of experimentation is today known as Provings. He was the first to make the proving of drugs a system. From 1790 he continued the proving of drugs, and throughout his writings he recommended the use of drugs only whose effects are accurately known, which knowledge is to be discovered only by proving upon the healthy; and this is keeping with his manner and acts, everywhere we find exactitude of thought and method.

In 1796, in an essay which appeared in the Hufeland's Journal, a part of the Lesser Writings, p.295 - " Essay on a New Principle for Discovering the Curative Power of Drugs " Hahnemann advises medicines in a crude, but small, doses.

"In a dose just strong enough to produce scarcely perceptible indication of the expected artificial disease." At this stage he had not discovered the nature of the vital dynamism. It was after 1801 that his centesimal scale was brought into use. Very soon he discovered that " the diminution of the action of the drug was not proportionate to the diminution of its quantity." Also the astounding fact became evident that " medicines could be so diluted that neither physics nor chemistry could discover any medicinal matter in them, and yet they possessed great healing power." After about ten years of clinical trials and experimentation, Hahnemann's hypothesis being proven over and over again no longer a hypothesis but now a law of nature, became known as "The Law of Similars" (Jouanny 1991:13). If Ameke's history, cited by Gypser (1987), be read he states that Hahnemann never admired metaphysical speculations; he always concluded on facts, never on theory or speculation.

As clearly shown in many books, Homoeopathy is not some mysterious or thought up idea, but rather a more than well founded form of "...prescribing a patient with a weak or infinitesimal doses of a substance which when administered to a healthy person causes symptoms similar to those exhibited by the ill patients..." (Jouanny 1991:14).

2.3.3

THE PRACTICE AND ART OF HOMOEOPATHY

The basic principle of practising Homoeopathy is " finding the remedy or remedies corresponding to the disease process "(Twentyman 1988:5-10). In order to do this, in other words, use effective Homoeotherapeutics, it requires (Hubbard 1965 and Baker 1990), " the physician to know the patient spiritually, emotionally, mentally, physically and physiologically and to base his prescription on the symptom complex with modifications which permit accurate individualization of the cases " in other words " KNOW YOUR PATIENT."

To do the above the homoeopath must always keep the four fundamentals of Homoeopathy as stated by Hahnemann himself (Jouanny 1991), those being:

1. The provings of the substance to be used as medicines on the healthy.
2. The selection and administration of so proved medicines according to the Law of Similars.
3. The single remedy.
4. The minimum dose.

In Homoeopathy the symptoms and signs present on the patient, thus producing " dis-ease" are seen as them arising due to a disturbance of the homoeostasis, or the " vital force " of the individual. The disturbance can be brought on by any varied emotion, the side effects of substances and poisons, trauma etc.

The disease picture as presented by the patient is then noted down very carefully including all details and particulars, giving that picture it's individuality and the matched up with the corresponding remedy. So as seen the cases history is of vital importance and as Hubbard (1965 58:46-49) and Baker (1990:6-11) said: " a case well taken is a case half cured." The choice in remedy is done by careful consideration of: aetiological factors, nervous or behavioural characteristics, symptoms with modalities (i.e aggravating and ameliorating factors), general and local symptoms.

2.4

PREMENSTRUAL TENSION AND HOMOEOPATHY

2.4.1

ALLOPATHIC TREATMENT VS HOMOEOPATHIC

TREATMENT

" What is the object of all conscientious physicians? To cure the sick, to prevent others from becoming ill, to raise the standard of ill health in all people."

(Hubbard 1965)

How does allopathic treatment go about doing this?

Firstly find out the normal physiology, anatomy and chemistry.

Secondly, find out the varieties of ill health.

Thirdly, search for any anatomical or physiological change in the sick person.

Fourthly, classify the changes under some disease nomenclature (i.e. make a medical diagnosis). In short as Hubbard (1965:46-49) said: " Modern medicine feels that it must find out all the facts which fit in with the concept of disease."

How does Homoeopathy go about doing the above?

The homoeopath does subscribe to the above, but he takes a whole lot more into account, as mentioned by Baker (1990:6-11) "... effective use of Homoeotherapeutics requires the physician to know the patient - spiritually, mentally, physically and physiologically...", thus looking at the patient as a whole, as an entire individual, where allopathic treatment differs in this case as Hubbard (1965:168-173), a medical doctor herself, said:" the majority of modern drugs are given for a definite physiological effect on some organ or function of the body...and...most of the modern drugging, in short, is aimed at individual annoying symptoms and make no attempt to back the constitutional cause of the disease."

Jouanny (1991:20) stated: "...that Homoeopathic treatment is strictly individualization of the treatment.

Homoeopathy constitutes an individual terrain therapy and the Homoeopathic remedy is a specific stimulant to the organism, unlike traditional medicine which is coercive."

As stated by Jouanny (1991:), in point form:

" 1. Traditional therapeutics are coercive, using the approach of inhibiting unpleasant or painful physiological reactions or acts as an antidote to those physiological or metabolic substances whose levels are abnormally high."

" 2. Medicine is also used to destroy or attempt to destroy a germ or parasite."

" 3. It chemically replaces insufficient physiological substances."

Homoeopathy on the other hand treats by acting together with the body's reactions. Homoeopathy or rather the remedy/remedies, so carefully chosen stimulate the patients defense mechanism so as to make them work more effectively and at the end the body itself heals it's abnormalities or disease, not the medicine given. This is why it is necessary to use small or infinitesimal doses because according to the Arndt Shultz Law: " Small doses stimulate, medium doses paralyse and large doses kill" (Jouanny 1991).

2.4.2

PAST RESEARCH

Allopathically extensive research has been done and is still being done. Unfortunately past research on Homoeopathic treatment of premenstrual tension has not been as extensive and information was not obtainable anywhere in Durban. The Scottish Homoeopathic Research and Educational Trust, Glasgow have promptly sent two articles on the use of Folliculinum in Premenstrual Tension (Assilem 1991). The articles are written by practising Homoeopaths who have observed the effectiveness on Folliculinum on Premenstrual complaints and have recorded their observations and published them, each author states that in their opinion further research in this field will be beneficial and that " research funds could be profitably invested in this field." Boiron Laboratories, France have researched the effects of Folliculinum, and I have presently not had a response from them.

The information obtainable at Technikon Natal's Library was obtained used the CD ROM "med-line" scanning over 142 articles from 1988 to 1993. Journals and books were obtained from all over the country on past and present research, treatment, aetiology, diagnosis, differential diagnosis, advisory centres, management and so on.

2.4.3

CLINICAL PICTURE OF FOLLICULINUM

GENERALITIES

A female remedy, affecting primarily the syndrome known as " hyperfolliculinia." But this syndrome is rarely observed in laboratory tests, so that one wonders whether it should really keep its name. However, at a purely clinical level, it has the advantage of grouping a certain number of symptoms together, which would be hard to classify otherwise. We would maintain that true hyperfolliculinia exists when the biopsy of the uterine endometrium reveals glandocystic hyperplasia (feminizing tumours of the ovary, persistent follicle, follicular cysts). Besides this true hyperfolliculinia, there is a functional hyperfolliculinia, which does not always correspond to the biopsy of the endometrium, but which can be revealed by the Hirschberg's test (Julian 1987:231). It shows an allergy to oestrogen: the intra-dermic reaction employed together with a titrated solution of folliculin at 20mg per 1\10th of a millimetre, causes a red papule, 3-4 cm in diameter, to appear 15-40 minutes after an injection; this papule remains for 24 hours. In this case, Folliculin in a Homoeopathic dilution could be indicated, as well as for all functional symptoms present in the patient who reacts positively to the test.

MIND

Hypersensitive to heat, noise, and contact

Congestive headaches, either with redness of the face, or the opposite with pallor, but still with the sensation of chilliness at the extremities.

Premenstrual migraine

Extreme instability, anguish, worse at nightfall.

Alteration of excitability and depression, worse before menses.

Sexual hyper-excitability.

Fixed ideas of a sexual nature.

DIGESTIVE SYSTEM

Swallowing of liquids very painful.

Abdominal meteorism, worse 3-4 days before menses.

Liver soft, swollen and hypertrophic.

Feeling of heaviness in rectum.

Stubborn constipation, sometimes alternation of constipation and diarrhoea.

Nausea, vomiting, premenstrual pain in the right hypochondrium.

CIRCULATORY SYSTEM

Tachycardia.

Palpitations with faintness.

Sensation of constriction around the heart, with a feeling of a bar in the precordial region, spreading to the left arm.

Frequent ecchymosis, bruise very easily.

Need for fresh air.

Takes large breathes of air, and sighs deeply.

coryza, with a headache and profuse nasal discharge.

Hayfever.

Fitful cough, worse when in company, with a sensation of constriction around the heart.

Cannot bear pressure on the pharynx.

URINARY SYSTEM

Recurrent cystitis in women.

GENTIAL SYSTEM

Vulvular pruritus, worse before menses.

Small losses of blood during ovulation.

Menses prolonged, blood bright red, with clotting.

Menses painful for the first few days.

Yellow or brownish discharge, sometimes blood-streaked, between menses, especially during ovulation.

Uterus is fibrous, with metrorrhagia.

Congestive mastitis.

Congestion, premenstrual pain.

Breasts enormous, swollen, cannot bear being constricted or touched.

The pain is ameliorated, or disappears with menses.

SKIN

Acne on the face, and seborrhoea of the nostrils.

Dry eczema, worse during ovulation, before menses.

Dry eruptions at the extremities of the fingers, with splitting and chapping of the skin.

Alopecia in women.

Swelling, oedema of the conjunctival tissue and cellitic nucleus.

Weight gain, without excessive eating, worse before menses or during ovulation (a women can easily put on a kilo in weight).

LOCOMOTOR

Lumbar pains, worse during ovulation, before menses.

Chronic acroparaesthesia.

MODALITIES

AGGRAVATION

Folliculin shows aggravation before menses, during ovulation, from heat, and from resting.

AMELIORATION

Ameliorated after the third day of menses, with movement, and fresh air,(Julian 1987:231).

SUMMARY

The literature review attempts to show, as objectively as possible, a little on premenstrual tension so as to know what we are getting ourselves into in attempting to help or even try to prevent this problem from affecting so many women every month.

Included are the various forms of medical treatment available to these women, as well as the prospect of Homoeopathy also contributing to the treatment and management of premenstrual tension. At the end of the day, if any form of therapy can provide these women with some sort of effective, non-destructive or invasive and permanent relief, then that's all that matters and throughout all trials and tribulations all the physician must keep in mind is:

" The sole mission of the physician is to cure rapidly, gently and permanently." - CHRISTIAN SAMUEL HAHNEMANN.

Martinez, observed that Folliculinum is effective in the treatment of premenstrual tension yet no formal trial has been conducted to prove how effective Folliculinum is in the treatment of premenstrual tension. It is for this reason that the purpose of this investigation is to evaluate the efficacy of Folliculinum 15CH on a patient experiencing premenstrual tension, with reference to the patient's perception of the treatment, in order to determine how effective homoeopathy is in the treatment of premenstrual tension.

CHAPTER THREE: THE DATA, THEIR TREATMENT AND THEIR INTERPRETATION

3.1 THE DATA

The data of this research is of two kinds: primary data and secondary data. The nature of each of these two types of data will be given briefly below.

3.1.1 THE PRIMARY DATA

The primary data will be collected by means of communication (i.e. a questionnaire).

Two types of primary data are needed:

1. The patients perception to the treatment determined by using questionnaires and a personal interview.
2. The integration of the patients perception to the treatment and the response of the patients symptoms to the medication.

3.1.2 THE SECONDARY DATA

This data will be current and historical in nature obtained by a number of source documents. The following will be needed:

- Medical textbooks containing information on Premenstrual Tension.
- Medical journal articles on Premenstrual Tension.
- Past and present medical research on Premenstrual Tension.
- Homoeopathic journal articles on Premenstrual tension.
- Past and present Homoeopathic research on Premenstrual

Tension.

- Homoeopathic Repertories.
- Materia Medica's (There is a large selection).
- Literature on questionnaire design.

3.2

THE SAMPLE

The sample used in this study was conveniently drawn from the population in Natal.

Possible candidates must qualify in the following areas;

1. The patients was selected from the greater Durban area with access to the Technikon Natal Homoeopathic Clinic.
2. The patient was then assessed to see if they fitted into the parameters of the research project. (See delimitations)
3. This group study limits itself to 31 patients, conveniently selected, that fulfils the requirements of the research project. Four extra patients were assessed and treated, this was due to the fact that on average 10-20% of participating patients drop out for known/unknown reasons.

3.3

CRITERIA FOR THE ADMISSIBILITY OF DATA

Data regarding the patients perception to the treatment will be extracted using questionnaires:

1. Moos Menstrual distress Questionnaire (Jonker 1992).

2. Premenstrual Assessment Form (PAF) (Jonker 1992).
3. Menstrual chart (Dalton 1984).

3.4

THE INSTRUMENTS

The data will be obtained using the above questionnaires (which assesses the patients response to the treatment). The use of computer spread sheets will allow for the capture and manipulation of the above data. The computer program for statistical analysis of the captured data was the SGPLUS 6.0 (Statgraphics Plus Version 6.0.)

3.5

ADMINISTRATION

How the project was pursued:

- Advertised for patient's with premenstrual tension.
- A convenient sample group was selected from the Durban Area.
- The selected sample group was checked for any delimitations.
- Each patient then underwent an evaluation:

STEP ONE: PATIENT HISTORY

A Homoeopathic case history was taken. The first step when evaluating a woman with the self made diagnosis of premenstrual tension is to record the history of her problems, beginning with a detailed description of the symptoms and the timing of those symptoms throughout the menstrual cycle.

Inquiries were made about the presence of symptoms during and after menses to determine the presence of moderate or severe dysmenorrhoea or chronic physical or psychological problems. The patient's were asked about reproductive problems such as infertility, oligoamenorrhoea, spontaneous abortions, luteal phase defects, marked fluctuations in the non-pregnant state, and an intolerance to alcohol and oral contraceptives. This will help eliminate chronic problems. Data was gathered about the time and events surrounding the onset of her symptoms. Finally a standard medical history including a family history and physical examination was be carried out.

STEP TWO: PROSPECTIVE CHARTING

The patient was asked to describe and evaluate the symptoms she experienced during the menstrual cycle by answering Moos Menstrual Distress questionnaire, Premenstrual Assessment Form and Menstrual chart for two months. The questionnaires were returned at the next consultation.

STEP THREE: CALENDER EVALUATION

The calender was used to determine whether there was a premenstrual pattern to the patients symptoms by evaluating the pattern of each symptom. Invariably, some symptoms occur premenstrually, some are present throughout the menstrual cycle but are worse in the premenstruum, and some are present throughout the cycle without a pattern. However, by recording their severity, it is possible to rank the symptoms and thereby establish priorities for evaluation.

STEP FOUR: DIFFERENTIAL DIAGNOSIS

The presence of premenstrual symptoms is not in itself definitive evidence of premenstrual tension. If the presenting symptoms occur in the postmenstruum, then the patient symptoms need further investigation, and the patient was referred.

STEP FIVE: DIAGNOSIS

For a diagnosis of premenstrual tension to be made the following requirements needed to be met:

1. Symptoms occur in the second half of the menstrual cycle.
2. Symptoms increase in severity as the cycle progresses.
3. Symptoms must be relieved by the onset of full menstrual flow.
4. There must be an absence of symptoms in the postmenstruum.

5. Symptoms must be present for two consecutive cycles.

- If the diagnosis of premenstrual tension is made then a Homoeopathic prescription was handed to the Homoeopathic Pharmacist who was neutral member in the study.

-The Homoeopathic pharmacist then randomly divided the sample in half, dispensing one half of the sample with Folliculinum 15CH and the other half with placebo medicine. Folliculinum 15 CH was selected on the success claimed by Martinez (1990) and by Dr Boyer (personal communication). One group was the control group, and the other the treatment group. (The researcher was not informed which patients received treatment or placebo medication-Double blind study.)

- The patient was informed on how to take her medication. (i.e. The patient took five pills twice a day from day 14 of her menstrual cycle until the onset of menstruation for a 28 day cycle, for a 31 day menstrual cycle the patient will take five pills twice a day from day 16 of her menstrual cycle.)

- The patient attended a follow up consultation each month, one to four days after they have menstruated, where the case history and physical examination was re-assessed. The questionnaires were returned and the patient and researcher discussed the questionnaire to ensure that the relevant information has been entered correctly on the questionnaire. Questionnaires for the next month were given.

- These steps were repeated six consecutive times.
- All data gathered from the questionnaires and consultations were analyzed and interpreted, and hypothesis were tested.

3.6

TREATMENT OF THE DATA

Screening of the questionnaires on the patients response to the treatment was done to determine whether all information was filled out correctly and whether the respondents meet all the selection criteria.

THE DATA NEEDED

The data needed for testing the hypothesis was obtained from questionnaires assessing the patients perception of the treatment, Homoeopathic and medical case histories and physical examinations were performed on the respective patients.

The following data from the questionnaires was needed:

- a. How the patient thus far perceives the treatment to be.
- b. How the patient would rate their premenstrual tension before and after treatment.
- c. How the patients attitude concerning their premenstrual tension has changed since they began Homoeopathic treatment.
- d. The onset of the symptoms.
- e. Rating of the mental, emotional and physical symptoms experienced.

THE LOCATION OF THE DATA

The data was obtained from each female patient and was extrapolated by using the Moos Menstrual Distress Questionnaire, Premenstrual Assessment Form and the Menstrual chart.

THE MEANS OF OBTAINING THE DATA

All the data concerning the patients perception to the treatment was collected by means of the Moos Menstrual Distress Questionnaire, Premenstrual Assessment Form, Menstrual chart, Homoeopathic and medical case histories and physical examinations. The case histories and physical examinations were done at each consultation. The questionnaires was given to the patients at their consultation to be completed during the month and returned at their next consultation during the 1-4 day after menstruation has begun. The researcher and patient went through the questionnaires to ensure all relevant information was entered correctly.

TREATMENT OF THE DATA

Screening of the questionnaires was done to determine whether the information has been entered correctly and whether all respondents meet the selection criteria.

The following data from the questionnaires was needed:

- a. A description of the symptoms during the most recent menstrual flow.

- b. A description of the symptoms 7-10 days prior to the most recent menstrual flow.
- c. A description of the symptoms during the remainder of the menstrual cycle.
- d. Severity of the symptoms.
- e. Frequency of the symptoms.
- f. Periodicity of the symptoms.
- g. Age
- h. Marital status
- i. Occupation.
- j. Onset of menstruation

The questionnaires were presented in the form of semantic differential scale, providing values for each question that can be transferred onto a spreadsheet. The values on the spreadsheet were used to draft graphs showing any trends in the patients perception to the treatment, and to test hypothesis.

CHAPTER FOUR: THE RESULTS

Data was collected on 141 different symptoms. The same fourteen symptoms were selected from questionnaire one (Moos Menstrual Distress questionnaire) and questionnaire two (The Premenstrual Assessment Form). The symptoms that were selected were chosen purely by the principle that these symptoms are the symptoms that Folliculinum has an effect on according to the Homoeopathic clinical picture.

They were analyzed using SGPLUS 6.0 (Statgraphic version 6.0) and all the data gathered is represented graphically or in tabular form in this chapter.

Muscle stiffness

Headaches

Skin disorders

Loneliness

Cramps

Dizziness and fainting

Anxiety

Nausea and vomiting

Swollen breasts

Abdominal swelling

Irritability

Mood swings

Heart palpitations

Depression

Mann-Whitney U-tests were performed utilising all the data obtained from 31 patients on each symptom that was selected. It is an excellent alternative to the t-test, and of course it does not have the restricted assumptions and requirements associated with the t-tests (Siegel 1956). The patients rated the severity of the premenstrual symptoms according to a 1-6 scale where 1= no experience of symptoms, 2= barely noticeable, 3= present mild, 4= present moderate, 5= present strong, and 6= acute or partially disabling. A P value was obtained and a P value of $< 0,05$ is considered statistically significant.

4.1.1.A MUSCLE STIFFNESS IN QUESTIONNAIRE ONE:

In treatment one, two, and three, the treated group was worse than the placebo group, but at treatment four, the placebo group was worse than the treated group. In treatment five, the treated group were worse than the placebo group, in treatment six, the placebo group was worse than the treated group. P was found to have a value of 0,056 in treatment six. (See Figure 1.)

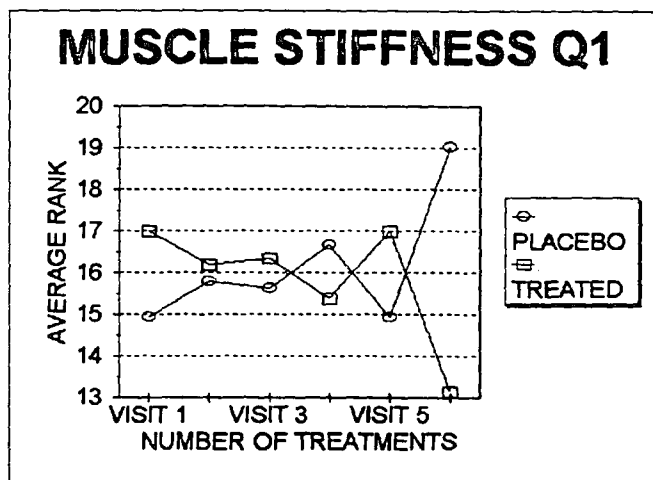


FIGURE 1: A graph showing the evolution of the patient's perception of muscle stiffness in both the treated and placebo groups over a period of six months.

4.1.1.B. MUSCLE STIFFNESS IN QUESTIONNAIRE TWO:

In treatment one and four, the treated group was worse than the placebo group. In treatment two and three, the placebo group was worse than the treatment group. In treatment five they were similar and in treatment six the placebo group was worse than the treated group. P was found to have a value of 0.09 in treatment six.

4.1.2.A. HEADACHES IN QUESTIONNAIRE ONE:

In treatment one, two and three, the treated group was worse than the placebo group, in treatment four, the placebo and treated group were very similar, in treatment five and six, the placebo group was worse than the treated group. P was found to have a value of 0,274 in treatment six.

4.1.2.B. HEADACHES IN QUESTIONNAIRE TWO:

In treatment one and two, the placebo group was worse than the treated group, in treatment three, four, five and six, the treated group was worse than the placebo group. P was found to have a value of 0,671 in treatment six.

4.1.3.A. SKIN DISORDERS IN QUESTIONNAIRE ONE:

In treatment one, two and three, the treated group was worse than the placebo group. At treatment four, the treated and placebo groups were very similar and in treatment five, the placebo group was worse than the treated group. In treatment six, the treated group and placebo group are similar. P was found to have a value of 0,694 in treatment six.

4.1.3.B. SKIN DISORDERS IN QUESTIONNAIRE TWO:

In treatment one and two, the treated group was worse than the placebo group. At treatment three, the treated and placebo groups were very similar. In treatment four, five and six, the placebo group was worse than the treated group. P was found to have a value of 0,08 in treatment six. (See Figure 2.)

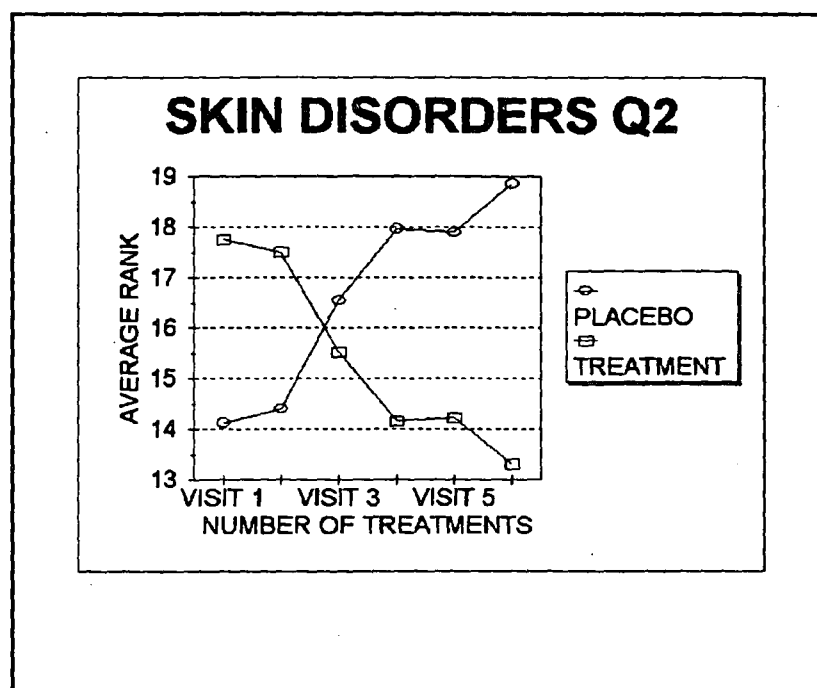


FIGURE 2: A graph showing the evolution of the patient's perception of skin disorders in both the treated and placebo groups over a period of six months.

4.1.4.A. LONELINESS IN QUESTIONNAIRE ONE:

In treatment one, the placebo group is worse than the treated group. In treatment two, three, four and five, the treated group and the placebo group were similar and in treatment six, the placebo group is worse than the treated group. P was found to have a value of 0,022 in treatment six. (See Figure 3.)

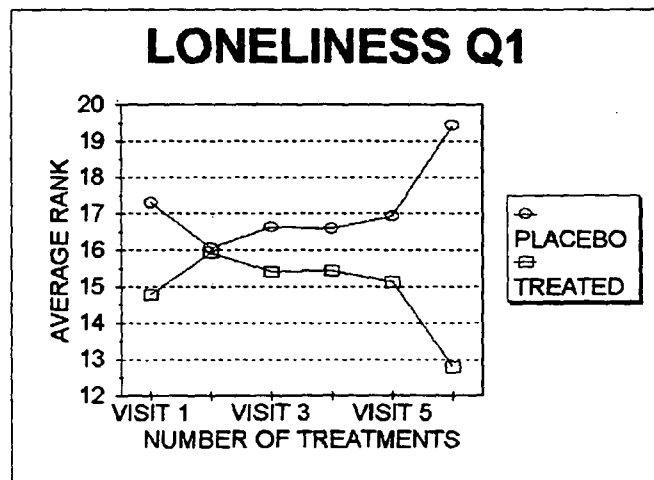


FIGURE 3: A graph showing the patient's perception of the treatment of loneliness in both the treated and placebo groups over a period of six months.

4.1.4.B. LONELINESS IN QUESTIONNAIRE TWO:

In treatment one and two, the treated group was worse than the placebo group. In treatment three, the placebo group is worse than the treated group. In treatment four, the treated group and the placebo group are similar. In treatment five and six, the placebo group is worse than the treated group. P was found to have a value of 0,08 in treatment six. (See Figure 4.)

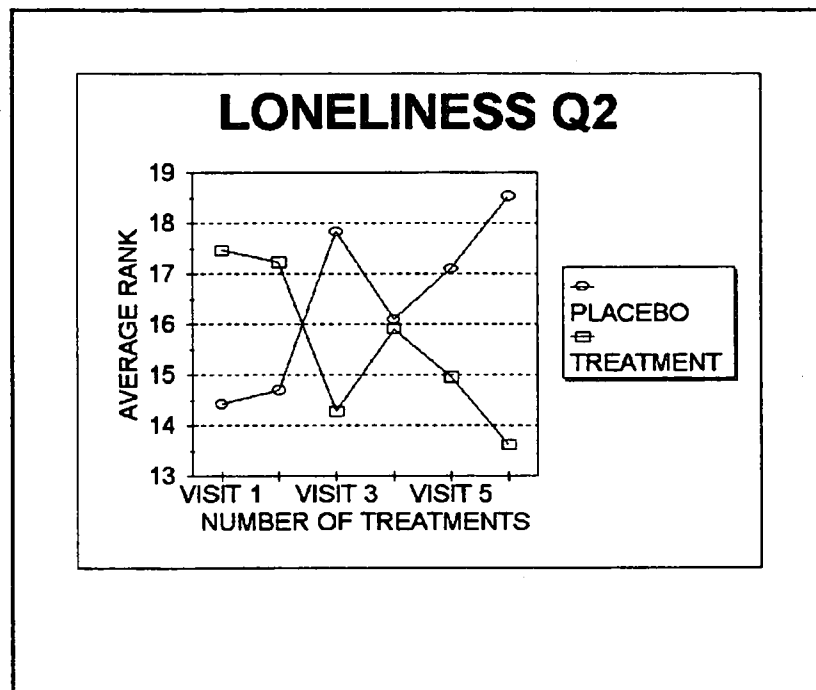


FIGURE 4: A graph showing the evolution of the patient's perception of the treatment of loneliness in questionnaire two in both the treated and placebo groups over a period of six months.

4.1.5.A. CRAMPS IN QUESTIONNAIRE ONE:

In treatment one, two, four, five and six, the placebo group was worse than the treated group. In treatment three, the treated group and the placebo group were similar. P was found to have a value of 0,02 in treatment five and a P value of 0,075 in treatment six. (See Figure 5.)

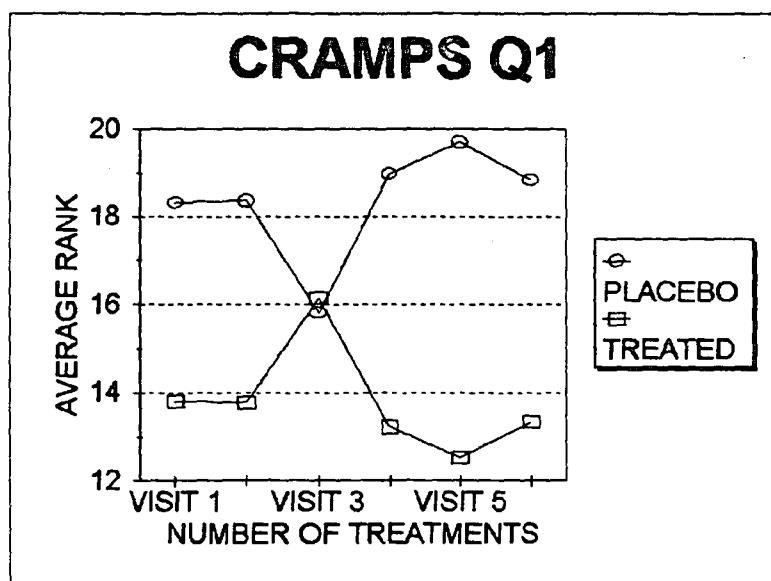


FIGURE 5: A graph showing the evolution of the patient's perception of the treatment of cramps in questionnaire one in both the treated and the placebo groups over a period of six months.

4.1.5.B. CRAMPS IN QUESTIONNAIRE TWO:

In treatment one, two, three, four, five and six, the treated group was worse than the treated group. P was found to have a value of 0,414 in treatment six.

4.1.6.A. DIZZINESS AND FAINTING IN QUESTIONNAIRE ONE:

In treatment one and two, the treated group and the placebo group were similar and in treatment three, the treated group were worse than the placebo group. In treatment four, the treated and placebo group were similar. In treatment five and six, the placebo group is worse than the treated group. P was found to have a value of 0,454 in treatment six.

4.1.6.B. DIZZINESS AND FAINTING IN QUESTIONNAIRE TWO:

In treatment one and two, the treatment group was worse than the placebo group, in treatment three and four, the treated group and the placebo group were similar. In treatment five, the treated group was worse than the placebo group and in treatment six, the treated group and the placebo group were similar. P was found to have a value of 0,95 in treatment six.

4.1.7.A. ANXIETY IN QUESTIONNAIRE ONE:

In treatment one, two, four, five and six, the placebo group is worse than the treated group. In treatment three, the treated group and the placebo group were similar. P was found to have a value of 0,174 in treatment six.

4.1.7.B. ANXIETY IN QUESTIONNAIRE TWO:

In treatment one, two, three, four and five, the treated group and the placebo group were similar. In treatment six, the placebo group was worse than the treated group. P was found to have a value of 0,411 in treatment six.

4.1.8.A. NAUSEA AND VOMITING IN QUESTIONNAIRE ONE:

In treatment, one the placebo group is worse than the treated group. In treatment two, the treated group and the placebo group were similar. In treatment three, the treated group was worse than the placebo group and in treatment four, five and six, the placebo group was worse than the treated group. P was found to have a value of 0,535 in treatment six.

4.1.8.B. NAUSEA AND VOMITING IN QUESTIONNAIRE TWO:

In treatment one, the treated group and the placebo group were similar. In treatment two, the placebo group was worse than the treated group. In treatment three, the treated group was worse than the placebo group, in treatment four, the treated group and the placebo group were similar. In treatment five and six, the placebo group was worse than the treated group. P was found to have a value of 0,03 in treatment six. (See Figure 6.)

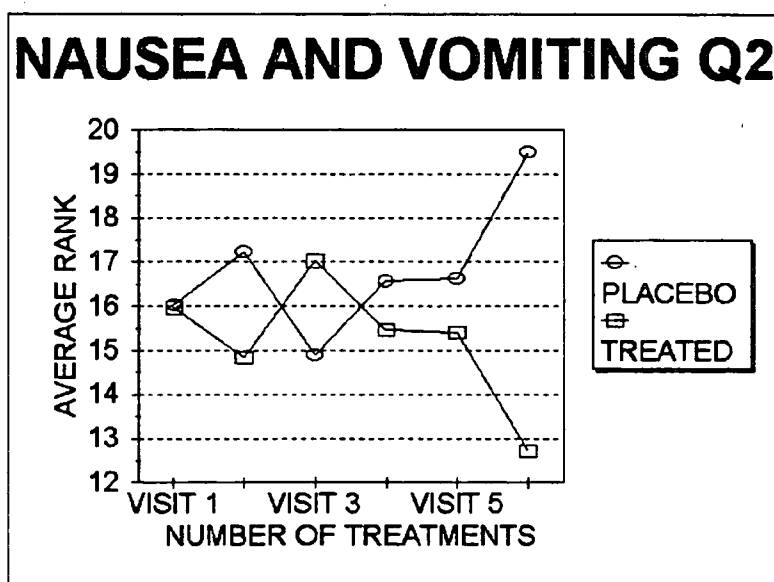


FIGURE 6: A graph showing the evolution of the patient's perception of the treatment of nausea and vomiting in questionnaire two in both the treated and the placebo groups.

4.1.9.A. SWOLLEN BREASTS IN QUESTIONNAIRE ONE:

In treatment one and two, the placebo group was worse than the treated group. In treatment three, the results were similar. In treatment four, five and six, the placebo group was worse than the treated group. P was found to have a value of 0,071 in treatment six. (See Figure 7.)

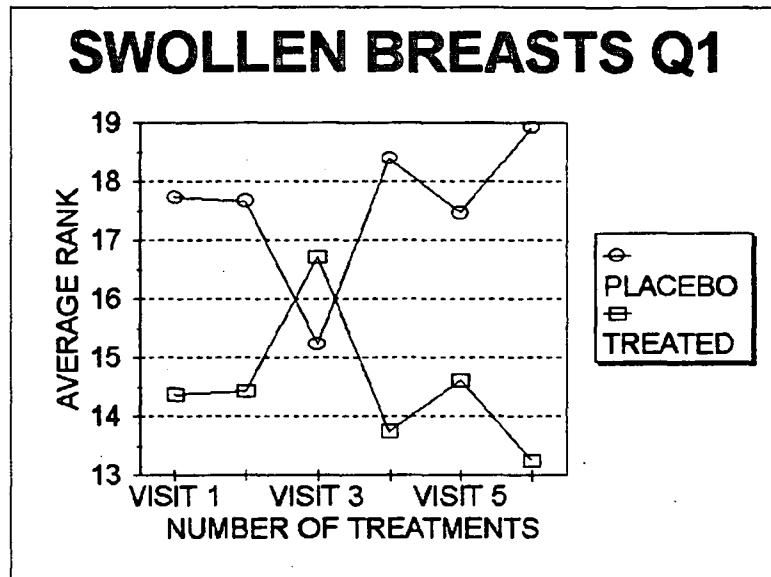


FIGURE 7: A graph showing the evolution of the patient's perception of the treatment of swollen breasts in questionnaire one in both the treated and placebo groups.

4.1.9.B. SWOLLEN BREASTS IN QUESTIONNAIRE TWO:

In treatment one, two, four, five and six, the placebo group was worse than the treated group. In treatment three, the treated group and the placebo group were similar. P was found to have a value of 0,015 in treatment five and a P value of 0,018 in treatment six. (see Figure 8)

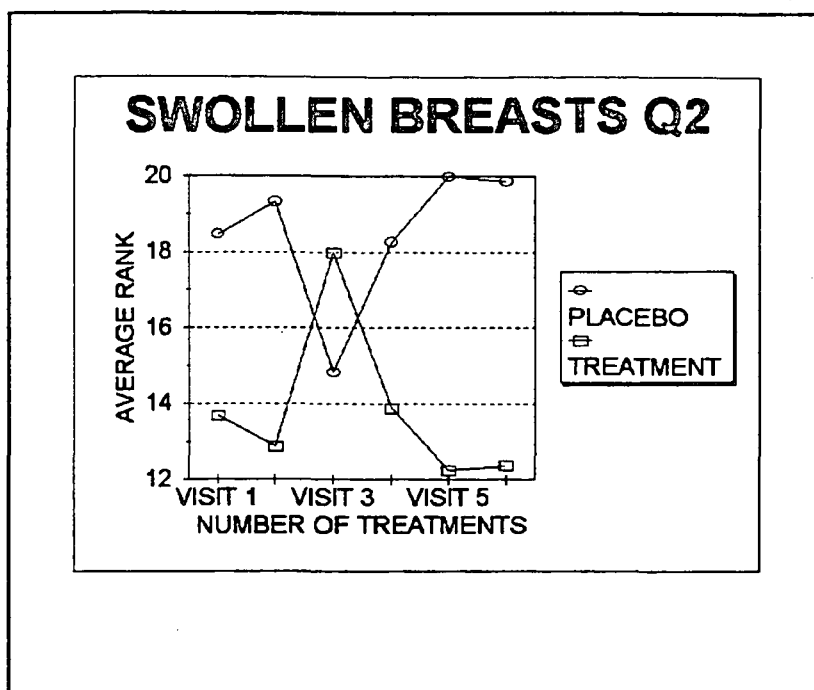


FIGURE 8: A graph showing the evolution of the patient's perception of the treatment of swollen breasts in questionnaire two in both the treated and placebo groups.

4.1.10.A. ABDOMINAL SWELLING IN QUESTIONNAIRE ONE:

In treatment one, two and three, the treated group is worse than the placebo group. In treatment four and five, the treated group and the placebo group were similar. In treatment six, the placebo group was worse than the treated group. P was found to have a value of 0,466 in treatment six.

4.1.10.B. ABDOMINAL SWELLING IN QUESTIONNAIRE TWO:

In treatment one, two, three, four, five and six, the treatment group was worse than the placebo group. P was found to have a value of 0,148 in treatment six.

4.1.11.A. IRRITABILITY IN QUESTIONNAIRE ONE:

In treatment one and two, the treated group and the placebo group were similar. In treatment three, the treated group was worse than the placebo group. In treatment four, the treated group and the placebo group were similar. In treatment five and six, the placebo was worse than the treated group. P was found to have a value of 0,014 in treatment six. (See Figure 9.)

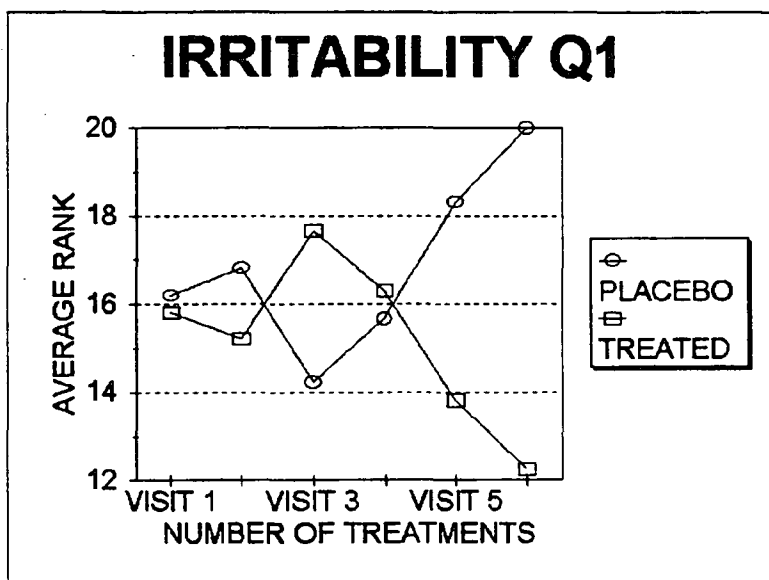


FIGURE 9: A graph showing the evolution of the patient's perception of the treatment of irritability in questionnaire one in both the treated and placebo groups.

4.1.11.B. IRRITABILITY IN QUESTIONNAIRE TWO:

In treatment one, two and three, the treated group was worse than the placebo group. In treatment four, the treated group and the placebo group were similar. In treatment five and six, the placebo group was worse than the treated group. P was found to have a value of 0,084 in treatment six. (See Figure 10.)

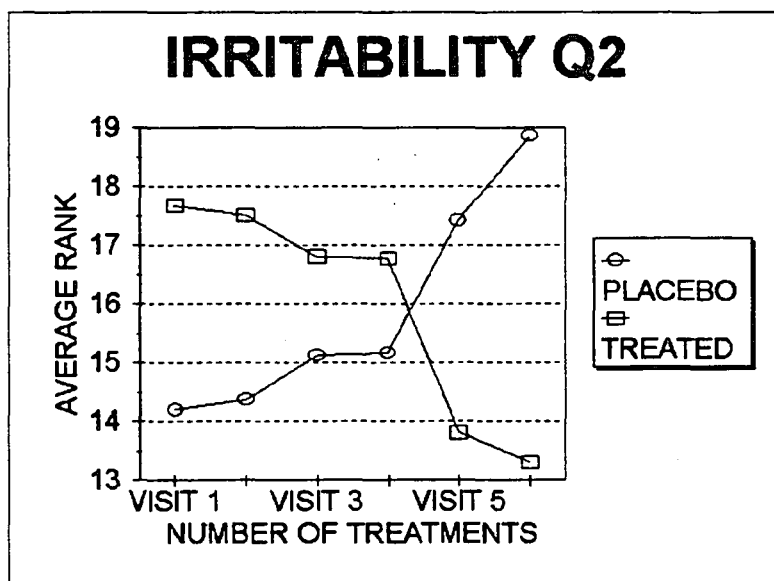


FIGURE 10: A graph showing the patient's perception of the treatment of irritability in questionnaire two in both the treated and the placebo groups.

4.1.12.A. MOOD SWINGS IN QUESTIONNAIRE ONE:

In treatment one, the treated group was worse than the placebo group. In treatment two, the placebo group was worse than the treated group. In treatment three, the treated group and the placebo group were similar and in treatment five and six, the placebo group was worse than the treated group. P was found to have a value of 0,05 in treatment six. (See Figure 11.)

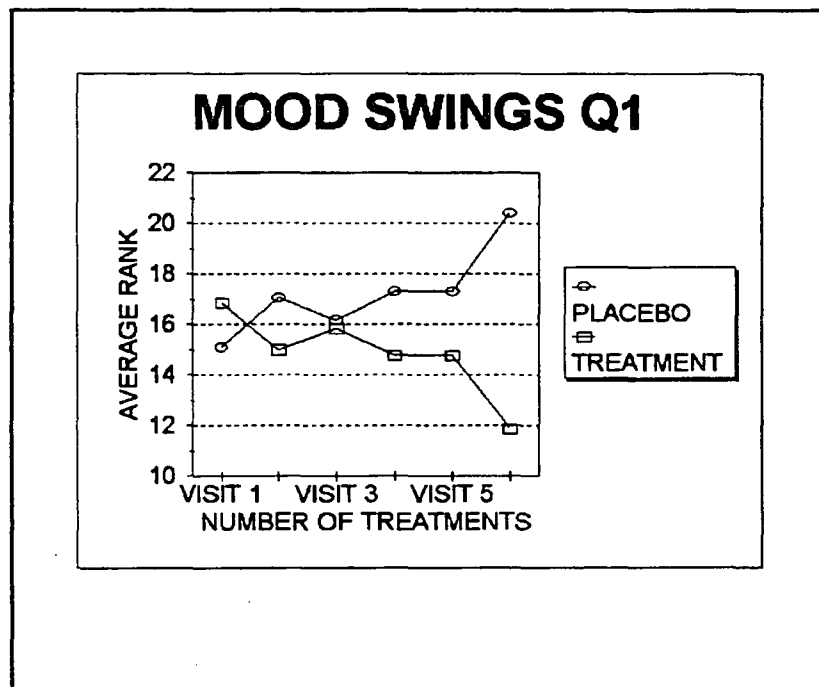


FIGURE 11: A graph showing the evolution of the patient's perception of the treatment of mood swings in both the treated and the placebo groups.

4.1.12.B. MOOD SWINGS IN QUESTIONNAIRE TWO:

In treatment one, the treated group was worse than the placebo group. In treatment two and three, the placebo group was worse than the treated group. In treatment four, the treated group and the placebo group were similar and in treatment five and six, the placebo group was worse than the treated group. P was found to have a value of 0,28 in treatment six.

4.1.13.A. HEART PALPITATIONS IN QUESTIONNAIRE ONE:

In treatment one, two and three, the treated group was worse than the placebo group. In treatment four, the treated group and the placebo group were similar. In treatment five and six, the placebo group was worse than the treated group. P was found to have a value of 0,194 in treatment six.

4.1.13.B. HEART PALPITATIONS IN QUESTIONNAIRE TWO:

In treatment one, the treated group and the placebo group were similar. In treatment two, the placebo group was worse than the treated group. In treatment three, the treated group and the placebo group were similar. In treatment four, the treated group was worse than the placebo group. In treatment five and six, the placebo group was worse than the treated group. P was found to have a value of 0,25 in treatment six.

4.1.14.A. DEPRESSION IN QUESTIONNAIRE ONE:

In treatment one, two ,three and four, the treated group is worse than the placebo group. In treatment five, the treated group and the placebo group were similar. In treatment six, the placebo group was worse than the treated group. P was found to have a value of 0,251 in treatment six.

4.1.14.B. DEPRESSION IN QUESTIONNAIRE TWO:

In treatment one, two and three, the treated group and the placebo group were similar. In treatment four, five and six, the placebo group was worse than the treated group. P was found to have a value of 0,005 in treatment five and a P value of 0,03 in treatment six.(See Figure 12.)

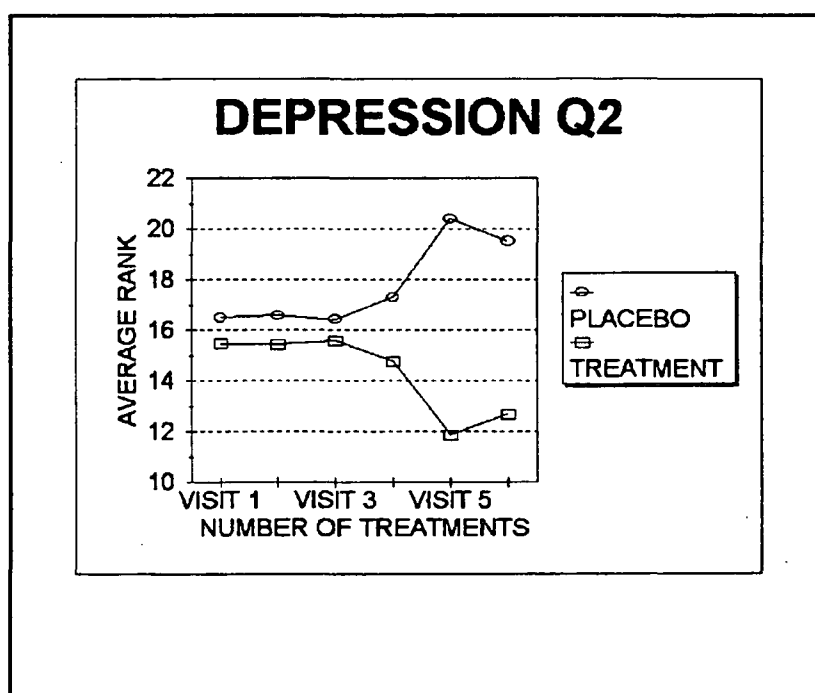


FIGURE 12: A graph showing the evolution of the patient's perception of the treatment of depression in questionnaire two in both the treated and the placebo groups.

TABLE 4.1: The changes in the patient's perception to the treatment, in the placebo group, in the fourth and sixth months.

SYMPTOMS	Plc4(%)	Plc6(%)
Q1 MUSCLE STIFFNESS	52	59
Q2 SKIN DISORDERS	58	59
Q1 LONELINESS	52	60
Q2 LONELINESS	50	58
Q1 CRAMPS	59	59
Q2 NAUSEA AND VOMITING	52	61
Q1 SWOLLEN BREASTS	57	59
Q2 SWOLLEN BREASTS	57	62
Q1 IRRITABILITY	54	62
Q2 IRRITABILITY	47	59
Q1 MOOD SWINGS	54	63
Q2 DEPRESSION	54	61

Figure 13 graphically represents all data tabulated in table 4.1.

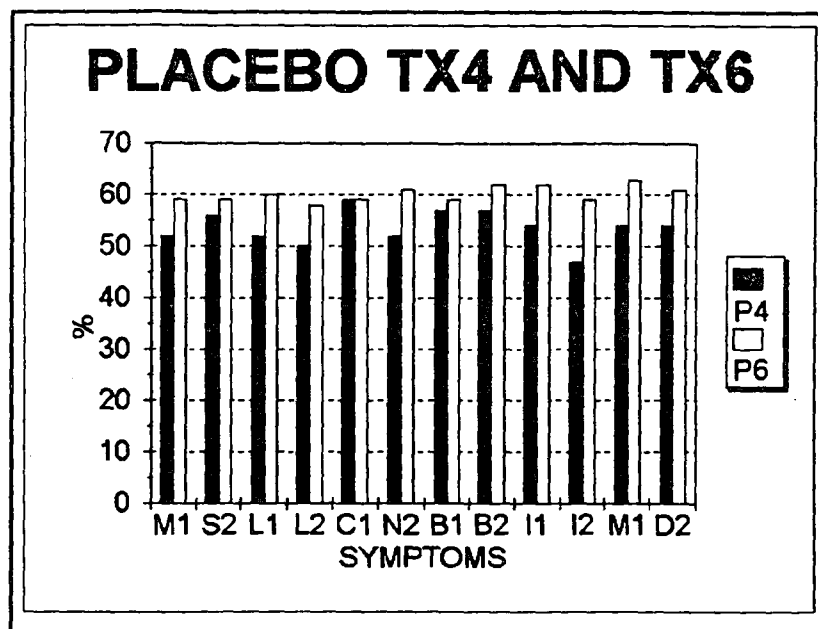


FIGURE 13: A graph showing the change in the patient's perception to the treatment, in the placebo group, at treatment four and six.

TABLE 4.2: A table showing the changes in the patient's perception to the treatment between the fourth and sixth set of observations in the placebo group.

	Improved	No change	Worse
Plc4-Plc6	7%	4%	89%

TABLE 4.3: The changes in the patient's perception to the treatment, in the treated group, in the fourth and sixth months.

SYMPTOMS	TX4(%)	TX6(%)
Q1 MUSCLE STIFFNESS	48	41
Q2 SKIN DISORDERS	49	44
Q1 LONELINESS	48	40
Q2 LONELINESS	50	42
Q1 CRAMPS	41	41
Q2 NAUSEA AND VOMITING	48	39
Q1 SWOLLEN BREASTS	43	41
Q2 SWOLLEN BREASTS	43	38
Q1 IRRITABILITY	46	38
Q2 IRRITABILITY	53	41
Q1 MOOD SWINGS	46	37
Q2 DEPRESSION	46	39

Figure 14 graphically represents all data tabulated in table 4.3.

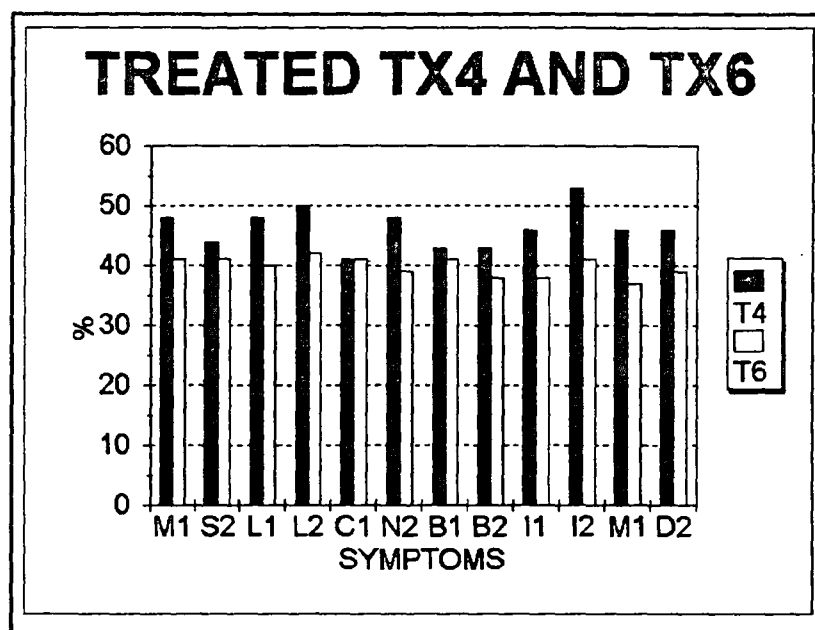


FIGURE 14: A graph showing the change in the patient's perception to the treatment, in the treated group, at treatment four and six.

TABLE 4.4: A table showing the changes in the patient's perception to the treatment between the fourth and sixth set of observations in the treated group.

	Improved	No change	Worse
Tx4-Tx6	89%	4%	7%

CHAPTER FIVE : DISCUSSION

The purpose of this investigation was to evaluate the effect of Folliculinum 15CH on patients experiencing premenstrual tension, with reference to the patients perception of the treatment, in order to determine how effective Homoeopathy is in the treatment of premenstrual tension.

Patients were screened according to the delimitations. The patients were asked to sign a consent form.

In total 34 patients were accepted into the study and allocated to either a treatment or placebo group according to a predesignated random sequence to prevent unwanted and unintentional bias on the part of the researcher. The designation was performed by a neutral Homoeopathic pharmacist.

Of the 34 patients accepted into the study, 3 dropped out for reasons unknown to the researcher.

It was noted that in the treated group (TABLE 4.4), 89% of the patient's improved at the end of treatment six, and in the placebo group (TABLE 4.2) only 7% improved at the end of treatment six.

On performing the Mann-Whitney U tests utilising observations represented by the changes, it was seen that there was a statistically significant difference in the following symptoms for the treated group: Muscle stiffness in questionnaire one ($P=0,056$), loneliness in questionnaire one ($P=0,022$), nausea and vomiting in questionnaire two ($P=0,03$), swollen breasts in questionnaire two ($P=0,018$), irritability in questionnaire one ($P=0,014$), mood swings in questionnaire one ($P=0,05$), depression in questionnaire two ($P=0,03$). Several symptoms appeared to improve but the results were not statistically significant: Skin disorders in questionnaire two ($P=0,08$), loneliness in questionnaire two ($P=0,08$), cramps in questionnaire one ($P=0,075$), swollen breasts in questionnaire one ($P=0,071$), irritability in questionnaire two ($P=0,084$).

These results would indicate that the patient's perception to the treatment was influenced by the homoeopathic medication.

As can be observed by the following graph, the patient's perception of the treatment for both of the groups were similar in treatment four.

This graph incorporates the data for the treated and placebo groups in the fourth month of treatment, allowing a comparison to be made between the two sets of data.

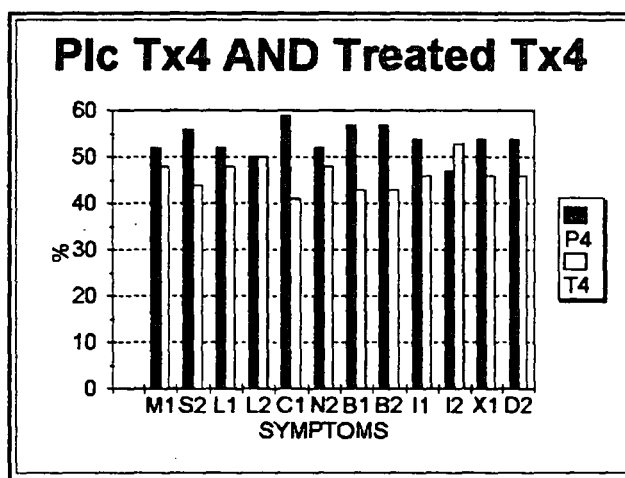


FIGURE 15: A graph showing the evolution of the patient's perception of the treatment in the fourth month, for both the treated and placebo group.

As can be observed by the figure 15, the treated group did in fact show a trend towards improvement. The patient's perception in the placebo group however appeared to worsen, though not significantly, or remain fairly constant throughout the fourth treatment.

This influencing factors can have both a positive and negative effect on the patient's perception to the treatment. There can be extraneous factors, which affect the efficacy of the medication, i.e. eating while taking the medication, deactivation of the medication by aromatic substances such as toothpaste, camphor, eucalyptus, menthol, sunlight etc. It could also partly be attributed to the fact that in any trial, a proportion of the patients will fail to take their medication, i.e. they will not comply with the treatment instructions given. This can be minimised by ensuring that the patient understands what was required of him, both by explanation and clear labelling of the labels (Lawson and Richards, 1982). It was also noted that the patient's perception of a certain percentage of the patients in the placebo group worsened. This could be ascribed to the fact that, either the patients were not receiving any homoeopathic medication nor were they influenced by the placebo effect. It may also be due to the fact that some patients react unfavourably to almost any drug or even a placebo because they are psychologically opposed to the use of drugs or medication of any kind (Remenchik and Talso, 1968). Although this study indicated that patients participated voluntarily (Appendix A), there could have been extraneous factors unknown to the researcher that may have forced the patients to take part against their will.

These factors were not investigated during the study due to the fact that this was a double blind study and one could not ascertain which factors were influencing the evolution of the premenstrual symptoms and thus the patient's perception towards the treatment.

The following symptoms were statistically insignificant: Muscle stiffness in questionnaire two ($P=0,09$); Headaches in questionnaire one ($P=0,274$); headaches in questionnaire two ($P=0,671$); skin disorders in questionnaire one ($P=0,694$); Cramps in questionnaire two ($P=0,414$); dizziness and fainting in questionnaire one ($P=0,454$); dizziness and fainting in questionnaire two ($P=0,95$); anxiety in questionnaire one ($P=0,174$); anxiety in questionnaire two ($P=0,411$); nausea and vomiting in questionnaire one ($P=0,535$); abdominal swelling in questionnaire one ($P=0,466$); abdominal swelling in questionnaire two ($P=0,148$); mood swings in questionnaire one ($P=0,28$); Heart palpitations in questionnaire one ($P=0,194$); heart palpitations in questionnaire two ($P=0,25$) and depression in questionnaire one ($P=0,251$).

The reasons for the change of opinion between the same or similar questions asked in the different questionnaires is unknown, although every patient commented on the length of the Premenstrual Assessment Form (Appendix C) and that they put the questionnaire two down and returned to it at a later stage. This could be the reason for different results between questionnaire one (Moos Menstrual Distress Questionnaire) and questionnaire two (Premenstrual Assessment Form).

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APPENDIX A:

PERSONAL DETAILS

Complete the following:

1. Name: _____
2. Surname: _____
3. Age: _____
4. Marital status: _____
5. Occupation: _____
6. Age at which menstruation began: _____
7. When are your symptoms worse: _____
8. How long do the symptoms last for: _____

9. Do you take any medication to alleviate the symptoms:

10. If you answered yes what medication do you use and what do you take it for: _____
11. Do you have any children, if so how many children: _____

12. Present weight: _____

CONSENT: I, the undersigned, hereby agree to take part in the discussed study conducted at Technikon Natal. I understand that I am in no way obliged to participate in the project conducted by Miss K.A.Kirtland and that all information that I volunteer will be regarded as confidential.

NAME: _____

SIGNATURE: _____

DATE: _____

WITNESS 1: _____

WITNESS 2: _____

APPENDIX B:

MOOS MENSTRUAL DISTRESS QUESTIONNAIRE

Write the approximate date of your most recent menstrual flow in the space marked "A" below. Then write the date of the menstrual flow that preceded the most recent flow in the space marked "D".

A: Most recent flow from _____ to _____

B: Week before the most recent flow.

C: Other times during the most recent cycle.

D: Flow preceding the most recent menstrual flow _____ to _____

On the following pages is a list of symptoms women sometimes experience. Please describe your experience of each of these symptoms during the three different periods listed below:

Column 1: During your most recent menstrual flow. (A)

Column 2: One week before menstrual flow. (B)

Column 3: During the remainder of your most recent menstrual flow.
(C)

Note: The answers you put in columns 1, 2 and 3 should describe your experience specifically during your most recent menstrual cycle. Please do not report your general symptoms. Please report if the symptoms are related to your menstrual cycle or not.

For each answer choose the category listed which best describes your experience of each symptom during that particular time. Write the number of that category in the space provided below. If none of the options accurately describe the symptom, please choose an option that is closest to your experience.

Categories:

- 1= No experience of symptoms
- 2= Barely noticeable
- 3= Present, mild
- 4= Present, moderate
- 5= Present, strong
- 6= Acute or partially disabling

		1: Most recent flow (A)	2: The week before (B)	3: Rest of the month (C)
	Weight gain			
	Insomnia			
	Crying			
	Lowered work performance			
	Muscle stiffness			
	Forgetfulness			
	Confusion			
	Take naps and stay in bed			
	Headaches			
	Skin disorders			
	Loneliness			
	Feeling of suffocation			
	Affectionate			
	Orderliness			

	Stay home from school or work			
	Uterine or pelvic cramps			
	Dizziness and fainting			
	Excitement			
	Chest pains			
	Avoid social activities			
	Anxiety			
	Backache			
	Cold sweats			
	Lowered judgement			
	Fatigue			
	Nausea and vomiting			
	Restlessness			
	Hot flushes			
	Difficulty concentrating			
	Painful/tender breasts			
	Feeling of well-being			
	Buzzing/ringing in ears			
	Distractible			
	Swelling(e.g. ankles, breasts, abdomen)			
	Accidents (e.g. cut fingers, break dishes)			
	Irritability			
	General aches and pains			

APPENDIX C:

PREMENSTRUAL ASSESSMENT FORM (PAF)

SCREENING VERSION

Name _____

Age _____

Date of first bleed _____

Date of next bleed _____

This form is used to determine the nature of your usual premenstrual changes. Think about the changes that occur premenstrually. Consider each symptom. Decide whether it describes a new condition or change which usually has occurred during your last three premenstrual periods.

The premenstrual period may range from one to fourteen days. Each woman should determine the duration of her individual premenstrual period using the following factors and guidelines.

Physical, behavioral and mood changes are considered as part of the premenstrual period if:

- 1). They appear or change during a premenstrual period.
- 2). They do not occur in the same form of severity immediately prior to the premenstrual period or during the days after the menstrual bleeding.
- 3). They disappear or return to the usual state during the full flow of menstrual bleeding.

The physical, behavioral and mood changes which take place during the premenstrual period may be either positive or negative.

Circle the appropriate number to indicate the severity of change from your usual state.

1= Not applicable, not present at all, no change from the usual level.

2= Minimal change (only slightly apparent to you, others would probably not be aware of the changes).

3= Mild changes (definitely apparent to you and perhaps to others who are close to you).

4= Moderate changes (Clearly apparent to you and/or others who know you well).

5= Severe changes (Very apparent to you and/or others who know you well).

6= Extreme changes (The degree of change in severity is so different from your usual state that it is apparent to you and to people who do not know you well).

Changes Present During Premenstrual Period						
Changes in mood (eg. laughing, crying, anger, happiness, etc)	1	2	3	4	5	6
Decrease energy or tend to fatigue easily	1	2	3	4	5	6
Decreased ability to coordinate fine movements, poor motor coordination or clumsiness	1	2	3	4	5	6
Feel anxious or more anxious	1	2	3	4	5	6
Sleep too much have difficulty getting up in the morning	1	2	3	4	5	6

Changes Present During Premenstrual Period						
Feeling of malaise (i.e. general or non specific bad feelings or a vague sense of mental or physical health.)	1	2	3	4	5	6
Feel jittery or restless	1	2	3	4	5	6
Have loss of appetite	1	2	3	4	5	6
Have pain, tenderness, enlargement or swelling of breasts	1	2	3	4	5	6
Headaches or migraine	1	2	3	4	5	6
Be more easily distracted (i.e. attention shifts rapidly and easily)	1	2	3	4	5	6
Tend to have accidents, fall, cut self, or break things unintentionally	1	2	3	4	5	6
Nausea and vomiting	1	2	3	4	5	6
Show physical agitation (i.e. fidgeting, hand wringing, pacing and can't stand still)	1	2	3	4	5	6
Feelings of weakness	1	2	3	4	5	6
Feel that they just "can't cope" or are overwhelmed by ordinary demands	1	2	3	4	5	6
Feel insecure	1	2	3	4	5	6
Have "flare ups" or allergies, difficulty breathing, stuffy feeling, or a watery discharge	1	2	3	4	5	6
Feel depressed	1	2	3	4	5	6
Have periods of dizziness, faintness, vertigo, ringing in the ears, numbness, tingling of the skin, trembling, light-headedness	1	2	3	4	5	6
Tend to nag and quarrel over unimportant issues	1	2	3	4	5	6
Think of what it would be like to do something to self, like crash the car, wish to go to sleep and not wake up, to have thoughts of death or suicide	1	2	3	4	5	6