

**THE RELATIVE EFFECTIVENESS OF MIASMATIC TREATMENT AS
OPPOSED TO SIMILLIMUM TREATMENT IN TERMS OF THE OBJECTIVE
CLINICAL FINDINGS IN PATIENTS WITH ACNE VULGARIS**

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I, Karin van Niekerk, do hereby declare that this dissertation represents my own work in
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ABSTRACT

The purpose of this study was to compare the relative effectiveness of miasmatic treatment as opposed to simillimum treatment in terms of the objective clinical findings in patients with acne vulgaris.

This study was a double blind, randomized clinical evaluation. Convenience sampling was employed to draw patients of both sexes with a median age of sixteen years from the greater Humansdorp area in the Eastern Cape. There were thirty five patients of which eighteen constituted the simillimum group and seventeen the miasmatic group. The treatment period was nine weeks with four consultations.

Patients suffering from acne fulminans, acne rosacea and conglobate acne or receiving any treatment that would affect the acne vulgaris was not accepted into the treatment.

The effect of the homoeopathic treatment was measured in terms of the reduction in the total number of lesions. The lesions were divided into two groups for analysis, namely non-inflamed and inflamed lesions. The Leeds Technique for assessing acne vulgaris, i.e. the counting technique was used.

The standardized statistical techniques for non-parametric data used, was the Wilcoxon Matched Pairs Test and the Mann-Whitney U Test. A Friedman ANOVA was also performed.

The results showed that there was no statistically significant difference between the reduction in the number of lesions in the two treatment groups, i.e. both showed a similar reduction. The Friedman ANOVA showed a statistically significant reduction in non-inflamed lesions ($p < 0.00013$) as well as inflamed lesions ($p < 0.00001$) for the whole group. Both treatment groups showed a statistically significant improvement.

It can be concluded that miasmatic treatment was as effective as simillimum treatment for patients with acne vulgaris. It can further be concluded that both methods significantly affected the clinical appearance of acne vulgaris in the patients examined. The relative effectiveness of the miasmatic treatment has important

implications for homoeopathic practice. It can be used as an effective alternative in cases where simillimum treatment fails to provide the expected results.

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DEFINITION OF TERMS

Acne vulgaris

Acne vulgaris is a common inflammatory pilosebaceous disease characterized by comedones, papules, pustules, inflamed nodules, superficial pus-filled cysts and in extreme cases canalizing and deep, inflamed, sometimes purulent sacs (Berkow, 1992 : 2429).

Miasm

A miasm is a predisposition toward chronic disease underlying the acute manifestations of illness,

- 1) which is transmissible from generation to generation, and
- 2) which may respond beneficially to the corresponding nosode prepared from either pathological tissue or from the appropriate drug or vaccine (Vithoulkas 1980 : 130).

Nosode

A nosode is a remedy, homoeopathically prepared from disease products, with its own, full, distinct drug picture (Hopkins 1997).

Remedy

A remedy refers to a homoeopathic medicine.

CHAPTER 1 - INTRODUCTION

It is estimated that 80 % of people develop acne vulgaris lesions at some point of their lives (Graham-Brown, 1996). Its prevalence is similar in both sexes but the peak age of severity in females is 16 - 17 years and in males 17 – 19 years. Acne vulgaris clears by the age of 23-25 years in 90% of patients but some 5% of women and 1% of men still need treatment in their thirties or even forties. (Edwards & Bouchier, 1991 : 915.) The effects of acne vulgaris on patients is diverse and vary from psychological effects like withdrawal, developmental problems, depression and anxiety to physical effects like scarring and disfigurement (Callan 1997).

The allopathic treatment of acne vulgaris is long term, ranging from a few months to years, and is usually aimed at **systemic** treatment. The major side-effects of the allopathic drugs commonly used to treat acne vulgaris include, drying of the skin and mucous membranes, soreness and irritation, skin pigmentation, gastrointestinal upsets, thrush, dizziness, nausea, weight gain, muscular aches and pains, hyperlipidaemia, liver damage and teratogenicity (Graham-Brown, 1996). Graham-Brown (1996) also notes that the most common reason allopathic treatments for acne vulgaris fail is because they were not given in high enough dosages and for long enough. He recommends persisting with the treatment for at least six months initially or longer until the expected results are seen before slowly reducing the daily dose. In the light of this, many patients seek alternative treatment for this problem. Master (1993 : 354) states that acne vulgaris is one of the problems for which patients often consult the homoeopath.

Acne vulgaris is a **chronic** problem or disease and according to Dox, Melloni & Eisner (1993 : 99) *chronic* denotes a disease of slow progress and persisting over a long period of time. In outlining the incidence of acne vulgaris, Edwards & Bouchier (1991 : 915) implies that it can affect the individual from between five to ten years. Choudhury (1988) in his preface states that the homoeopathic physician who ignores the miasmatic principle cannot eliminate deep-seated chronic ailments. It therefore appears that miasmatic treatment may be indicated for patients suffering from acne vulgaris.

According to the available literature on homoeopathic research in the treatment of acne vulgaris, the role of miasmatic treatment has not been investigated. Information on hand regarding this is mostly anecdotal. Lee (personal communication 1998) has found that some patients with acne vulgaris responded dramatically to the administration of the nosode *Medorrhinum*, which is used as a miasmatic treatment. Jouanny (1993 : 282) recommends treating the terrain, i.e. basic predisposition towards developing acne vulgaris with miasmatic treatment in conjunction with constitutional (simillimum) treatment.

McDavid (1994) investigating the use of simillimum in the treatment of acne vulgaris found that there was a statistically significant ($p = 0.006$) improvement in the clinical manifestations.

A search of the indexes of the British Homoeopathic Journal 1982-1998, LINKS 1987 - 1998, Hom-Inform Database (19 000 references to homoeopathy journals dating back to 1911) and Medline 1993 - 1998 reveals that no research on the relative effectiveness of miasmatic treatment singularly, or comparatively to simillimum treatment, for patients with acne vulgaris have been undertaken. It is therefore important to investigate the role of miasmatic treatment in patients with acne vulgaris. This study will be aimed at acne vulgaris specifically as a **chronic** condition and will exclude other types of acne.

CHAPTER 2 - REVIEW OF THE RELATED LITERATURE

2.1 Acne vulgaris

The term acne refers to an eruption caused by inflammation of the pilosebaceous glands, while acne vulgaris refers to **chronic** acne, occurring commonly on the face, chest and back of adolescents and young adults (Dox *et al.* 1993 : 6). Acne vulgaris can be defined as a common inflammatory pilosebaceous disease characterized by comedones, papules, pustules, inflamed nodules, superficial pus-filled cysts and in extreme cases canalizing and deep, inflamed, sometimes purulent sacs (Berkow 1992 : 2429).

In describing the pathogenesis of acne vulgaris, Graham-Brown (1996) describes two basic 'defects'. The first is a surge of increased sebum production driven by circulating androgens. This gives rise to the clinical appearance of greasiness. Secondly, the mouths of hair follicles become occluded as a result of hyperkeratosis. The reason for this is unclear, but it may also be androgen-dependent. These two phenomena result in dilated chambers full of sebum, in which grow the obligate anaerobe *Propionobacterium acnes*. These units are known as **comedones** and are clinically demonstrable as small, non-inflamed swellings, white heads and blackheads. Inflammation is thought to develop around comedones as a result of the diffusion of inflammatory mediators through the follicle wall and into the surrounding dermis. This leads to an acute inflammatory reaction. The inflamed lesions are usually small and are referred to as a 'spot' or 'pimple' in lay man's terms. Sometimes these lesions are much larger and become nodular or cystic. The inflammatory lesions may leave scars when they heal. Graham-Brown (1996) also points out several factors that are irrelevant in the pathogenesis of acne. These include the consumption of sweets, chocolate or fatty foods, lack of personal hygiene and excessive or absent sexual activity.

Acne comes in widely varying degrees of severity, some patients have only a few comedones and others have nodulocystic lesions from scalp to midback, with extensive keloid scarring (Graham-Brown, 1996). Burke and Cunliffe (1984) described a counting system, the Leeds technique, which is used for detailed work in therapeutic trials. They distinguish between non-inflamed and inflamed acne vulgaris lesions. They recommend the technique as relatively simple and reproducible.

2.2 Allopathic treatment

The allopathic treatment of acne vulgaris includes both local and systemic treatment. Local measures are the topical agents. Systemic measures are antibiotics, anti-androgens, isotretinoin, steroids and surgery.

Local measures are **topical agents** like antibacterials, irritants and drying agents applied to specific lesions (Edwards, 1991 : 916). Most of these are thought to work by unblocking the hair follicle orifices. A number of these proprietary agents, available without prescription, contain sulphur, an age-old remedy for acne vulgaris and others contain either benzoyl peroxide or tretinoin. Major side-effects experienced by patients are drying and soreness of the skin. (Graham-Brown, 1996.)

Although there is no evidence that the severity of acne is related to the bacterial counts, reduction in bacterial load is associated, initially at least, with clinical improvement. The **antibiotics** of choice are the tetracyclines. It is thought that the tetracyclines in particular have anti-acne activity by directly interfering with the inflammatory response as well as their anti-bacterial effect. They may also interact with inflammatory mediators. Major side-effects of the antibiotics commonly used are increased photosensitivity, oesophagitis, dizziness, nausea, skin pigmentation, diarrhoea, recurrent thrush, allergic rashes and upper gastrointestinal symptoms. The tetracyclines are absolutely contra-indicated in growing children and pregnant or lactating mothers. There is also possible drug interaction between these and the contraceptive pill. (Graham-Brown, 1996.) Another side-effect of treatment with tetracyclines is benign intracranial hypertension, which can be potentially dangerous (Edwards, 1991 : 917). Topical antibiotic preparations are used in individuals who cannot tolerate systemic treatment. These are in alcoholic lotions and can also cause drying and soreness. Topical tetracycline may cause fluorescence under ultraviolet light. (Graham-Brown, 1996.)

Anti-androgens and oestrogen are widely used in women. This inhibits the androgen drive that causes the excessive sebum production in acne vulgaris. Treatment needs to be continued long-term. It is, however, contra-indicated in anyone who has a history of thrombosis or any other disorder that contra-indicates the use of the contraceptive pill. Side-effects are weight gain, nausea and the other side-effects associated with taking the contraceptive pill (Graham-Brown, 1996).

Isotretinoin (Roaccutane), a vitamin A derivative, is considered by Graham-Brown (1996) to be the major therapeutic advance in dermatology in the past 10 years. It has several effects, including anti-inflammatory activity, a probable reduction in the hyperkeratosis of the duct orifice and a direct inhibition of sebaceous gland function. It dramatically reduces sebum excretion and is used for severe acne vulgaris. Side-effects include drying of the skin and mucous membranes, abnormalities of liver function, musculoskeletal aches and pains and hyperlipidaemia. This drug is highly teratogenic. (Graham-Brown, 1996.)

Steroids are used in large cystic acne lesions. Intralesional injections are used to reduce pain and inflammation. Occasionally **surgical excision** is used for resistant, unsightly, nodulocystic lesions. (Graham-Brown, 1996.)

2.3 Homoeopathic treatment

Master (1993 : 354) states that patients often consult the homoeopath for treatment for acne vulgaris. He adds that the problem should never be tackled with superficial, local acting remedies. Instead, deep acting constitutional treatment should be used.

The information on the homoeopathic approach and the clinical results obtained during the treatment of patients with acne vulgaris is mostly anecdotal. Clinical studies into the homoeopathic treatment of acne vulgaris have only recently been conducted. In terms of local treatment, Jouanny (1993 : 284) recommends that it should be as discreet and non-aggressive as possible.

McDavid (1994) investigated the use of simillimum in the treatment of acne vulgaris where an experimental group of 15 patients received the simillimum and a group of 15 patients received placebo. The treatment period was 4 months with 5 consultations. It was found that there was a statistically significant ($p = 0.006$) improvement in the clinical manifestations of the acne vulgaris in those receiving simillimum.

In another clinical trial Lee (1997) investigated the role of a homoeopathic complex in the treatment of acne vulgaris. In the study, a control group of 16 patients received placebo and an experimental group of 18

patients received a homoeopathic acne complex of Silicea 30CH, Selenium 9CH, Hepar sulphuris 30CH, Kali bromatum 9CH, Arctium lappa 3CH and Pulsatilla 30CH. The treatment period was 2 months with 5 consultations. The results showed no statistically significant improvement over the period of 5 consultations within or between the groups.

The above studies suggest that simillimum treatment may be the most effective form of homoeopathic treatment for patients with acne vulgaris. However, acne vulgaris is often familial (Edwards, 1991: 916). This **inherited** tendency of the condition is also an indication for miasmatic treatment (Watson, 1991: 41).

2.4 Miasmatic treatment

Miasmatic treatment in homoeopathy is based on the assumption that there exists in virtually everyone an inherited or acquired energy blockage or disturbance producing a **predisposition** towards a particular and recognizable pattern of illness (Watson, 1991: 41). In the patient with acne vulgaris it would mean that there is an inherited or acquired tendency to develop this disease and this predisposition must be treated in order to cure the patient of acne vulgaris.

Implicit in miasmatic treatment is the idea formulated by Hahnemann that it is impossible to fundamentally and permanently cure a chronic disease state unless treatment is directed towards the underlying miasm (Watson 1991: 41). This may be taken to imply that the way acne vulgaris keep recurring in the patient is an indication for miasmatic treatment. Vithoulkas (1980:134) states that chronic disease predispositions are the **primary** reason why some cases continue to relapse despite good therapy.

Eisayaga (1991: 68) also states that if it becomes clear during treatment that there is an active miasm in the patient, administering the medicine that responds to this miasm often solves or clarifies the case. He refers to this type of treatment as similitude according to miasm. He continues to describe two cases, both with skin affections that had almost no homoeopathically significant symptoms, i.e. no mental or general symptoms or special modalities. In the one case the administration of the corresponding nosode cured the patient. The other case was also cured with a miasmatic prescription.

An active miasm means that the miasm is actively (i.e. currently) producing a tendency to certain problems, which continue to recur in spite of homoeopathic treatment (Watson, 1991: 35). Evidence for this tendency of the problem to recur in patients with acne vulgaris, even after the administration of a well-selected remedy, is anecdotal but confirmed by homoeopathic practitioners as occurring frequently (McDavid, personal communication 1998). Eizayaga (1991:85) also confirms that if the miasm is in activity in a patient, whether it is hereditary or acquired, it may interfere markedly with the cure.

According to Vithoulkas (1980: 34) a miasm is characterised by transmission from generation to generation and by relief from the corresponding nosode.

2.4.1. Nosodes for miasmatic treatment

Wright Hubbard (1990: 113) states that in the nosodes we have remedies applicable to long-range tendencies, even several generations back. She also says that those homoeopaths who specialize in chronic constitutional prescribing find them invaluable (Wright Hubbard, 1990: 225).

Watson (1991: 41) acknowledges that some homoeopaths consider the nosodes to be no different from other remedies and that there is no reason to prescribe them other than on symptom similarity. He further states that this is in contrast with the bulk of clinical experience. He notes that the nosodes are inadequately represented in the repertories and that if repertorisation is taken as the basis for the prescription, then a nosode is most unlikely to be prescribed. Morrison (1993: 240) in his description of *Medorrhinum* states that this nosode, together with the nosode *Carcinosin*, are under-represented polycrests in the repertory and that they will almost never be prescribed on the basis of repertorisation.

Watson (1991: 42) states that in his and other homoeopaths' experience the nosodes are in fact among the most frequently indicated remedies. He lists the five major miasmatic nosodes as *Psorinum*, *Medorrhinum*, *Syphilinum*, *Tuberculinum* and *Carcinosin*. He gives the different situations in which a major nosode ought to be considered as:

- The nosode is the indicated remedy.
- Indicated remedies fail.
- Patient relapses.
- Acute disease fails to resolve.
- The miasm obscures the symptom-picture.

Wright Hubbard (1990 : 116) lists the different ways in which homoeopathic prescribers would use the nosodes:

- Where the miasmatic history is clear and the symptoms are mixed or obscure.
- Others put them in as 'intercurrents'.
- The French school combines or alternates the most suitable miasmatic nosode with the most similar remedy for the top layer, or recent symptoms.
- In cases where no remedy stands out even after patient questioning and repertorizing, the nosode of the main miasm is given in order to stir up the depths and throw out indications for a curative prescription.
- When seemingly well chosen remedies fail to act or hold.
- In the clearing up of recalcitrant relapses.

2.5 Summary

It should be clear that miasmatic treatment probably has an important role to play in the treatment of patients with acne vulgaris. The relapsing or chronic nature of the complaint (acne vulgaris) also points towards possible miasmatic tendencies. In the light of the important role that miasmatic treatment plays in homoeopathic practice, it seems imperative that its role be investigated in patients suffering from this chronic condition.

It has also become clear that the nosodes are largely underrepresented in the repertory and as such are often not indicated in the cases of patients with acne vulgaris. The miasmatic treatment will therefore be administered in the form of nosodes, this being one of the accepted ways of treating a miasmatic tendency.

CHAPTER 3 - MATERIALS AND METHODS

3.1 ADVERTISING

Posters detailing the research and inviting participation was placed on notice boards at secondary schools, health shops and pharmacies in the Humansdorp district in the Eastern Cape. Announcements detailing the research and inviting participation were also made at all secondary schools in the area.

3.2 SELECTION CRITERIA

Inclusion criteria:

Patients must have acne vulgaris lesions on the face as defined by Burke and Cunliffe (1984) to be included in the research.

Exclusion criteria:

Patients who are pregnant.

Patients undergoing any other form of treatment or medication for acne vulgaris.

Patients in which the indicated simillimum treatment is a miasmatic nosode.

Establishing a baseline reading:

Only persons who had not received any treatment for acne vulgaris in the preceding six months were included in this research. Burke and Cunliffe (1984) recommend a minimum of a 3-month washout period in order to establish an adequate baseline.

3.3 SELECTION OF PATIENTS BY CONVENIENCE SAMPLING

A minimum of 35 persons was selected for this research. Patients were randomly divided into 2 groups (simillimum and miasmatic) in such a way that each patient had an equal chance of being selected for either group.

Thirty six numbers were written on separate pieces of paper and placed in a box. The numbers were drawn and the first eighteen drawn were placed on the simillimum list with the rest on the miasmatic treatment list. This list was drawn up and kept by an independent dispenser. As patients entered the research they were numbered sequentially by the researcher. The independent dispenser dispensed to each patient either the miasmatic or simillimum treatment in a powder according to the list.

3.4 TREATMENT

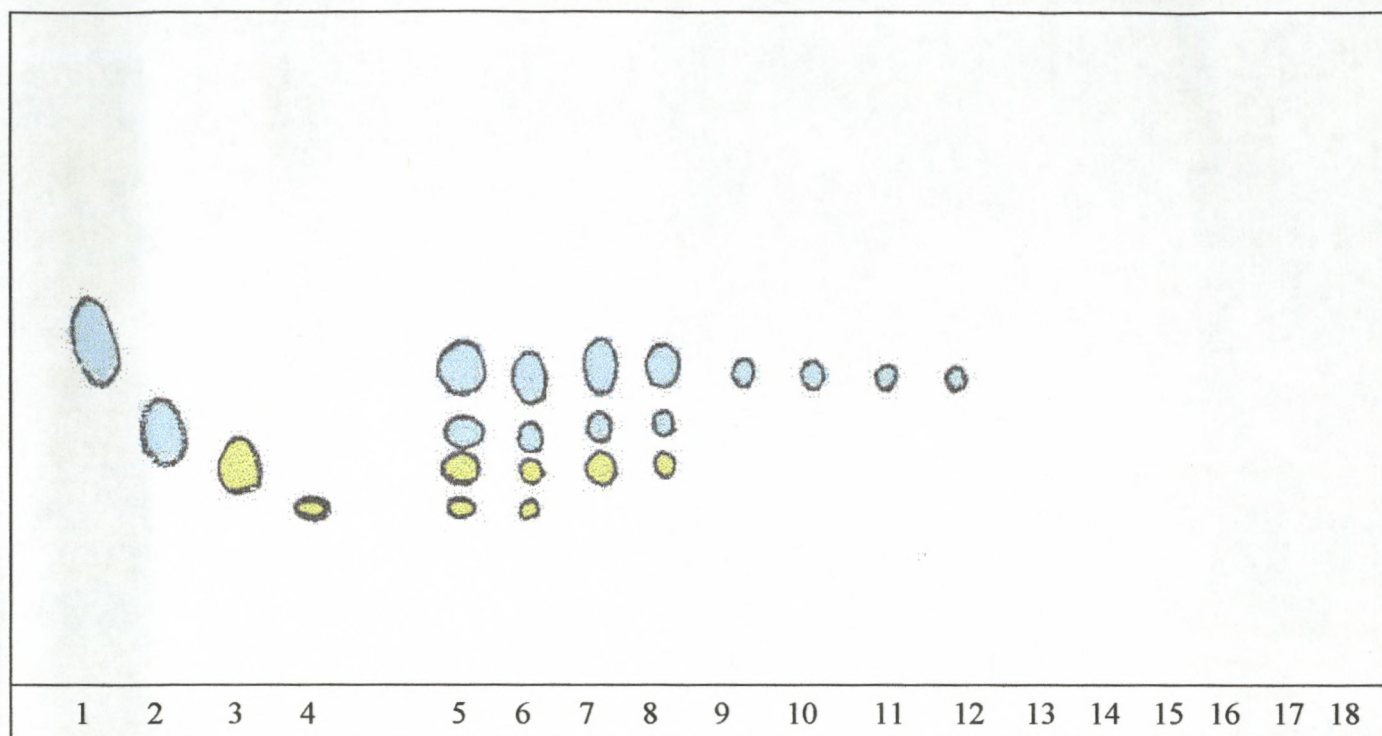
This was a double blind study. An independent dispenser administered either the miasmatic or simillimum treatment to each patient.

Simillimum treatment was based on homoeopathic principles and each case was supervised, by a qualified homoeopath, as to the correct selection of the simillimum. The simillimum was selected based on the totality of the symptoms as presented by the patient and those which were elicited by careful and extensive case history taking by the researcher. The symptom picture of the patient was matched with the symptom picture of a remedy selected from the *Materia Medica* in order to give the most similar prescription.

Based on the extensive case history taken by the researcher the dominant miasmatic predisposition of each case was determined according to homoeopathic principles. The following were also taken into account in the selection of the miasmatic treatment, based on Watson's (1991: 44) recommendations:

- Family history: When there is a prevalence of diseases in the ancestors of the patient, it can give clues as to the probable miasmatic inheritance.
- Personal medical history: The pattern of illness throughout the patient's life, including the presenting disorder can usually be matched to a particular miasm.
- If the patient has been on homoeopathic treatment in the past, then remedies which have been prescribed to the patient and have acted well can be used.

Nosodes are homoeopathic remedies prepared from the products of disease or diseased tissues. Each miasm has only **one** nosode belonging to it. The appropriate nosode was therefore selected as the miasmatic



1	=	AFB ₁	7 & 8	=	0.03 ppm clove oil
2	=	AFB ₂	9 & 10	=	0.05 ppm clove oil
3	=	AFG ₁	11 & 12	=	0.10 ppm clove oil
4	=	AFG ₂	13 & 14	=	0.15 ppm clove oil
5 & 6	=	control	15 & 16	=	0.20 ppm clove oil
			17 & 18	=	0.25 ppm clove oil

TLC plate showing aflatoxins produced by *Aspergillus parasiticus* grown in the presence of various concentrations of clove oil in broth culture.

treatment. This is one of the accepted methods of miasmatic prescribing (Watson, 1991: 41).

The independent dispenser was provided with a script for both the simillimum and miasmatic treatment for each patient. One of the treatments was randomly selected for each patient, using the list, as already discussed. The treatment was administered in the form of a single powder at the onset of the research, after the establishment of a baseline for each patient. Most of the treatments were administered in the 200CH potency. Appendix A gives a list of the different remedies used during this research.

Patients were seen after three weeks, six weeks and nine weeks for evaluation of the treatment. During each of these consultations the patient's acne vulgaris were assessed and the results recorded.

3.5 EVALUATION OF PATIENTS

First consultation:

The clinical manifestations of the acne vulgaris in the patients were measured by using the Leeds Technique (Burke and Cunliffe, 1984). Each patient's acne vulgaris were carefully observed and the number and type of lesions tabulated. Only acne vulgaris lesions on the face and neck were counted. Those on the nose and hairline were excluded (Burke and Cunliffe, 1984).

Lesions were divided into non-inflamed or inflamed lesions and counted.

(a) **Non-inflamed** lesions consist of blackheads and whiteheads.

Any intermediate lesions were counted according to their major component.

(b) **Inflamed lesions** are either superficial (papules and pustules) or deep (nodules, cysts and deep pustules).

(i) superficial papules and pustules vary in size from 0.1 to 0.5 cm in diameter.

(ii) deep inflamed lesions are nodules which are 0.5 cm in diameter or larger.

(iii) macules represent the resolving phase of either superficial or deep lesions and are either large or small.

A vernier calliper was used to measure the size of lesions in order to classify them.

Subsequent visits:

Patients returned for assessment after three, six and nine weeks.

During each follow-up consultation, the patient's acne vulgaris lesions were observed and the number and type of lesions tabulated as above.

3.6 INTERPRETATION OF DATA

The numbers and types of lesions were tabulated at every consultation in order for statistical analyses to be made. The inflamed lesions were added together for the purpose of statistical analysis.

There were eighteen patients in the simillimum treatment group and seventeen in the miasmatic treatment group. Since the sample size per group is small (< 30), non-parametric tests were used for data analysis.

3.6.1 Procedure 1:

The first purpose was to find out whether or not there were statistically significant differences between the two groups with respect to the reduction in lesions as observed. To do this the Mann-Whitney U Test for unpaired data were performed to test the null hypothesis.

The null hypothesis assumes that the reduction in lesions resulting from treatment A (simillimum) is the same as the reduction in lesions resulting from treatment B (miasmatic).

Accept the null hypothesis if $p > 0.05$.

Reject the null hypothesis if $p < 0.05$.

3.6.2 Procedure 2:

The null hypothesis was found to be true. Therefore a Friedman ANOVA was performed on the combined results of the two treatments to determine if there was a statistically significant reduction in the two types of lesions for the whole group.

3.6.3. Procedure 3:

The purpose of this analysis was to find out whether there were significant improvements within each of the two groups between consultation 1 and 2, 1 and 3, 1 and 4, 2 and 3, 2 and 4, and 3 and 4 with respect to each variable of interest. To achieve this, the Wilcoxon's Matched Pairs Test was performed to test the null hypothesis.

The null hypothesis assumes that the improvement between the consultations that are compared are the same.

Accept the null hypothesis if $p > 0.05$.

Reject the null hypothesis if $p < 0.05$.

Box & Whisker Plots were constructed to graphically illustrate the reduction in number of lesions for the two groups.

Statistical package:

STATGRAPHICS version 6+ was used for data entry and analysis.

CHAPTER 4 - RESULTS

Statistical procedure 1:

The null hypothesis assumes that the results of treatments A (simillimum) and B (miasmatic) are statistically the same.

Reject the null hypothesis if $p < 0.05$.

Accept the null hypothesis if $p > 0.05$.

The Mann-Whitney U Test for non-parametric data was performed.

Table 1: Mann-Whitney U Test : Comparison of treatments A (simillimum) and B (miasmatic) at each stage

Non-Inflamed Lesions				
	Rank Sum	Rank Sum		2*Isided
	A	B	U	exact p
BASE_NI	336.5	293.5	140.5	0.683657
NI_W3	338	292	139	0.659844
NI_W6	350	280	127	0.404757
NI_W9	320.5	309.5	149.5	0.909223

Inflamed Lesions				
	Rank Sum	Rank Sum		2*Isided
	A	B	U	exact p
BASE_I	311	319	140	0.683657
I_W3	364.5	265.5	112.5	0.183697
I_W6	333.5	296.5	143.5	0.756873
I_W9	317	313	146	0.832281

A = simillimum treatment
 NI = non-inflamed lesions
 Base = baseline observations
 W6 = observations at week 6

B = miasmatic treatment
 I = inflamed lesions
 W3 = observations at week 3
 W9 = observations at week 9

All the p-values are larger than 0.05. Therefore, accept the null hypothesis that it can not be statistically proven that there is a significant difference between the response to treatment A (simillimum) and treatment B (miasmatic).

Statistical procedure 2:

Following procedure 1, which showed that the responses of the two treatment groups were statistically similar, a Friedman ANOVA was performed on the combined results of the two groups. This was performed to determine if there was a statistically significant reduction in both non-inflamed and inflamed lesions for the whole group.

The null hypothesis assumes that there is no statistically significant difference between the initial observations (base) and the observations at week three (W3), six (W6) and nine (W9).

Accept the null hypothesis if $p > 0.05$.

Reject the null hypothesis if $p < 0.05$.

The results were:

For the *non-inflamed* lesions $p < 0.00013$

For the *inflamed* lesions $p < 0.00001$

Therefore the null hypothesis was rejected and it can be concluded that the whole group showed a statistically significant improvement over the observation period for both types of lesions.

Statistical procedure 3 :

The Wilcoxon Matched Pairs Test was performed on both treatment groups.

The null hypothesis assumes that there is no significant difference between the initial observations and the observations after three, six and nine weeks.

The null hypothesis was also tested between weeks 3 & 6, 3 & 9 and 6 & 9.

Accept the null hypothesis if $p > 0.05$.

Reject the null hypothesis if $p < 0.05$.

Table 2: Wilcoxon Matched Pairs Test

	Treatment A : Simillimum treatment			
	Non-inflamed lesions		Inflamed lesions	
Comparison	Z-scores	p-level	Z-scores	p-level
Base-W3	2.068642	0.038588	2.016642	0.043741
Base-W6	3.24266	0.001185	3.549354	0.000387
Base-W9	3.479351	0.000503	3.527579	0.00042
W3-W6	1.197635	0.231068	2.792274	0.005237
W3-W9	3.418703	0.00063	3.195322	0.001398
W6-W9	1.230791	0.21841	0.568057	0.57

Base = baseline observations
W6 = observations at week 6

W3 = observations at week 3
W9 = observations at week 9

	Treatment B : Miasmatic treatment			
	Non-inflamed lesions		Inflamed lesions	
Comparison	Z-scores	p-level	Z - scores	p-level
Base-W3	2.343236	0.019123	3.384675	0.000713
Base-W6	3.257653	0.001125	3.516196	0.000438
Base-W9	3.147984	0.001646	2.982301	0.002863
W3-W6	2.224891	0.026096	0.709952	0.477739
W3-W9	0.970431	0.331839	0.568796	0.569498
W6-W9	1.112445	0.265955	0.64636	0.518051

Base = baseline observations
W6 = observations at week 6

W3 = observations at week 3
W9 = observations at week 9

From table 2 the following conclusions can be drawn :

For treatment A (simillimum treatment)

There has been a statistically significant reduction in the number of **non-inflamed** lesions.

The exception is that the reduction in lesions between weeks 3 & 6 and weeks 6 & 9 were not statistically significant. The overall reduction in lesions was statistically significant.

There has been a statistically significant reduction in the number of **inflamed** lesions in all the comparisons made, except between weeks 6 & 9.

For treatment B (miasmatic treatment)

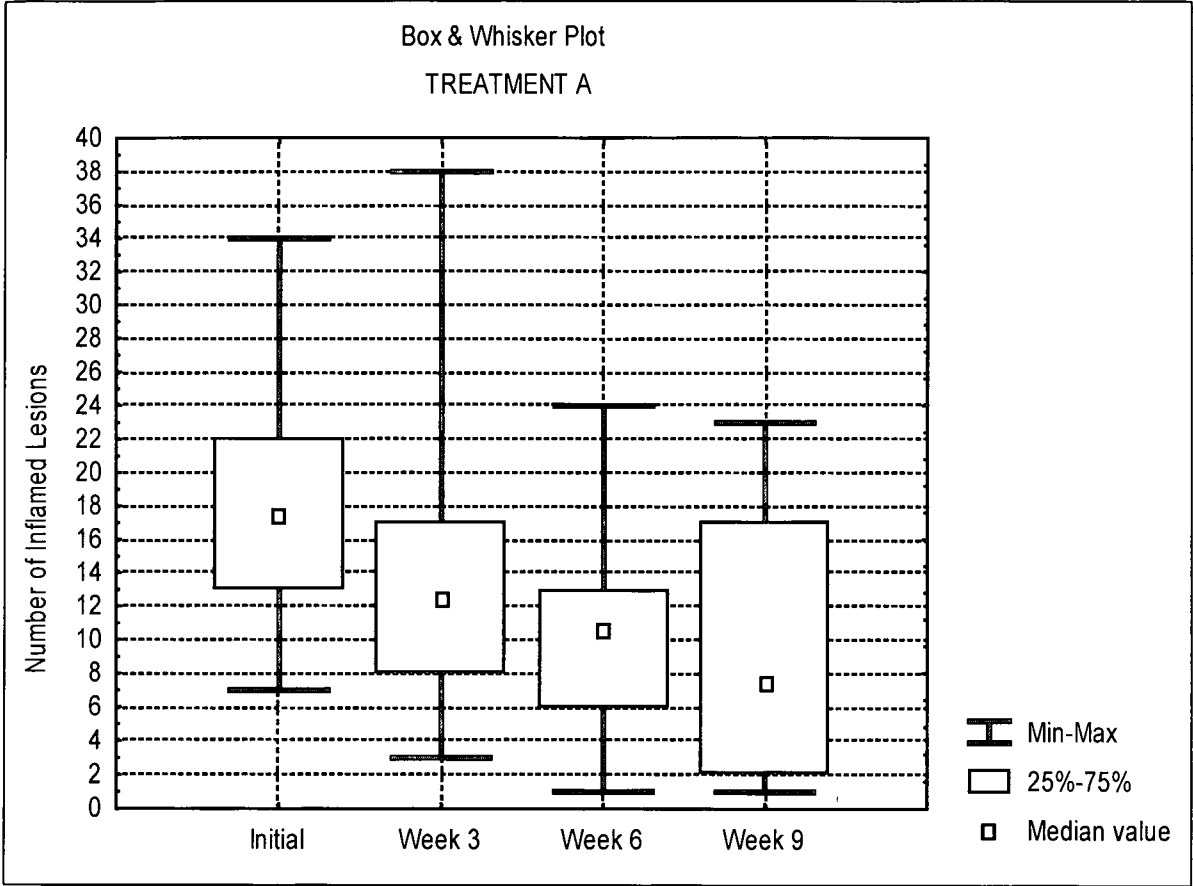
There has been a statistically significant reduction in the number of **non-inflamed** lesions with the exception that the changes between weeks 3 & 9 and 6 & 9 were not statistically significant. The overall reduction in lesions was statistically significant.

There has been a statistically significant reduction in the number of **inflamed** lesions with the exception that the changes between weeks 3 & 6, 3 & 9 and 6 & 9 were not statistically significant. The overall reduction in lesions was statistically significant.

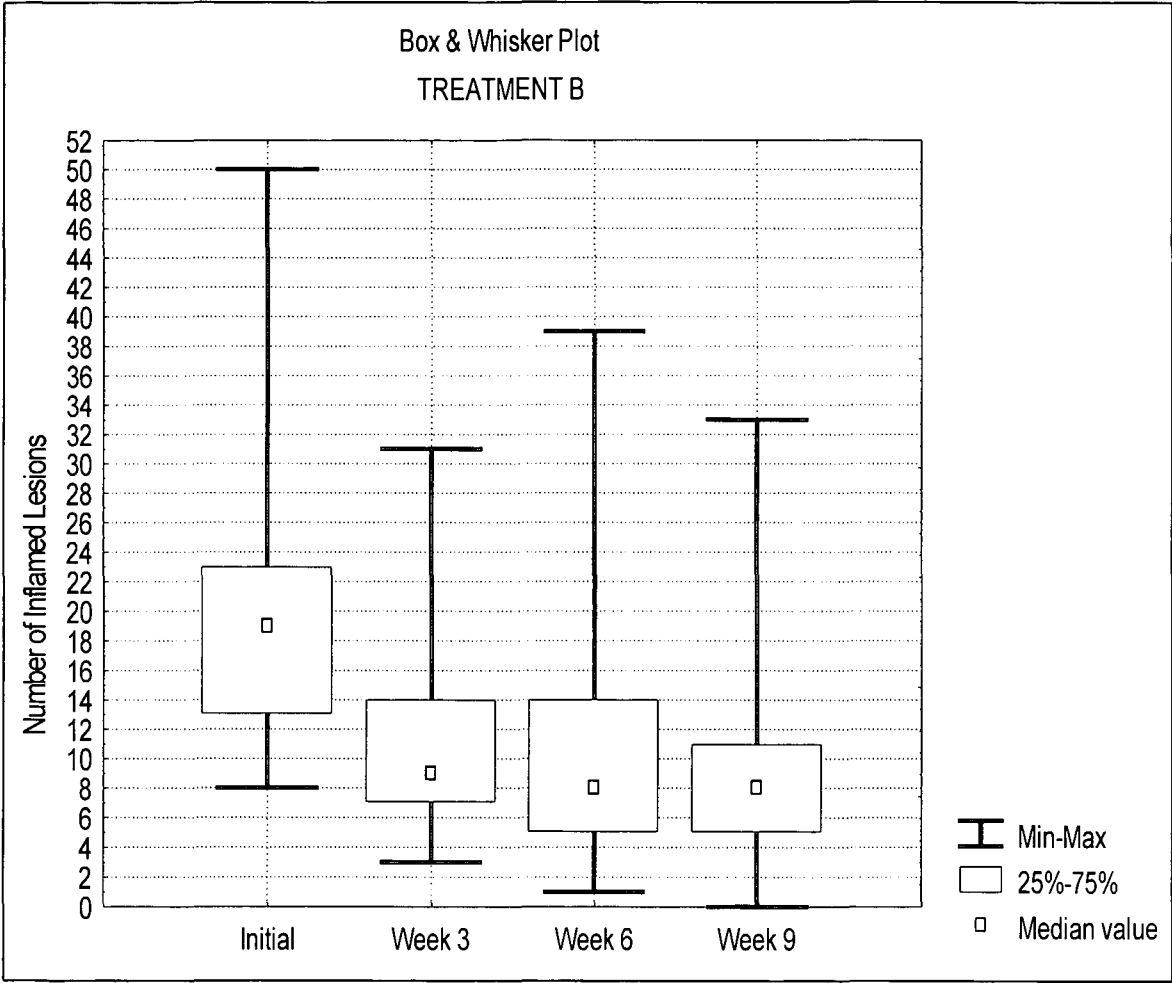
For both treatments

From the above it is also clear that there was no further statistically significant reduction in the number of lesions after the sixth week, for both types of lesions in all patients.

Graph 1: Graphic illustration of the changes in the number of inflamed lesions in the simillimum group.



Graph 2: Graphic illustration of the changes in the number of inflamed lesions in the miasmatic group.



CHAPTER 5 – DISCUSSION

5.1 Interpretation

It was found that there was no statistically significant difference between the two treatments (Table 1). The miasmatic treatment for patients with acne vulgaris was found to be as significant as the simillimum treatment. Referring to Vithoulkas's (1980:130) definition of a miasm as existing if it is transferable from generation to generation and if it **responds** to a nosode, it can be proposed that in the case of these patients a miasm does exist. According to Watson (1991:35), this will imply an active miasm, i.e. one that is currently producing symptoms, which continue to recur in spite of homoeopathic treatment.

It was also found that both treatments reduced the clinical manifestations of the acne vulgaris significantly (Table 2). Both simillimum treatment and miasmatic treatment therefore play an important role in the treatment of patients with acne vulgaris.

From Table 2 it also became clear that no further statistically significant reduction in lesions for both treatment groups were observed after six weeks. This means that a period of six weeks was long enough to observe the effect of either a nosode or a similar remedy on the clinical manifestations of acne vulgaris.

5.2 Argument

In homoeopathic practice, the practitioner will be faced with the difficulty of deciding whether to administer the nosode or another well-selected similar remedy in patients with acne vulgaris. The following arguments can be useful.

Banerjea ([s.a]: 40) states that if a single remedy is very clearly indicated in the case, the miasmatic influence is probably very small. In a patient with acne vulgaris, where more than one remedy seems indicated after careful repertorization, the miasmatic influence is probably active and the appropriate nosode would be the indicated treatment. If, however one single remedy is clearly indicated, this should be administered as the

treatment of choice.

It is also recommended that in cases of patients with acne vulgaris that does not respond adequately to a carefully selected homoeopathic remedy, the appropriate nosode be given. This will also apply to cases that initially show progress and then relapses.

Some homoeopaths will argue that the nosode should be given first, regardless of the case, in order to clear the miasm. This is not in accordance with the homoeopathic principles that every case must be treated on its own merits and only after careful case taking and repertorization, should a decision be made.

5.3 Speculation

Arising from this study is the question of whether the nosode should be repeated or should it be followed with another remedy?

Further studies comparing initial miasmatic treatment in the form of a nosode followed by simillimum treatment versus simillimum treatment alone needs to be undertaken. This combined approach is often used in homoeopathic practice and hasn't been clinically verified.

As it was found that after six weeks no further significant improvements were observed in either of the miasmatic or simillimum treatment groups for any of the variables under investigation, the next dose of the treatment remedy could be administered.

CHAPTER 6 – CONCLUSIONS AND RECOMMENDATIONS

The aim of this research was to investigate the relative effectiveness of miasmatic treatment as compared to simillimum treatment in patients with acne vulgaris. It was found that miasmatic treatment showed the same significant reduction in the number of lesions as simillimum treatment. This supports the findings of McDavid (1994) that simillimum treatment significantly affected the clinical manifestations of acne vulgaris ($p = 0.006$). In this study both the non-inflamed lesions ($p < 0.00013$) and the inflamed lesions ($p < 0.00001$) were significantly reduced. It can be concluded that both treatments have important application in homoeopathic practice with regard to patients with acne vulgaris.

The counting technique (Leeds) plays an important role in monitoring progress in patients with acne vulgaris. It can be useful as a tool in homoeopathic practice to provide an objective measurement of the change in the clinical manifestations of acne vulgaris.

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APPENDIX A – Homoeopathic medicines used

Remedies used in Simillimum treatment	Number of patients
Calcarea carbonica	1
Calcarea phosphorica	1
Lycopodium clavatum	4
Natrum carbonicum	1
Natrum muriaticum	3
Phosphorus	2
Pulsatilla pratensis	2
Sepia	1
Sulphur	3
TOTAL	18

Nosodes used in Miasmatic treatment	Number of patients
Carcinosinum	1
Medorrhinum	7
Psorinum	1
Tuberculinum bovinum	8
TOTAL	17