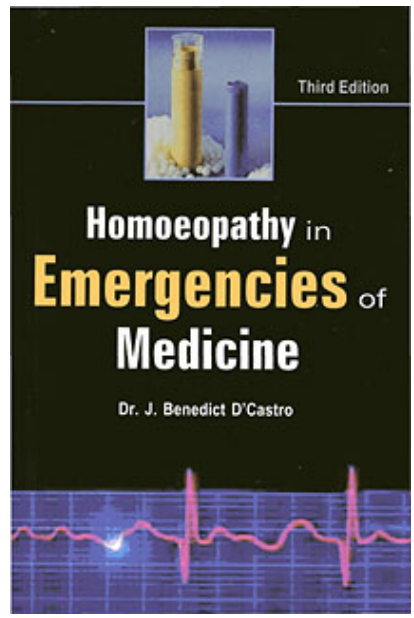
J. Benedict D'Castro
Homoeopathy in Emergencies of Medicine

Leseprobe

Homoeopathy in Emergencies of Medicine
von J. Benedict D'Castro
Herausgeber: B. Jain



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1 CARDIOVASCULAR EMERGENCIES

CARDIOVASCULAR EMERGENCIES

- Cardiac arrest
- Acute myocardial infarction
- Angina
- Pulmonary embolism and infarction
- Stokes-Adams syndrome
- Acute cardiac tamponade

CARDIAC ARREST

If the patient is unconscious with absence of heart beat and carotid, femoral, axillary and brachial pulsations, it is a case of cardiac arrest. Dilated pupils, apnoea and cyanosis are the other associated symptoms.

It demands immediate cardiopulmonary resuscitation. A team of four persons must get ready immediately. Then the senior most or the most experienced should guide the team. The second person is required for cardiac resuscitation, the third for pulmonary resuscitation and the fourth to observe the therapeutic hints. If there is only one person the cardiac and pulmonary resuscitation should be performed alternately. Before resorting to cardio-pulmonary resuscitation, the following procedure may be adopted:-

1. Put the patient flat on the ground (hard surface) legs elevated and head lowered (Fig. 1) Keep in this position for 5-10 seconds or for half a minute. This may increase the venous return to the heart by as much as 1000 ml.

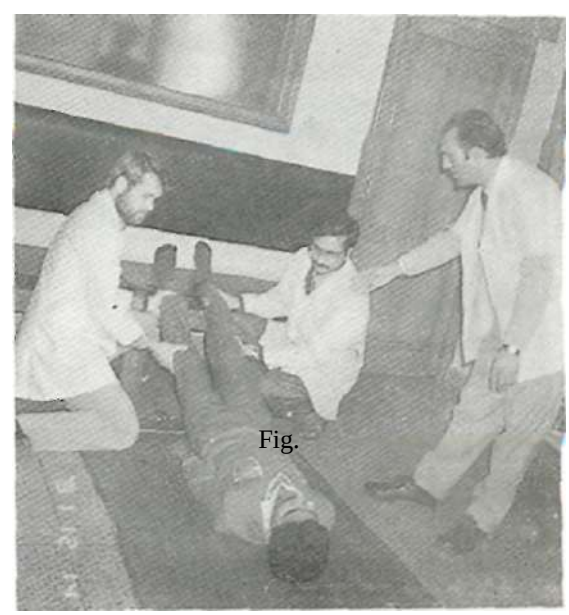


Fig.

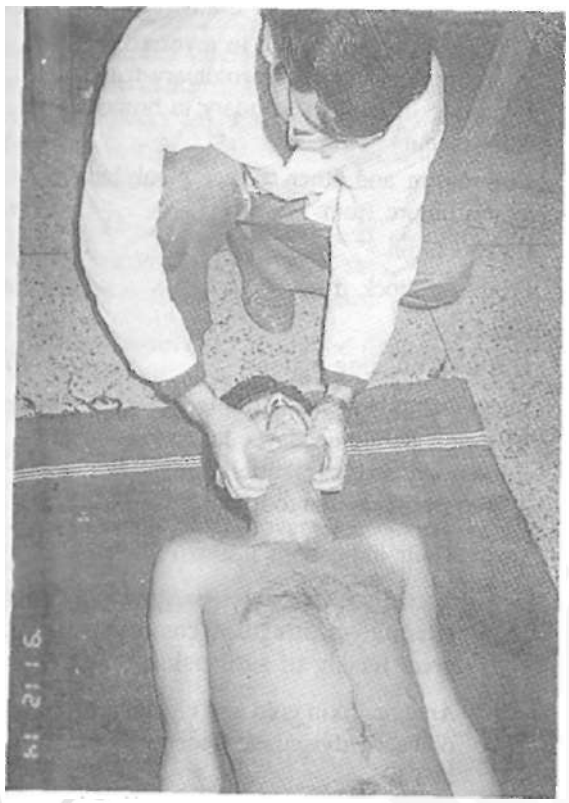


Fig. 5

forehead of the patient and pressing the head down and the right hand supporting the neck. (Fig. 6).

(b) Open your mouth wide and take a deep breath, make a tight seal on the patient's lips with your lips so that no air escapes (Fig. 7).

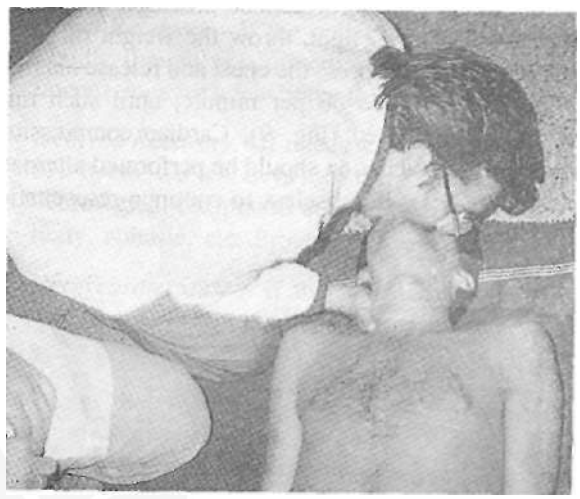


Fig. 7

(c) Give a forceful and sudden blow so that the amount of air blown in each breath is about lOOOcc (double the average air inhaled normally). Give such three or lour quick breaths initially without allowing the air to come out of the lungs of the patient completely. After that continue at the rale of 12 breaths per minute.

iii. Cardiac Compression (Cardiac Resuscitation)

(a) Place the heel of one hand at lower third of the sternum at 90° to the long axis of the sternum and the other above it, interlocking the fingers of both the hands (Fig. 8),

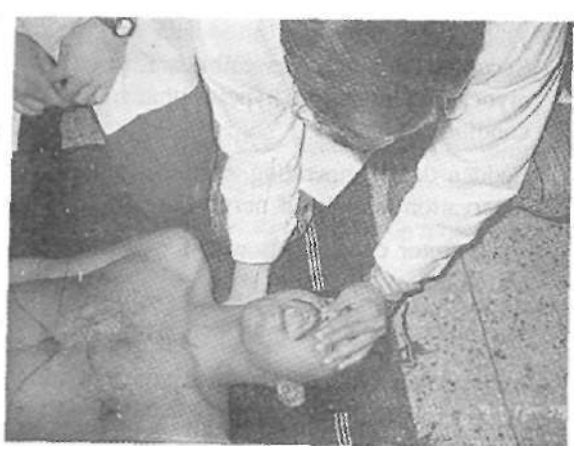


Fig. 6

Fig. 8

Periodical discharge of small - Lye.
Passes frequently small crystals of uric acid - Pareir.

Other homoeopathic medicines

Apis — Frequent sudden attacks of pain along ureters, lasting some minutes.

Argentum-nit. — Nephralgia from *congestions of kidney or from passage of calculi,* face dark red with dried up look ; dull aching across small of back and over region of bladder; urine burns while passing, is dark and contains blood, renal epithelium and uric acid; urethra feels as if swollen; sudden urging to urinate. Often useful after failure of *Canth.*

Arnica —Piercing pain as if a knife was plunged into renal region, with violent tenesmus of bladder; patient is chilly and inclined to vomit. -

Arsenicum — Passage of gravel from time to time, causing dull pain in renal region and down the ureter, accompanied by gastralgia, tickling in urethra and difficult micturition; excessive restlessness.

Belladona —Spasmodic, crampy pains, straining along ureter as far as the bladder; pain comes and goes quickly; eyes injected, face dark red.

Berber is vulg. —Sticking, digging, tearing or pulsative pain in region of one or both kidneys; or violent cutting sticking pain from kidney to bladder and urethra; red sediment in urine; yellow, muddy complexion; dyspepsia.

Calcarea carb. —Pressing pain in kidneys and loins; aching in kidneys and lumbar region when riding; pain while urinating after getting feet wet; gravel and stone in bladder.

Cannabis sat. — Drawing pain in renal region, extending into inguinal glands, with nauseous sensation at pit of stomach.

Cantharis — Dull, pressing pain in both kidneys and urging to urinate, steadily increasing in severity; paroxysmal cutting and burning pain in both kidneys, the region is very sensitive to slightest touch alternating with pain at tip of penis; urging to urinate; painful passage, by drops, of bloody urine; dull, heavy, distensive pain in renal region no relief in any position; groaning and crying followed by nausea, retching and vomiting; no great desire to urinate, but a tingling thrill running down dorsum of penis to glans.

Coccus cacti — Acute desquamative nephritis, fit of unconsciousness and absence of mind; headache in forehead and temples; face deeply red; sweetish taste, little appetite, thirst; severe abdominal pain at night; urging to urinate; urine dark coloured, with white sediment covered by a granular layer deeply tinged with blood; general lassitude; pain in limbs.

Colchicum — Pain in kidneys; urine bloody, ink like, albuminous; urging to urinate and discharge of hot highly coloured urine.

Dioscorea —Agonizing pain in small spot over crest of right ileum; pain radiate from this spot upto renal region and down right leg into right testicles; loud cry with excitement, twisting and turning in bed; skin bathed with cold, clammy sweat; pulse feeble and weak, retching; frequent desire to urinate.

Equisetum — Dull pain in the region of right kidney, with urging to urinate; slight pain in right kidney, then in left, extending down left side of sacrum.

Erigeron — Sharp, stinging pain in left renal region, complete suppression of urine, urging to urinate with emission of only a few burning drops.

Nux vomica — Renal colic, especially right side, extending to genitals and right leg, aggravates on lying on that side, ameliorates on back; painful, ineffectual urging to urinate; urine passes in drops with burning and tearing; stitches in the back while turning, with dull pain while sitting.

Ocimum canum —Renal colic, right side, with violent vomiting every few minutes; she twists about, screams and groans; red urine with brickdust sediment or blood after the attack.

Pareira brava —Violent pains in bladder and at times in back; left testicle painfully drawn up; pain in thighs, shooting down into toes and soles of feets; strongly ammoniacal smell of urine.

Tabacum — Renal colic; violent pains along ureters; cold sweat and deathly nausea.

In the presence of urinary infection in addition to homoeopathic medicine, a large fluid intake should be advised to all patients and a thorough investigation of the urinary tract should be conducted to establish the cause of colic. A plain X-ray of the urinary tract is done in all cases. An IVP should be advised after the pain has subsided. An IVFdone during the acute pain leads to wrong

URGENT TRACHEOSTOMY

Tracheostomy is usually done as a planned procedure, but sometimes it has to be done in an emergency without anaesthesia and with only a pen knife at hand, as explained below.

Lay the patient flat and extend the neck by keeping a pillow under the shoulders. Hold the head in midline and keep larynx in position, with the help of the left thumb and middle finger. Give a midline incision from the thyroid cartilage to just above the manubrium sternum. Incision over the neck muscles should be deep enough for the tracheal muscles to be felt. Trachea should be incised through second and third ring. Introduce dilator and the tube with knife still in place. Hold 'dilator' in left hand and introduce tracheostomy tube. Then remove the knife and the dilator and fix the tube firmly against the neck with lecoplaster tied behind neck.

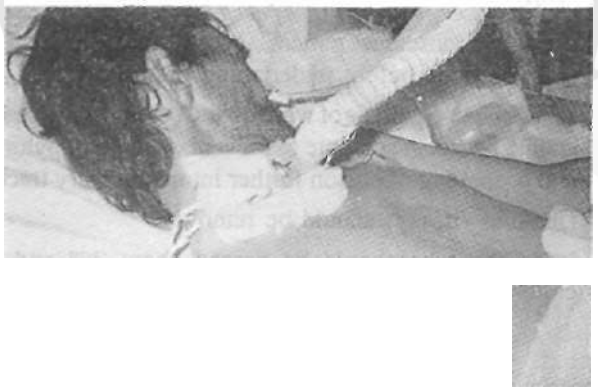


Fig. 46

If dilator and tracheostomy tube is not at hand, insert a short rubber tube after incision and use artery forceps instead of dilator.

Precautions

1. Incision should be strictly in midline.
2. Trachea should never be incised through first ring.

ENDOTRACHEAL INTUBATION

Endotracheal intubation, which should be known to every physician is a life saving procedure which ensures clear airway in an unconscious patient.

Procedure

Rex the lower end of the patient's neck by keeping a pillow under the occiput and extend upper end of the neck bimanually to bring the long axis of larynx, pharynx and the oral cavity into one line.

Introduce a laryngoscope (Fig. 47) so that the blade slides over the tongue till epiglottis is visible.

Fig. 47 — Laryngoscope

Lift the tongue and epiglottis forward so that vocal cord is in view, and then pass endotracheal tube (Fig. 43) between the cords.

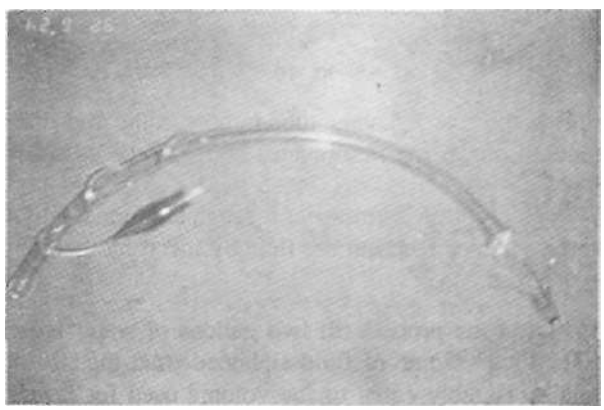
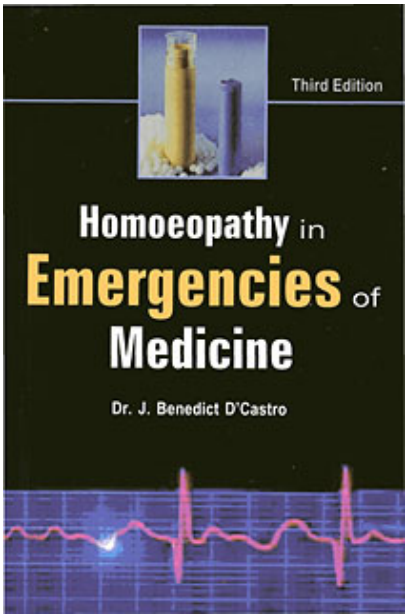


Fig. 48 — Endotracheal tube



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