BIOLOGICAL THERAPY

JOURNAL OF NATURAL MEDICINE

BT

Reprinted from
Volume VI No. 4
pp 73-78

SEP 063

Latest Clinical Results with Traumeel Ointment in Sports Injuries

by Dr. Wilfried Stock

This lecture was given by Dr. Wilfried Stock on the occasion of the second HEEL U.S. Symposium in San Francisco on October 17, 1987. In it, he reports on the composition of HEEL's Traumeel ointment and its various indications concerning sports injuries. He follows with results of a Traumeel vs. placebo study performed on injured athletes.

In our modern societies, sport has been endowed with immense socio-cultural significance. A great amount of leisure and mass-enjoyment sport is enjoyed in most advanced countries of the earth, in addition to championship sport activities. Jogging is a prime international example.

This enormous number of human beings who are engaged in sports activities brings with it, of course, an unfortunate negative phenomenon: a continuous rise in the number of registered sports accidents. In advanced countries, almost twenty percent of all accidents are suffered during engagement in sport. In the Federal Republic of Germany alone, the estimate is currently at approximately one million sports injuries per year, including an estimate of the great number of nonregistered accidents. About one-fourth of these injuries require treatment by a physician [source: "The Treatment of Sports Injuries and Disabilities with Traumeel Injection Solution," data by Erler and Schneider reported by Thiel in *Biological Medicine*, 4/1986].

The length of time during which victims of sports injuries are unable to work has been more extensively recorded than other criteria, and these data indicate that such injuries are primarily minor in nature. Statistics collected in this area show that around eighty percent of the injuries requiring treatment, as stated previously, involve missing work for fewer than six weeks, ten percent are out for several months, and one-half of one percent cannot work for more than one year.

As reported by the researcher Groh, the average length of time off the job due to a sports injury amounts to approximately three weeks in West Germany.

From these data, it is not difficult to conclude that sports accidents represent an economic factor of non-negligible degree — one for which national economies incur considerable expense by way of the consequences of such injuries. According to estimates made by Mellerowicz in *The German Medical Journal*, on the other hand, enormous costs also accrue owing to the lack of exercise on the part of the general population. Losses here are reckoned at around 65 billion marks annually — about 30 billion dollars — for the Federal Republic of Germany alone [source: *Deutsches Ärzteblatt* 80, 37, 68, 1983].

As is logically understandable, injured sportsmen and sportswomen would like to be healed as soon as possible. Treatment, therefore, should be directed toward optimal recovery and ability to return to athletic engagement as rapidly as is justifiable.

Techniques of treatment for sports injuries are derived fundamentally from general surgical-orthopedic and traumatological principles gained from general medical experience. As an unavoidable consequence of the continually growing demands placed on championship athletes over the past years and decades, however, new and special methods of treatment have had to be developed. These methods are primarily of interest to sports physicians, but will also be of considerable concern to trainers and, not least, to the athletes themselves.

In addition to important physiotherapeutical measures for treating sports injuries, **medication therapy** presently consists for the most part of the application of logically administered preparations. To a lesser degree, administration is also made systematically of pharmaceutical preparations.

Today, locally applied medication very often is administered through the media of sprays, salves, gels and ointment dressings. It is especially important for the application of percutaneously acting preparations that the administered substances effectively penetrate the skin. The essential resorption mechanisms of such pharmaceutical preparations are based on the process of passive diffusion. There are two possibilities for movement of the substances along this path:

1. Direct transport through the cells of the skin, and/or
2. Transport via the hair follicles and the sweat glands.

CAUSES OF SPORTING ACCIDENTS

1. Insufficient preparation
   - faulty technique
   - insufficient warming up
   - bad conditions and coordination
2. Breach of rules
   - lack of fairness
3. Overtiredness and overfatigue
4. Risks relating to a specific kind of sports
5. Exaggerated ambition

What various kinds of injuries can most frequently be observed among those who actively engage in sports? We will restrict ourselves only to the most *common* sports injuries – a discussion of *all* kinds of injuries is beyond the scope of this lecture.

In the case of the most types of sport – especially the aggressively competitive team games such as soccer, American football, team handball, basketball and volleyball, brusies and contusions are involved. These sports injuries arise through the direct action of force in the form of impacts or blows, without injury to the skin. Bruising of the soft parts of the subcutaneous fatty tissue, or panniculus adiposus, takes place. Muscles are also sometimes injured. Rupture of blood vessels occurs, with associated hemorrhages and hematomas, and with subsequent discoloration of the skin. Such bruises can initially be very painful, especially when they occur on the feet, knees, shins and thighs.

The second most frequent kind of sports injury is represented by sprains, as the result of twisting. Joints and ligaments are injured here. These injuries take place when the normal limits of movement of the joints are exceeded, such as happens when the ankle joint (articulatio talocruralis) is twisted, or when the knee joint is excessively turned. In cases in which the injury is not exceptional, damage is often limited to an extension of the capsular ligament system, with usually only slight swelling and hemarthrosis.

After healing, the joint is usually completely stable and again fully able to support loads. In the case of severe sprains with torn ligaments, however, there is later danger of instability of the joint as a result of loosening of the ligaments. Loose joints, and the frequent "wobble knee" are then often the result. These injuries are characterized most frequently by pronounced swelling of the joint and by great pain.

A further type of sports injury is dislocation, or luxation. As a rule, these are serious joint injuries which, in the case of a number of joints, can also be so severe as to include luxation fractures through involvement of the articular, or glenoid, surfaces. Even simple dislocations represent severe traumatization, however, and can often heal only with permanent restriction of the joint function, even when properly treated. Typical sports dislocations are encountered at the finger joints, the elbows, shoulder joints, acromioclavicular joints (the articulatio acromioclavicularis), the knee joints and the ankle joints (articulatio talocruralis).

Bone fractures, even for the aggressively competetive types of sports, are relatively rare. The extraordinarily increased popularity of Alpine skiing over the past ten years in Germany, however, has been accompanied by a similarly unusual increase in the number of bone fractures observed by us there. Many of the latest developments in modern operative treatment methods – for example – osteosynthesis – can be traced in some good degree to the enormous increase in bone fractures from skiing.

Most such sport fractures involve torsion breakage of the diaphysis, or shaft, of the bones.

Last, but not least, I would like to mention sports injuries which include wounds to the skin. These are minor abrasions, cuts or lacerations. The danger of infection is of course great for open skin wounds, and the treating physician should not neglect the prophylactic administration of tetanus serum in the event that it is necessary.

Top-level sport today includes great demands on athletes during intensive training sessions and of course under rugged competitive conditions. It is well known that many athletes can, after a phase of high-pressure sports competition lasting for years of their lives, experience late effects and permanent damage as the consequence of these great demands of modern sport. The syndromes are greatly differentiated here, as far as they concern subsequent damage to ligaments and to large and small joints. Such damages are many and various in nature, depending on the type of demands placed by the specific sport practiced. One might almost sarcastically comment here that sports are bad for your health. Or give Sir Winston Churchill's reply when they asked him for the secret of his health at such an old age: "No sports at all!" I would not like to dwell excessively on this somewhat exaggerated outlook of the great English statesman, but there is certainly a kernel of truth there. After all, anything unduly put under exaggerated stress will suffer damage. And, in the case of the human body, it is often irreparable.

If we once again recall the many and varied types of injuries which can indeed be suffered during engagement in sport, then it will appear logical that any medicinal preparation which is intended to cover as many as possible of the symptoms mentioned will of necessity be a complex medication. One single substance could hardly fill the needs for so many different disorders. The significant and primary characteristics of such a preparation should be as follows:

- Antiphlogistic
- Anti-edematous
- Anti-exudative
- Regenerative, and
- Promotive of wound healing.

Under closer study of the composition of the preparation Traumeel, we see that all these healing properties are fulfilled by its constituents for all forms of administration: in the form of ointment, as well as for the other forms of ampules, drops and tablets. We also see that "old friends" from the areas of natural remedies and homeopathy are represented: **Arnica montana, Calendula officinalis, Hypericum perforatum** and **Chamomilla.** These four homeopathic constituents alone have demonstrated amply proved effectiveness for many centuries in the therapy of traumata of great variety.

The two perhaps most critical components of Traumeel could be said to be **Arnica montana** – the classical remedy for traumata of many kinds – and **Hypericum** – a remedy which has gained the nickname "Arnica of the nerves," especially for therapy of nerve lesions, particularly those following contusions.

A further effective constituent is the thoroughly investigated **Belladonna,** which covers all rubor, tumor, calor, and dolor symptoms among its total effective characteristics.

Now, if one subsumes the individual effects of all 14 Traumeel components, then the following profile can be constructed in accordance with Bürgi's combination effect:

- Enhancement of wound healing following blows, falls and contusions, through the effects of the components **Arnica, Calendula** and **Symphytum**
- Analgesic effects through **Aconitum, Arnica, Chamomilla, Hamamelis, Hypericum** and **Bellis perennis**
- Hemostatic effects through **Aconitum, Arnica, Hamamelis** (especially for venous bleeding), and **Millefolium** (for arterial bleeding), as well as the sealing of blood vessels demonstrated by **Hepar sulfuris**
- Action against inflammation and virus through **Mercurius solubilis**
- Stimulation of overall bodily defense mechanisms through **Echinacea purpurea** and **angustifolia.**

Therapists and physicians not yet familiar with the homeopathic **Materia medica** may not be well acquainted with the effective medicinal action of the constituents as just listed. Therapists well versed in the effectiveness of homeopathic agents, on the other hand, will find nothing new in this information. We must, however, assume that the great majority of physicians today have been purely traditionally and conventionally trained in our modern medical schools, and that they have only scant – if any – knowledge from the area of natural remedies.

Now, in order to demonstrate the validity of homeopathic symptomatology and therapy for such conventionally trained therapists, we have tested Traumeel ointment in controlled clinical investigations, in accordance with clinical and scientific criteria currently valid in medical therapy.

As mentioned earlier, sprains of the ankle are among the most common of sports injuries. Athletes engaged in soccer and football, team handball, gymnastics, and track and field events are most often the victims here.

The following listed consequences of injuries such as ankle sprains are of particular significance, both for the future performance prospects of the patient, as well as for the therapy administered by the treating physician:

1. Damage to soft tissues
2. The accompanying hematoma, and
3. The development of hemarthrosis.

The length of time the athlete will be unable to compete will depend on the severity of the just-stated trauma consequences. The primary criteria here, of course, will be the pain suffered upon applying weight to the ankle, as well as the restriction of ankle mobility. The actual therapeutic measures taken by the physician or therapist are therefore of critical importance to the top-level athlete as well as for all who are seriously engaged in sport.

The pathophysiological sequence of such injuries is depicted in the following rough schematic representation:

Vascular rupture and increase in permeability to the terminal vascular system ⇐ TRAUMA

⇩

Release of prostaglandin and release of histamine ⇒ COMPLEX INFLAMMATION, WITH DEVELOPMENT OF EDEMAS AND PAIN REACTION

The conventional first-aid treatment of sprains usually takes place in the following forms:

- Mild compression bandaging, often accompanied by the application of salve (ointment dressings)
- Immobilization
- Cold packs
- Electrotherapy.

In addition to electrotherapy, local as well as oral medication in the form of antiphlogistic and analgesic preparations is frequently administered.

Today, the administration of non-steroid medication against rheumatism is coming under increasingly critical attack. It is particularly the side effects of such treatment which have promoted the search for local therapy, without such undesirable action, which demonstrate the following effects:

- Good analgesic action
- Fast resorption of edemas and hematomas
- Enhancement of microcirculation, with promotion of the natural healing processes

and, finally,

- A minimum of side effects.

TRAUMEEL Constituents:	Characteristics:
MERCURIUS SOLUBILIS HAHNEMANNI	Antisuppurative (= Antiphlogistic action), especially for *beginning* infections, lymphangitis/lymphadenitis, anti-exudative action
HEPAR SULFURIS (calcium sulfide)	Tendency to suppuration and phlegmon (furuncles, carbuncles, pyoderma, panaritium, angina). Reduces vascular permeability. Regenerative effect on sulfide ferments and oxidations-reduction-systems containing sulfide groups. – Enhances the oxidation processes and internal respiration in traumatized tissue.
CHAMOMILLA (chamomile)	Antiphlogistic, promotes development of granulation tissue and the healing of wounds, restlessness and excitement (teething pains, otitis media, and the like)
SYMPHYTUM (comfrey)	"ARNICA of the BONES": fractures: promotion of callus formation; periostitis, contusions, causalgia, pain at amputation stumps
BELLIS PERENNIS (small European daisy)	Resorption of edemas and hematomas: bruises, contusions, myalgic complaints
BELLADONNA (deadly nightshade)	RUBOR-CALOR-TUMOR-DOLOR-SYMPTOMS with particular affinity for the head (arterial hyperemia)
ECHINACEA ANGUSTIFOLIA (small-leafed coneflower)	Enhancement of mesenchyme defense, inflammatory processes of all kinds and localizations, septic processes, inhibits hyaluronidase, antiphlogistic action promotes healing of wounds
ECHINACEA PURPUREA (purple coneflower)	Activation of histogenous and hematogenous defense capability in the case of inflammatory processes and general infections. Fibroblast stimulation
HYPERICUM (St. John's wort)	"ARNICA of the NERVES": injuries to the nerves and brain: neuralgic pain accompanying injury, commotio cerebri, - hemostatic effects
ARNICA (mountain arnica)	Promotes healing of wounds: fractures, dislocations, contusions, hematomas, neuralgia, myalgia, hemostatic and analgesic
CALENDULA (garden marigold)	Promotes granulation: poorly healing wounds, is analgesic
ACONITUM (monk's hood)	Analgesic and antineuralgic! Inflammatory rheumatism. Is hemostatic: acts on the arterial system, enhancement of vascular tone
HAMAMELIS (witch hazel)	"ACONITUM of the VEINS": venostasis, varices, (thrombo-)phlebitis, ulcus cruris, hemorrhoids, venous bleeding, antiphlogistic and analgesic
MILLEFOLIUM (milefoil)	Hemorrhages, especially precapillary and arterivenous, (anastomosis-)seeping hemorrhages

Traumeel ointment fulfills all these expectations, as we have had confirmed from countless examples of administration and from reports from medical practice. The side-effect rate, for example, is less than three ten-thousandths of one percent. This means about three cases of side effects in one million applications.

The very few side-effect cases which did occur were basically the results of minor allergic reactions in the form of extreme sensitivity to the Mercurius component or to the plant constituent Arnica.

Now allow me to elaborate in greater detail on the tests in order that you can imagine how it was confirmed that Traumeel does in fact satisfy the indication requirements as stipulated in my list just mentioned.

GOAL OF THE TESTS:

The objective was to determine how the preparation Traumeel ointment influences the progress of disorders among patients with the following diagnosis:

"Straining of the articular-capsule ligaments (sprain) and of the tendons of the ankle."

Testing was to be performed on Traumeel ointment in combination with basic therapy consisting of interference-current therapy (the VARIODYN treatment) and the application of compression ointment bandages. Testing was conducted with respect to the goal criterion defined below and to the secondary comparative criteria, as differentiated from placebo conditions. The placebo was administered in the form of the ointment base, which had no therapeutic effects.

The tests were conducted for the patient population in such a manner that a pilot test was conducted before the main test. This arrangement was designed to obtain the measured values for definition of the goal criterion in the sense of the final statistical analysis.

The pilot test included 47 patients in two groups: Traumeel and placebo, with distribution of therapy to these groups on a random basis. The random distribution was performed in equalized blocks of six patients each, in accordance with a computer program. The same therapist was employed to administer both the Traumeel and the placebo salves: these were identically packed and were identical in appearance. Only a code number differentiated the packaging. Neither the therapist nor the patients were able to determine when the placebo or when Traumeel was administered. Until the end of testing, the list of random assignments was known only to the test coordinator.

The test results from the pilot study enabled us to design the statistical model for the main test. To ensure a difference between the placebo and Traumeel groups on the five-percent level in the main test, the measured data from the pilot tests were used to ascertain a number of at least 35 per group from the patient population which represented cases which could be effectively evaluated. In the main test, a total of 73 additional patients were incorporated, with assignment of Traumeel and placebo performed by the already described method.

CRITERION FOR SELECTION OF THE PATIENTS STUDIED

Patients were selected from both sexes, up to the age of 30, with sprains of the upper and lower ankle areas (Articulatio talocruralis and Articulatio talocalcaneonavicularis) as suffered while engaged in sports activities. This selection criterion ensured that persons with approximately equal physical training condition were studied in the test.

Therapy was administered in all cases on an out-patient basis in the Department for Physiotherapy of the Orthopedic Section of a German university clinic. Total immobilization of the injured ankles was not enforced, but the patients were not allowed to engage in sports for the duration of the therapy. Furthermore, the patients were advised to maintain the injured leg in an elevated position for the first three days at home after their injuries. Approximately 70 to 80% of the injuries

had been incurred while participating in a ball sport; the remaining cases were distributed among track and field and aggressively competitive types of sport.

Patients who fell into the following categories were excluded from this study:

1. Patients with joint injuries on both sides or with multiple joint injuries on the same side
2. Patients who had been injured more than 24 hours before the opportunity of their inclusion in the test
3. Patients with prior injuries at the same joint within six months before the test began
4. Patients with open wounds and the danger of infection
5. Patients with bone fractures
6. Patients for whom local or systematic long-term therapy with non-steroid anti-rheumatic medication was deemed necessary
7. Patients for whom static loadbearing deficiency of the joints concerned was present, on either a hereditary or an acquired basis
8. Patients with degeneratively pre-damaged joints, chronic joint disorders or post-operative joint conditions
9. Persons in poor physical condition and patients who did not engage in sport
10. Pregnant patients
11. Patients for whom the Movement-Pain Score was under two at the time that the initial test was conducted
12. Patients for whom the difference was less than 20 degrees between the injured and non-injured joints for the angular sum from raising and lowering at the time that the initial test was conducted.
13. Patients for whom the difference was less than 15 degrees between the injured and non-injured ankles for the inversion angle at the time that the initial test was conducted

PLAN OF THERAPY

The duration of therapy did not exceed 14 days. Patients were instructed to visit the clinic for in-patient treatment on the first, third, fifth, eighth, tenth, twelfth and fifteenth days after the injury. In all cases, the same therapist made the measurements, evaluated the conditions, and administered the medication in the form of applying a compression ointment bandage in accordance with the lesion concerned. Approximately 10 to 12 grams of salve were administered, and the basic VARIODYN treatment was conducted. Where required, the therapy was continued past the fifteenth day. For purposes of statistical evaluation, however, only findings until the fifteenth day were considered.

Testing was discontinued in those individual cases in which strong analgesic medications, adrenocortical steroids or nicotinamides were required. Allergic reactions also led to termination of the testing. Testing was furthermore interrupted if, after the third or fourth treatment sessions (about five to eight days after the injury), the injury was determined to be more severe than judged upon initial evaluation, as a result of not readily apparent symptomatic conditions. Patients for whom total immobilization of the injured joint became necessary, or who had to be admitted on an in-patient basis, were also not further studied.

Accompanying medication allowed for test continuation was provided only in the form of PARACETAMOL suppositories during the first three days after injury, as required for severe pain. Such administration was noted in the test forms.

RECORDING OF DATA

Upon initial examination, fundamental data such as age, body size, weight and time of injury before acceptance in the study were recorded. The type of sport, the side of the injured joint, other disorders, and medication therapy being taken were also recorded.

Data on patient pain were recorded each time medication was administered in the consecutive examination sessions. Immobile pain, pain after movement, and pain upon pressure were reported on a three-point scale with the score values of zero for no pain, one for mild pain, and two for severe pain.

Clinical findings were recorded in the form of skin temperature measurements made above the injured joint. A standardized contact thermometer with thermistor surface sensor, type NTC, with precision of plus-or-minus one-tenth of one degree Celsuis, was used. Measurement of the swelling was performed with a flexible tape measure around the circumference of the joint. Mobility of the joint was determined by the neutral-zero method. Joint mobility angles were measured by a goniometer angle-measuring device, with a precision of two to five degrees. The initial, or reference, point is usually the anatomical normal position for such measurements. Starting from this zero position, the opposing directions of movement are indicated, with movement *away* from the body being designated first in the recorded measurements. Measurement was principally recorded of the deflection of movement as actively performed by the patient himself. In order to arrive at a calculated reference difference, measurement was recorded of movement at the contra-lateral, healthy joint on one occasion only, during the first testing session. The movement deflection for the upper ankle (Articulatio talocruralis) is the sum of the angular measurement for lowering and raising. For the lower ankle (Articulatio talocalcaneonavicularis), differentiation is made between the eversion, or outward-turning, angle and the inversion angle.

A total of seven treatment consultations and examination sessions were provided in accordance with the therapy plan. In the event that the patient was able to terminate his visits earlier, owing to recovery from complaints, then the last treatment session was considered to be the follow-up examination. For patients who required longer treatment, follow-up examination was again conducted on the nineteenth day after the injury.

TEST RESULTS

First, the results of the pilot test. The measurements taken on the 47 patients included in the pilot study were used for determination of the variables required for design of the

statistical model for the main study. Their data were evaluated immediately after therapy was completed, with the aid of a personal computer at our company facilities.

It was determined from the measured values of the clinical findings from the pilot study that the skin temperature and the degree of swelling *do not represent sufficiently precise characteristics* for assessment of the course of therapy for the medical treatment of sprains. Only the following factors were found to be adequately precise to afford a basis for evaluation of sprain therapy:

- The angular sum taken from raising and lowering tests, in determination of joint mobility
- The inversion angle, and
- The pain suffered upon movement

A total of 36 patients were included for the main tests in the group to which Traumeel was administered. On the basis of test qualification criteria, however, only 33 patients were able to be evaluated, owing to the fact that three patients did not satisfy initial data criteria for angular differences and inversion angles.

The group treated with Traumeel included 8 women and 25 men, for whom the mean age was 23, plus-or-minus 5 years. The youngest patient was 14 and the oldest 33. The average height was five feet nine inches, plus-or-minus two-point-four inches. Average weight was 154 pounds, plus-or-minus 18 pounds. The average time for occurrence of the injury until the patients were included into the study was ten-point-eight hours, plus-or-minus three-point-five hours.

Seventy-five percent of the injuries were suffered while engaging in a ball sport, primarily soccer. None of the patients had been previously injured at the joint being studied. None of the patients suffered from other disorders or were being administered other medication. None of the victims took advantage of the opportunity to take PARACETAMOL suppositories for pain.

A total of 37 patients were included into the placebo group. One patient was excluded from the study on the same criteria as stated above for the Traumeel group.

The placebo group included 11 women and 25 men. The mean age was 22, plus-or-minus 4 years. The youngest patient was 16 and the oldest 30. The average height was five feet nine inches, plus-or-minus two-point-four inches. Average weight was 154 pounds, plus-or-minus fourteen-point-three pounds. The average time from occurrrence of the injury until the patients were included into the study was ten-point-five hours, plus-or-minus three-point-two hours.

Eighty percent of the injuries were suffered while engaging in a ball sport, primarily soccer. None of the patients had been previously injured at the joint being studied, in the sense of the exclusion criteria. None of the patients suffered from other disorders or were being administered other medication. None of the victims requested administration of PARACETAMOL suppositories for pain.

RESULTS AND COURSE OF THERAPY

For both the Traumeel as well as for the placebo groups, improvement in mobility of the joint — as evidenced by reduction in the angular difference — was clearly manifested as a result of the VARIODYN therapy and the compression bandage applied in accordance with Feuerstake. Improvement was more quickly achieved in the Traumeel group, however, by virtue of the action of the additional active components in the ointment. You will recall that only the ointment base was administered to the placebo group.

It was clearly seen, beginning from the second examination — at the fifth day after injury — that there was a difference between the progress of recovery of the two groups, to the advantage of the Traumeel patients. This advantage was maintained throughout the remainder of the course of treatment.

For the fourth examination — the tenth day after injury — a significant difference was determined between the measured values for the two groups. Calculations were made in accordance with the U Test after Wilcoxon-Mann-Whitney, with P equal to five ten-thousandths. In the sense of the definition of the goal criterion before beginning of the main study, the significance of the difference can be further assessed with the aid of the Chi-Square Test. The result of this test showed that the probability for successful therapy was significantly greater for treatment with Traumeel than for administration of the placebo (P equals three hundredths).

Additional evaluation of the course of treatment could be made by inclusion of the secondary comparison criteria such as pain upon movement.

It is quite apparent that a definite improvement of the Traumeel group over the placebo group was evidenced after the second examination on the fifth post-injury day. This positive trend was clearly continued for the Traumeel group up until the conclusion of the testing period.

We are fully convinced that modern clinical investigative methods will provide commendable findings for those preparations which have been developed on the basis of the following:

- The Materia Medica Homeopathica
- The tenets from the study of homotoxins
- The symptomatology and characteristic complexes pertaining to drugs

The chief difference between a preparation manufactured by the pharmaceutical and chemical industries, and a homeopathic preparation is that a chemical-pharmaceutical product has been synthesized step by step, whereas such developmental phases are not as a rule involved with homeopathic medications. These latter preparations have been combined by specialists in the tenets of homeopathy on the basis of their therapeutic experience. As confirmed again and again by those who prescribe homeopathic medication, this experience can at any time be gained by other physicians and therapists in like manner.

Until now, however, the effectiveness of homeopathic

preparations and the legitimacy of this experience has not been able to be confirmed with the aid of modern, controlled clinical studies.

It is true in Germany that classical, traditional homeopathic physicians and specialists will principally refuse to have a homeopathic medication tested in clinical studies. Their justification for this refusal is that homeopathic therapy is a strictly individual therapy for which randomization and statistical comparison could be applied only as a "contradictio per se." Since, however, this rule of strict individualization applies in a rigid sense only to *single* homeopathic agents which have been repertorized in accordance with the principles of Christian Friedrich Hahnemann, it is my opinion that this strict construction does not apply to *complex* preparations such as is generally the case with biotherapeutic antihomotoxic medications.

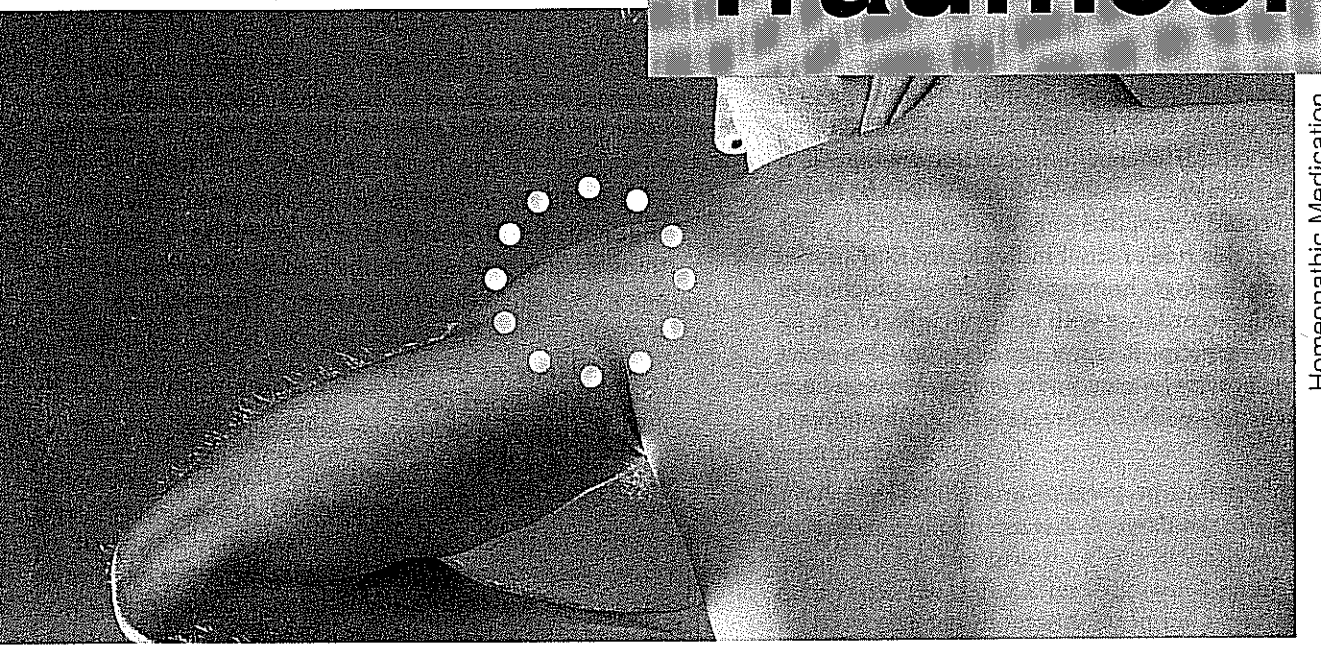
Complex homeopathic preparations, as I hope to have demonstrated for you, possess therapeutic effectiveness which can unequivocally be confirmed by modern, statistically evaluated clinical investigation.

To conclude, allow me to add a sentence which expresses my innermost conviction with respect to the dogmatic struggle currently being conducted in this context on medical methodology:

> In medicine, it is senseless to attempt to prove the one or the other side right or wrong: the main thing in each case is to do the best for the patient being treated. As the proverb goes, "Whoever heals is right."

Address of the author:
Dr. Wilfried Stock
Scheffelweg 9
D-7573 Sinzheim
West Germany

Traumeel®

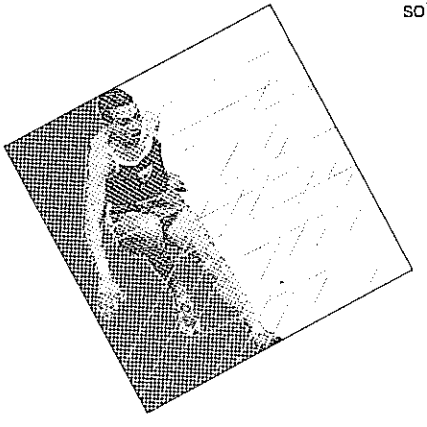


Homeopathic Medication

Your pro-biotic alternative for:

Sports injuries
Sprains and bruises
Inflammatory processes

Active ingredients: 100 g ointment cont.: Arnica montana radix 3X 4.416 g; Calendula officinalis 1X, Hamamelis virginiana 1X 1.326 g each; Echinacea angustifolia 1X, Echinacea purpurea 1X, Chamomilla 1X 0.442 g each; Symphytum officinale 1X, Bellis perennis 1X, Hypericum perforatum 3X, Millefolium 1X 0.265 g each; Aconitum napellus 3X, Belladonna 3X 0.147 g each; Mercurius solubilis 6X 0.118 g; Hepar sulfuris calcareum 6X 0.074 g.
Inactive ingredients: Hydrophylic ointment base according to USP XXI.
Package sizes: Tubes of 1.6 oz. (50 g) and of 3.2 oz. (100 g).
Also available in: Ampules (prescription only), tablets and drops.



Exclusive U.S. distributor of Heel Biotherapeutics:
BHI, Biological Homeopathic Industries, Inc.
11600 Cochiti S.E.
Albuquerque, NM 87123-3376
1-800-621-7644 or 505-293-3843

-Heel
Biotherapeutics