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Peripheral Circulatory Disorders and their Biological Treatment

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How many patients beyond the age of 50 can honestly claim to be completely free of peripheral circulatory problems? Under the high-pressure conditions that most of us are forced to endure in our stress-obsessed societies, any patient in advanced years must be truly thankful if he or she does not not suffer from more or less severe symptoms of cerebral ischemia. Millions are invested for the development of effective medications, and even more millions are spent by our patients in swallowing medicine for such complaints (unless, that is, cerebral sclerosis precludes remembering even to take the pills). Ut aliquid fiat? Or does such therapy have any sense at all once the vessels have begun to atrophy? We are all well acquainted with the myriad of vasodilative agents for the arterial circulation branch, as well as tonicizing agents for the venous circulatory system.

Given this practically endless palette of expensive chemical agents — the efficiency of which has again and again been verified in comparative clinical tests, so that even the physician now believes in them — what would then be the use in attempting to present biotherapeutic and antihomotoxic medication as an alternative to the treatment of such disorders?

Give us a chance to explain. In order to understand the action of such biotheraputic agents, one must first consider the basic laws which govern homeopathy and homotoxicology.

Homeopathy is a phenomenological therapeutic method. Any one phenomenon in this connection must be seen as a phenotype in its natural environment.

In this sense, disease is a phenomenon of the individual human being.

In all cases, however, in which illness is considered exclusively from its physical and chemical aspects — as modern science presently does — a grave restriction is involved in our consideration of the broad reality of life.

The two basic principles on which homeopathy is based are the following:

1. The principle of "similia similibus curentur": likes are cured by likes.

That drug is employed which, when employed on a healthy human being, will produce that complex of symptoms which corresponds, in mirror-image form, to the condition of the sick patient.

2. The second basic principle of homeopathy is that of potentization, as it is employed in the preparation of medications.

There are of course many substances found in nature which, in their coarse, unprocessed form, demonstrate no therapeutic effects. Two examples are natrium muriaticum (common salt)

or siliceous materials. Other substances such as arsenic, lead, mercury, and a great many medicinal plants such as Aconitum and Belladonna, are so toxic that they demonstrate poisonous rather than therapeutic effects in their normal or concentrated forms. As has become evident over many years of medicinal employment, many substances become therapeutic agents only after they have been attenuated, refined, or broken down.

This phenomenon represents a kind of reversal effect which is not explained by the law of mass action of chemistry. This reversal effect as exhibited in the relationship between concentrated substance and potentized substance is explained by the following natural phenomenon as formulated by Arndt-Schulz: human vital powers are stimulated by weak stimuli, promoted by stimuli of moderate strenth, and inhibited by strong stimuli.

How, then, can the great effectiveness as observed by physicians be explained for an attenuation which lies beyond the limits of Loschmidt's number, and for which no actual material substance — not even a molecule — can be detected by available scientific techniques?

These riddles and apparent contradictions can, however, be easily explained if we rigorously separate the two following concepts in our consideration:

1. The information in a therapeutic agent, i.e., the desired effectiveness of the drug

2. The information medium, i.e., the material substance with which potentization is performed.

Information is this sense is immaterial. If information is to be communicated, however, it requires a material medium.

Consider the example of a book as a medium of information. Scientific analysis can be employed to break down and analyze the physical properties and the chemical constituents of the physical book itself, down to the atomic level. Such methods are not able to determine, however, whether the book contains proverbs by Mao Tse-tung or a novel by Goethe. These techniques are of course not employed to provide insights into the intellectual content — the information — which such a medium is intended to communicate.

As this analogy hopefully illustrates, the information in a homeopathic drug — i.e., the therapeutic effectiveness — is what is communicated by the process of potentization to the carrier of information: the medium or the attenuated agent.

Now, after we have hopefully provided a little more clarity on the two foundations of homeopathy — the simile principle and the process of potentization — we will be in a position to better comprehend homeopathic therapy as it is practiced in accordance with understandable natural laws and principles.

Next we shall necessarily elaborate on the concept of antihomotoxicology and its intrinsic relationship to the principles of homeopathy, in an effort to enable the derivation of further concepts for sensible and effective therapeutic application.

The term "homotoxin" means "a poison to man." Homotoxins are therefore materials which are toxic to human beings. Such substances can enter the organism from without: examples are viruses, bacteria, foodstuffs, medications, drugs, radiation, and luxury articles consumed in the form of coffee, alcohol, tobacco, and sweets. Or, homotoxins can occur in intermediary metabolism in the form of ketone bodies, uric acid, urea, ammonia, cholesterol, histamine, etc.

From the standpoint of homotoxicology, illnesses are reaction sequences in organisms which are elicited in response to the presence of such homotoxic agents. These reactions serve to render such substances harmless — for example, in the course of an inflammatory disorder — and to eliminate them from the human body.

From this standpoint, symptoms of disease should be considered as the outward signs of biological (i.e., in accord with natural principles), effective processes for the defense against and elimination of toxins from the body — and not as enemies of health to be suppressed or superficially eliminated.

There are of course various degrees of toxin damage. The organism is either successful in its stuggle to render its toxins harmless, or it can be damaged to a lesser or greater degree by homotoxins. In the most extreme cases, homotoxins are entirely successful, and the body expires. The simplest procedure for the body to deal with homotoxins is their elimination via the normal processes of excretion: perspiration, mucous discharge, defecation, and urination. If these processes are not sufficient, the body's defense system incites an inflammatory disorder in which "burning" takes place to render the toxins harmless, and in which subsequent elimination takes place by means of exudation.

The site of action in inflammatory processes is the connective tissue system: those tissues of our body most prone to reaction. Connective tissues permeate the entire human body and perform an overall, holistically understandable, function — for which reason Pischinger gave them the name "basic autonomic system." Its organ substrate is the cell environment system, the formed elements of which are developed from connective-tissue cells, capillaries, and autonomic end fibers. These elements are mutually embedded in the nutritive and detoxifying medium of intercellular substance.

This basic autonomic system, and the intercellular substance bound up together with it in a functional unity, make up the so-called transit route through which the organ cells are nourished and via which the waste products of metabolism are transported away.

If, however, the processes of excretion or inflammation are not sufficient to eliminate toxins located in the organism, the body copes with them by storing them — primarily, again, in connective-tissue structures such as periosteum, cartilage, joints, vascular walls, and the connective tissue of muscles.

There are of course many cases in which the organism cannot easily and without damage cope with homotoxins. The consequence of such cases is that the greater defense system cannot successfully carry out the struggle against toxic effects. And one result is the damage or blocking of intracellular

enzyme mechanisms. A stage of damage is reached in which functional impairment occurs and in which damage is no longer easily reparable. Damage to organ cells occurs at this stage. Without major therapeutic aid, further deterioration can rapidly take place from organ-cell damage to organ-cell degeneration, and from there to destruction.

If we now attempt to mentally link the principles of homeopathy with those of homotoxicology, the result can lead to enhanced understanding of the effective mechanisms involved in biotherapeutic, antihomotoxic therapy. These mechanisms can be summarized as follows:

An antihomotoxic medication represents the similimum of the homotoxin. As a therapeutic agent, an antihomotoxic substance is employed which has been homeopathically prepared and which acts in a manner similar to the toxin which has triggered the disease.

Through administration of the similimum, moreover, additional defense mechanisms of the body which have been held in reserve are also triggered.

Now, after having presented a brief fundamental summary of what is meant by biological and antihomotoxic therapy, we would like to return to the original question: to what extent arterial and venous circulatory disorders, as well as affections of the lymphatic system, can sensibly and effectively be treated with these natural means of therapy.

Let us first consider one of the most common forms of arterial circulatory disease: peripheral arteriosclerotic vasoconstriction (chronic obliterating arteriosclerosis, or occlusive arterial disease).

The designation "peripheral arteriosclerotic vasoconstriction" is a generic term for syndromes which are associated with stenosis, or constriction, of arteries. Distinction can be made here between inflammatory forms of angiopathy (angiitis), and degenerative forms of angiopathy. The latter types predominate by far, in 90 to 95% of observed cases, and are arteriosclerotic in origin. Although clinical, chemical, and histological differentiation between inflammatory and degenerative causes is indeed possible, we in fact eventually encounter very similar alterations in the human body for all cases, even in a comparison between disorders of inflammatory and primarily degenerative origin. As a result, the designation "occlusive arterial disease" has come to be used in Germany, under the abbreviation "AVK," as the generic term, with intentional omission of etiological characterization. This practice is based in part on the insight that the arterial wall has relatively limited possibilities of structural alteration in response to damaging effects imposed on it. This practically uniform mode of reaction is opposed, on the other hand, by a whole myriad of noxae, the etiological significance of which are often difficult to assess.

Arteriosclerosis is characterized by a variable combination of alterations to the Tunica intima ("inner coat") of the arteries. These alterations involve focal configured accumulations of lipids, complex carbohydrates, blood constituents, fibrous tissues, and calcium deposits. These accumulations are accompanied by alterations in the Tunica media ("middl coat"). The pathological process here therefore involves a mor or less progressive development, with generalized alteratior of the vascular wall, loss of elasticity, and increasin constriction of the arteries.

The clinical syndrome can be broken down into four stages

1. Absence of symptoms, or uncharacteristic malaise
2. Pain due to exertion: Claudicatio intermittens and Dyspraxia intermittens
3. Pain while at rest
4. Destruction of tissues, necrosis, and gangrene.

Chronic arterial occlusive diseases afflict approximately 11% of the entire male population. The frequency of this disease among men is five times greater than among women

A number of risk factors closely associated with these disorders are listed below. Hans Heinrich Reckeweg terms them "homotoxic stress factors."

1. Hypertension
2. Nicotine
3. Hyperuricemia
4. Hyperlipidemia
5. Obesity
6. Diabetes mellitus.

The arterial occlusive syndrome has a long latency period, a phenomenon which is explained by two factors:

1. A decrease in the resting blood flow can be measured only after 50 to 70% of the vascular diameter has been constricted.
2. The human organism can counter occlusive arterial developments with a great diversity of compensatory mechanisms of mechanical and metabolic nature, with the result that the clinical symptoms of deficiency generally manifest themselves only after it is actually too late fc therapy.

It is worthy of note that the lower extremities are afflicte in almost 90% of cases involving occlusive arterial diseases This share can be broken down as follows:

* 30% as pelvic forms
* 50% as as femoral forms
* 20% as peripheral forms

Initial clinical symptoms characteristically and definitely appear as stress-response, or functional, insufficiency, with the typical symptom of Claudicato intermittens. With further development of the disorder, the patient will report sensations of paresthetic nature, feelings of cold, tropic disorders (e.g., of the soles of the feet and the nails), paleness of the skin upon elevation of bodily members, and cyanotic reddening upon lowering.

Typical for post-exertion pain with occlusive arterial diseases is the rapid cessation upon returning to rest; for pain at rest

elief is typically obtained by lowering of the extremity nvolved.

Diagnosis of occlusive arterial diseases is possible with the ıse of the five human senses, without employment of ;ophisticated apparatus. A summary follows:

1. By inspection: Skin coloration and trophicity
2. By feeling the pulse: Dorsalis pedis
   tib. posterior
   Poplitea, Femoralis
3. By exercise tests: e.g., after Ratschow, or claudication tests
   Tests conducted for localization of occlusions

4. Differential diagnosis: Must be employed to preclude compression syndromes of the spine, neurological disorders, as well as soft-tissue rheumatism.

A special form of occlusive arterial disease is diabetic macroangiopathy, which pathologically and anatomically cannot be differentiated from arteriosclerotic forms. The arterial system of the diabetic patient deteriorates prematurely, and rigidity in the elastic and muscular arteries develops 10 to 15 years sooner than among nondiabetics.

An additional form of disease of the peripheral arterial system is thromboangiitis obliterans, an inflammatory form of arteriopathy which manifests itself primarily among young men between 20 and 40. The homotoxin nicotine is the cause in 95% of cases.

The first symptom of thromboangiitis obliterans is often phlebitis saltans, and occasionally a secondary Raynaud syndrome. The disease progresses in pronounced episodes and can be halted only by withdrawal from nicotine.

The prognosis for amelioration of occlusive arterial diseases of the extremities is of course more favorable with early recognition and therapy — but how can biotherapeutic-antihomotoxic therapy be employed in treatment of these disorders?

If this form of disease is considered from the standpoint of homotoxicology, we find that all cases of such disorders involve pathological developments on the right half of Reckeweg's Biological Section. In their incipient phases, they can be assigned to the impregnation stages; if, however, they appear with clinically manifest symptoms, then these disorders are in all cases the expression of processes in the degeneration phases.

In the event of such hemodermal degeneration, severe damage to the arterial-wall cells is involved, as the result of retoxic impregnation.

Truly effective therapy cannot therefore be restricted to symptomatic treatment of such disorders, in the form of administration of vasodilative agents — which in any case cannot impede the progressive character of such diseases. Instead, biotherapeutic-antihomotoxic therapy is directed toward lessening the toxin affliction of connective tissue, to reviving the organism's stagnating detoxifying processes, and to intensifying the body's processes of excretion.

The physician practicing such therapy will naturally seek out the similimum associated with the symptomatology encountered. Only such extensive measures can ensure success in employing causal treatment in prevention of vascular obliteration.

But what does all this mean in practical terms? Let us first consider the salient symptoms for the patient which finally force him or her to consult a physician.

The patient will voice the following chief complaints, which are common to all arterial circulatory disorders:

1. Feelings of cold at acral points of the body
2. Paresthesia
3. Pain upon walking (Claudicatio intermittens)
4. Finally, pain while at rest, with development toward arteriosclerotic gangrene.

If we consult the main symptoms found in the long-established data of homeopathic drug proving in order to match them with these typical complaints, we find that the following natural substances elicit the symptoms as stated among the healthy:

Secale cornutum: elicits spasms in the Tunica media (vascular middle coat), accompanied by sensations of numbness and formication. Effective for Raynaud's gangrene, diabetic gangrene, and endarteritis.

Viscum album: elicits the tendency toward vascular spasms, as well as paresthesia with itching.

Tabacum: a strong affinity to the vascular systems, as a result of its vagus effects. It elicits cold hands and feet (while the rest of the body experiences heat sensations), as well as cold and blue limbs.

Arnica: elicits arterial and venous congestion toward the head, with cold limbs.

Barium jodatum: elicits arteriosclerotic vascular damage, accompanied by hypertension.

Phosphorus: elicits throbbing pain in the arteries.

If these agents — which produce among healthy trial persons a syndrome similar to occlusive arterial disease — are combined in a complex homeopathic preparation, then we have a broad-spectrum possibility of therapy for such a complex of complaints. One example of such a medication is Arteria-Heel (called Secale Compositum in the U.S. and available in drops.)

In the preceding elaboration on biological therapy, anti-homotoxic regulation therapy has not been treated. This is an essential element in such therapy, as will be explained below.

In cases of occlusive arterial disease, the organism is in a cellular degenerative phase which will further progress if the continuous retoxic impregnation is not halted or regressively vicariated.

In such cases, the patient must by all means improve his or her patterns of life as they affect these illnesses. Triggering noxae as a result of nicotine consumption, drug abuse, hyperalimentation, and alcohol abuse must by all means be eliminated.

Such measures, however, are generally implemented only very reluctantly, and in any case do not suffice without additional therapeutic support.

With one patient we made an agreement: he was entitled to three cigarettes a day, with six the absolute limit. As far as this patient's diet was concerned, I was able at least to convince him to replace pork by fish – a step not to be underestimated in slowing the progression of such a disorder.

As long-term therapy, his medication includes Aesculus Compositum, Arteria-Heel, and Cralonin drops (the last for latent cardiac insufficiency).

If we examine the cardinal symptoms associated with the homeopathic medication contained in this complex of agents, we may see how they closely correspond to the overall concept of cardio-vascular disorders.

Let us now consider the problem area of venous circulatory disorders.

Since the walls of the veins possess considerably less elastic and muscular material than those of the arteries, nature has provided special anatomical and functional features of the venous system in order to maintain its proper functioning.

One of the most obvious special features of the veins are their valves. These semilunar valves have a swallow's-nest fit against the walls of the veins and ensure that the flow of blood remains toward the direction of the heart, without backflow. The functional construction is represented in the "peripheral heart" effect of the muscle-vein pump system which drives the stream of blood back toward the heart.

The veins of the lower extremities are subject to especially great mechanical stress. For this reason, the intact connection of the superficial with the deeper veins, and the location of the veins in their surroundings with the aid of the firm collagen fiber structure of their adventitiae, are of primary importance – along with the two special characteristics mentioned above – in ensuring the proper return of venous blood from the lower extremities.

A particular weak point of this system is in the area of the lower leg, since blood normally should flow from the superficial to the deep veins here, by means of the venae communicantes and perforantes. If valve insufficiency occurs in these venous connections – among which the three Cockett's veins are of special clinical importance – the action of the muscular pump is associated with a reversal in the direction of blood flow in such a manner that the blood moves from the deep into the superficial venous network. The result is excessive strain in the superficial network. These phenomena are also involved with the fact that ulcera so frequently occur precisely in the lower-leg area.

Now let us briefly consider the most important disorders of the venous system which are capable of leading to circulatory problems.

We can start with varicosis. Primary varices are irregular distensions of superficial veins; they are apparently one result of our upright posture, since they occur only in human beings. The distension of these veins is accompanied by tortuous developments and the formation of knots (by which the symptom designation does justice to its Latin derivation, varus, which means "stretched, bent, or awry").

Thrombophlebitis often develops as a result of the retarded, and often stagnating, circulation of blood in the varices of the extremities. The varices, in turn, develop around the thrombi into highly inflamed, painful sections. Of particular severity can be thrombophlebitis of the deep leg veins, since rechanneling of the afflicted veins is possible only in a small minority of cases, and since subsequent development of the so-called post-thrombotic syndrome is generally the case. This condition often remains with the patient until the end of his or her life.

One consequence of restriction of flow out of the deep veins is relapsing inflammation in the superficial veins, in addition to edemas, infiltrates, congestive dermatitis, induration, and ulcera crures.

If we now examine the cardinal symptoms of venous circulatory disorders as we have done for arterial diseases, we can find a number of homeopathic agents which elicit the same complex of symptoms when administered to the healthy. Five of these cardinal symptoms are:

1. Feelings of tightening and excessive warmth in the legs
2. Cramps in the calves
3. Swelling, above all in case of the post-thrombotic syndrome
4. Congestive dermatitis
5. Ulcera crures.

We find the most important of these symptoms included in the effects of the complex medication Aesculus Compositum (drops). The name of this complex refers to the one drug which is most broadly analogous to (and therefore most important in the therapy of) the above complex of circulatory symptoms: the horse chestnut. Its use is of course well known from allopathic therapy of the varicose complex of symptoms.

In Aseculus Compositum, however, we also encounter the following long familiar, tried and proven homeopathic drugs: Secale cornutum, Viscum album, Tabacum, Arnica, and Solanum nigrum. These substances display their effectiveness at both the arterial as well as venous branches of the circulatory network. Also included is an important antispasmodic agent, Cuprum aceticum, associated with the cardinal symptom of nocturnal cramps in the calves as caused by venous circulatory disorders.

Another extremely potent complex medication is Hamamelis Homaccord, with the primary decongestive agents of witch hazel and Carduus marianus. In addition to biotherapeutic symptomatic therapy, basic antihomotoxic therapy

should for optimal effectiveness also be employed as a complement, in the same manner as for arterial circulatory disorders. This is especially critical for the successful prevention of such developments as thromboembolism and Ulcera crures.

From the antihomotoxic standpoint of therapy here, most important consideration must be given to Lymphomyosot and Coenzyme Compositum. Since congenital organ deficiencies are usually involved here, a broad-spectrum nosode such as Psorinoheel can also be helpful.

In the following, I would like to describe several cases from my practice which demonstrate how the above-described methods of treatment have proven highly successful in all stages of venous circulatory disorders.

A 64-year-old man came to my practice with the fully developed and advanced symptoms of severe varicosis, accompanied by congestive induration.

His initial complex of symptoms was as follows: sensations of heat and tightening, nocturnal cramps in the calves, and swelling of the ankles. Without a rubber stocking, he was not able to remain up or to walk for any length of time without development of edemas. He developed superficial phlebitis every few weeks. My therapy consisted of two injections a week, alternating between Placenta Compositum and Aesculus-Injeel, at the corresponding acupuncture points of the lower leg. The liver and kidney meridian was the primary site of treatment here. I prescribed regular oral dosage of Aesculus Compositum and Hamamelis-Homaccord.

After a quarter year of this therapy, my patient's symptom complex improved significantly. Phlebitis has not reappeared over the course of the past year. Even after considerable exertion, the patient suffers from practically no more swelling.

Another case involved a 50-year-old woman with typical congestive dermatitis, caused by venous insufficiency. I also treated her locally with Aesculus-Injeel (by injection), Placenta Compositum, and Hamamelis-Salbe-Heel ointment. I additionally prescribed oral administration of Aesculus Compositum, Hamamelis-Homaccord, Lymphomyosot, and Psorinoheel. Her symptoms of congestive dermatitis have practically disappeared.

A 74-year-old woman consulted me with a stubborn Ulcus cruris with greatly induced edges which had been open for nine months. There were no edemas. She also suffered at the same time from moderate, chronic portal congestion as a result of adiposis hepatica, and from hemorrhoids which developed in conjunction with her other symptoms.

Her ulcer closed after regular and thorough injection therapy with Aseculus Injeel and Placenta Compositum, orally administered Hamamelis-Homaccord, and Psorinoheel.

I of course administered liver therapy in the form of Hepar Compositum and Hepeel, which finally enabled my patient to sleep through the night. As is the case with almost all liver afflictions, she was typically unable to sleep between the hours of 2 and 4 a.m.

Another 54-year-old woman patient, however, has presented an especially difficult case. She has had open ulcers on her legs for ten years. When she first came to my practice one year ago, the ulcera were covered with a greasy black coat. The smell still filled my office two hours after her visit. My therapy included thorough mesenchyme purging and detoxification with the aid of Lymphomyosot, Coenzyme Compositum, Thyreoidea Compositum, and Solidago Compositum. I also administered suis organ preparations for treatment of her vascular, liver, and intestinal systems. The result of this therapy was tremendous exudation in the area of the wounds, with gradual disintegration of the greasy, black coating. I locally injected Lymphomyosot, Traumeel, Placenta Compositum, and Aesculus-Injeel. After each treatment, the discharge from the wounds greatly increased, and the edemas were reduced.

My patient's ulcera have become smaller, but I am not sure whether they will ever completely disappear. Throughout this therapy, she has felt considerably better than before, which can be easily understood from the great amounts of toxin which have been regularly excreted from her organism. Fortunately, such severe cases are rare.

In conclusion, I would like to comment briefly on disorders of the lymphatic system as encountered among older patients, and on the biological therapy of these diseases.

The topography and the detailed structure of the human system of lymph vessels are similar to those of the venous system. The lymphatic system represents a closed, oneway system in which the lymph does not circulate, but flows only in one direction. Valves are also provided in the vessels to guide the lymph flow in the proper direction. The lymph system especially serves to drain corpuscle components and macromolecular proteins from interstitial spaces. For these reasons, the lymph system plays an important role in the body's struggles with local inflammation, which are carried out in the cell milieu system of the connective tissue.

The most commonly occurring disease of the lymph system is chronic lymph edema. This disorder involves chronic swelling as the result of insufficient lymph drainage. In rare cases, to be sure, these disorders involve a primary lymph edema as an organ deficiency of congenital origin (Nonne-Milroy). In most cases, however, lymph edemas are secondary in nature, as they occur after trauma, after thrombotic developments, as a result of neoplasms, and as a consequence of radiotherapy.

Lymphatic diathesis among old patients is the result of serious stasis in the fundamental system of connecting tissue. The path of lymph transport has deteriorated under the influence of waste products from the sol to the gel state, and normal diffusion is no longer possible. Proper nutritive supply of the organ cells cannot take place, and waste products cannot be transported away. In such cases, antihomotoxic detoxification of the connective tissues is critically important: just as critical as, say, the unstopping of a congested sewage disposal plant in a large city in the middle of summer. What good would it do (to remain with this example), if we only removed

the water from the sludge lines and allowed the noxious sludge to thicken and concentrate all the more?

The same mistake is made, however, if we remove only the water from the human lymphatic system, in order that the outward appearance seems more aesthetic. If we as physicians do not want to drive such patients further into stages of auto-intoxication and, eventually, into destruction phases, intensive antihomotoxic therapy is absolutely necessary. In addition to lymph drainage with the aid of Lymphomyosot and enzyme-reactivating preparations such as Coenzyme Compositum and Ubichinon Compositum, broad-spectrum nosode therapy can be highly effectively employed in the form of such agents as Psorinoheel. Such a program of therapy can be understood all the better once we have assumed that the damages which these severe metabolic disorders have caused are multifactoral in nature, and that the origins can most probably be found both in acquired as well as in congenital system deficiencies. Galium-Heel and above all Sutoxol-Injeel are also to be highly recommended in such cases for the detoxification of such severe cases of homotoxin poisoning.

In any case, it can be assured that you as a physician are no longer forced to treat patients by expensive "ut aliquid fiat" methods of merely trying to eliminate disturbing symptoms. I hope to have demonstrated an effective alternative in cases of arterial and venous circulatory disorders, as well as for lymphatic diathesis, as these complexes are encountered among older patients.

I furthermore hope to have conveyed the following: that symptoms perform the functions of signals which call our attention to human disease, and point the way to its healing.

Elimination of symptoms cannot be the objective of responsible medicine. Once the origin of a disease has been properly treated, the symptom — the warning signal — will disappear as a normal consequence.

With the natural approach to health as represented by homeopathy, complemented by the principles of homotoxicology — especially adapated as they both have been to the no longer natural conditions of life under which we all live — we have gained sufficient insights and a tremendously broad scope of therapeutic possibilities to enable us to escape from the conventional strategy of mere struggle against symptoms. In using these powerfully effective biotherapeutic and antihomotoxic methods, we as physicians — working on the basis of a consciousness of full responsibility for our therapeutic actions — can rightly consider each disease to be the result of a departure from the laws governing the original healthful order of human life, and that healing may establish as its only rightful goal the re-establishment of this proper order of human health.

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