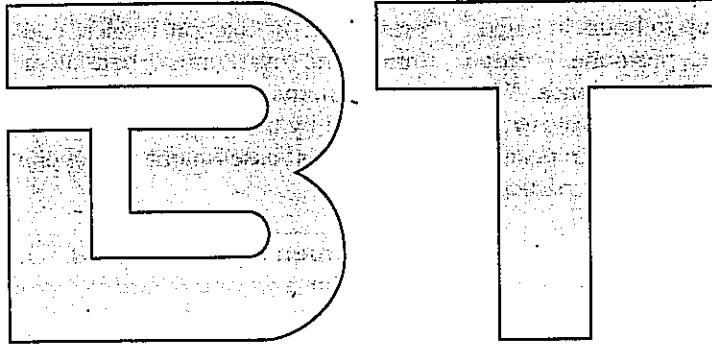


# BIOLOGICAL THERAPY

---

JOURNAL OF BIOLOGICAL MEDICINE

---



reprinted from Biological Therapy, Vol.  
VII, No. 3, June 1989, pp. 67-69

---

## REPORT FROM THE MEDICAL PRACTICE The Use of Vertigoheel in General Medical Practice

L. Mohr-Remacle, M.D.

BIOPATHICA LTD.  
P.O. BOX 217  
ASHFORD KENT TN23 6ZU GREAT BRITAIN  
TEL : 01233 636678  
FAX : 01233 638380

# The Use of Vertigoheel in General Medical Practice

L. Mohr-Remacle, M.D.

*In this article, Dr. Mohr-Remacle discusses various types of vertigo and their clinical assessment. Due to the great variety of vertiginous symptoms, a combination preparation for vertigo has widespread application. The author reports on studies which confirm the clinical effectiveness of Vertigoheel for patients of all ages and with varying symptoms.*

## I. Introduction

If a patient consults a general practitioner with the symptom of vertigo, a great variety of quite different subjective sensations can lie behind what may appear - upon initial superficial consideration - to be the rather simple and definite symptomatology of this disorder. Only an exact round of questioning can, however, provide the physician with a clear conception of precisely what sensation is involved in a complaint which the patient may more or less vaguely characterize as „vertigo“.

To begin, we have classical rotary vertigo - a feeling comparable to that experienced after spinning on the dance floor or riding a carousel. There is also staggering vertigo, or sway, in which the victim feels that the ground is lurching back and forth beneath his or her feet - as on a ship in heavy seas. Upon detailed questioning, some patients report that they experience a tendency to fall toward a particular side.

Another form of vertigo is elevator vertigo, with the sensation of being lifted. The patient has the feeling of being moved rapidly upward or downward, as in an elevator.

In the types of vertigo listed here, one can generally assume that the disorder involves a vestibular irritation or a deficiency in a vestibular organ. Vestibular vertigo has been characterized as „systematic vertigo of typical and defined quality“. It appears as

prolonged vertigo for considerable periods of time, as seizure vertigo for several minutes up to hours in length, or as postural - i.e., positional - vertigo for minutes - or only seconds. With positional vertigo, the symptoms occur when the body is in a certain position or when it changes to a particular position.

The quality of vertigo of non-vestibular origin cannot generally be described with such exactness as the types stated above. Such vertigo has been termed unsystematic in nature and is often encountered in conjunction with dizziness, giddiness, scotodinia, blurry vision, disorientation, or clouding of consciousness.

Investigation of the patient's system of equilibrium in conjunction with treatment of vertigo can be broken down into the following:

1. Testing of the vestibulospinal reflexes.
2. Testing for spontaneous and provocation nystagmus.
3. Experimental testing of the vestibular and optokinetic system.

## Testing of the vestibulospinal reflexes

Romberg's test is one of the means used for assessment of the vestibulospinal reflexes: it involves standing on one and two legs with closed eyes. Other methods are the walking test with closed eyes, Unterberg's step test (stepping in place with closed eyes), and the finger-nose test. These simple tests can be performed without equipment, either in the doctor's office or during a house call.

## Testing for spontaneous and provocation nystagmus

Nystagmus is most effectively investigated in a dark room with Frenzel

illuminated goggles. These goggles have lenses with +15 diopters for the prevention of fixation (which could inhibit the nystagmus phenomena). The illumination and enlargement provided by the goggles facilitate the physician's assessment of eyeball behavior.

## Experimental testing of the vestibular and optokinetic system

Experimental testing of the vestibular system requires extensive equipment and can therefore be performed only in a hospital or in the office of an ear, eye, nose, and throat specialist. The rotational test carried out here involves spinning the patient on an especially designed chair to assess the excitability of the semicircular canals upon patient subjection to angular acceleration. In the caloric test, cold or warm water is introduced into the auditory canal to effect a change in temperature in the labyrinth capsule and, in turn, to induce endolymph flow. This technique can confirm or exclude the presence of excessive or insufficient labyrinth excitability on a particular side. These functional tests can be complemented if required by a considerable number of further techniques such as optokinetic tests, electronystagmography, testing for the fistula syndrome, etc.

Although it would be desirable to employ all the diagnostic techniques listed here for every patient suffering from vertigo symptoms, time and cost factors of course often render such thoroughness unfeasible with general practitioners. If, however, a physician suspects a curable primary disease, adequate diagnostic clarification is absolutely necessary, since healing of the basic malady represents in any event the optimal therapy. Nevertheless, it is often quite difficult for the general practitioner to make a scientifically exact diagnosis upon encountering vertigo symptoms.

In such a situation, it can be extremely beneficial for the physician if he or she

has recourse to a medication which has proven highly reliable in the therapy of vertigo symptoms of various origins. Such a preparation is indeed available, in the form of Vertigoheel (drops, tablets, or ampules).

Vertigoheel is a complex homeopathic preparation for the therapy of vertigo resulting from any of various causes. It contains, as active constituents, homeopathic preparations of conium maculatum, anamirta cocculus, ambergris, and petroleum. As a result of the complex of individual homeopathic constituents contained in Vertigoheel, the product affords therapeutic possibilities for vertigo arising from a number of different causes:

- Vertigo caused by nervous factors or by arteriosclerotic alterations, with or without hypertension.
- Vertigo originating from labyrinth conditions.
- The Ménière's syndrome.
- Commotio cerebri acuta and post-commotio complaints.

The excellent effectiveness of Vertigoheel, empirically confirmed for decades, has also been scientifically verified in recent years, as treated below. In one study performed at the Research Institute for Neurotology at Bad Kissingen, Germany, Vertigoheel was administered in tablet form to a total of 40 patients suffering from various symptoms of vertigo. Dosage was 3 tablets, three times a day, for a period of 14 days. Before therapy began, information was recorded on the following symptoms: staggering vertigo, elevator sensations, rotary vertigo, falling tendency, scotodinia, and unsteadiness. Upon statistical evaluation of data after administration of Vertigoheel, it was revealed that there had been significant lessening of severity of these complaints in comparison with a control group of patients which had not been administered medication against vertigo.

In an additional test conducted at the same institute, the matter was investigated of the effectiveness of the separate individual components of Vertigoheel. In this study, 60 patients suffering from vertigo, nausea, and tinnitus were divided into 4 test groups,

of 15 persons each. Each group was then treated with only one different single component of Vertigoheel. In a comparison of the effectiveness of the individual components cocculus, conium, ambergris, and petroleum with the action of these constituents when combined to one medication, it was found that the single components develop additional therapeutic effectiveness by virtue of a synergistic effect, after being combined to a complex preparation.

## II. Patients and methodology

The study reported below was conducted with the objective of investigating the therapeutic feasibility of positively influencing the various types of vertigo suffered by patients who normally consult a general practitioner. This study involved the documentation and descriptive evaluation of therapeutic data on 65 patients who received Vertigoheel for the therapy of vertigo symptoms. Recording of data took place on a special test form for each patient and included the following: age, sex, diagnosis, dosage of Vertigoheel, type of application of Vertigoheel, and the nature of any accompanying medication which may have been administered. In order to enable more detailed assessment of therapeutic success, recorded data also included the duration until improvement for the symptom complex, and until complete disappearance of symptoms.

The average age of patients was 58.2, with all patients within the age range of 15 to 90 years. There were 52 female patients and 13 men.

In 37 cases, monotherapy was conducted in the form of tablets, with a

dosage of one tablet taken at a time, between three to nine times a day. Owing to the advanced age and severity of the main disease for one female patient with cerebral sclerosis, Vertigoheel was administered to her, as an exception, in injection form. The remaining 28 patients received various additional medication in addition to Vertigoheel tablets, as shown in Table 1.

Preparation group	Number of patients treated
Antihypotensives	13
Antihypertensives	4
Medications stimulating blood supply	4
Cardiac glycosides	3
Diuretics	2
Calcium antagonists	1
Analgesics/antipyretics	1
Psychotropics	1
Muscle relaxants	1

Table 1: Analysis of accompanying medication in accordance with the main grouping index of the German Physician's Desk Reference (owing to multiple administration, the sum of the patients is greater than 28).

## III. Results of testing

An improvement with respect to vertigo symptoms was experienced by a total of 61 of the 65 patients who were treated with Vertigoheel. Complete disappearance of symptoms was achieved during the further course of treatment in 47 of the cases. With one female patient, moreover, the vertigo symptoms disappeared immediately after commencement of therapy. The progress of her disease, however, must lead to the conclusion that a case of spontaneous remission was involved. Figure 1 shows a summary of percent data for the patients, with representation of improvements in symptomatology, or complete freedom of complaints, within the first eight days of treatment.

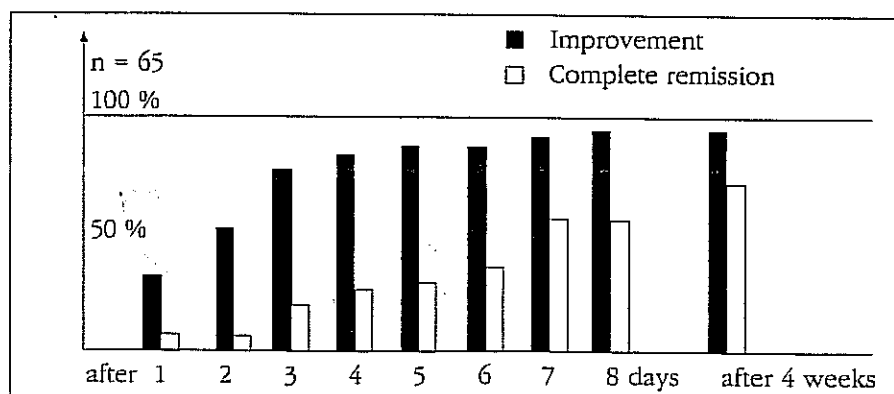


Figure 1: Cumulative representation of the percent share of the patients for whom improvement or complete remission was achieved after the number of days and weeks indicated (total evaluated patients).

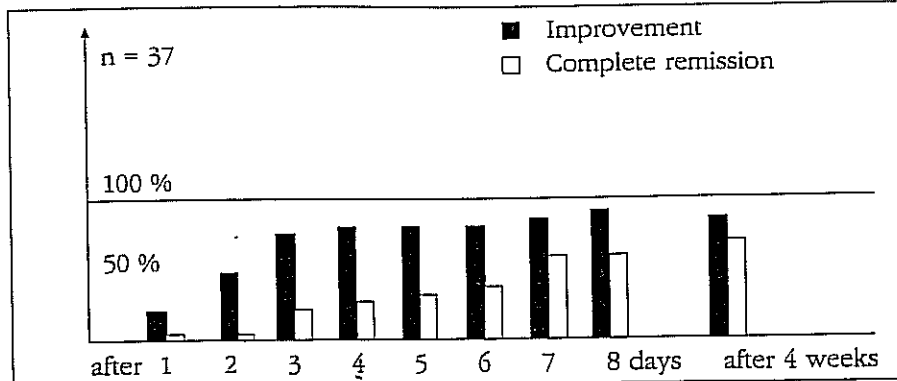


Figure 2: Cumulative representation of the percent share of the patients for whom improvement or complete remission was achieved after the number of days and weeks indicated (patients who received only Vertigoheel).

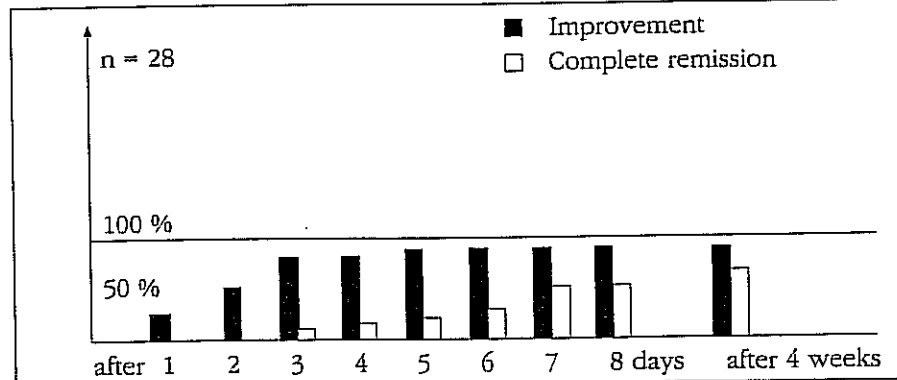


Figure 3: Cumulative representation of the percent share of the patients for whom improvement or complete remission was achieved after the number of days and weeks indicated (patients who received Vertigoheel + accompanying medication).

Age group (in years)	Number of patients	Average length of time since beginning of medication (in days)	Percent share of patients for whom complete remission was achieved
15 - 30	6	2.8*	67 %
31 - 45	7	2.7*	71 %
46 - 60	21	2.1**	81 %
61 - 75	18	2.7	78 %
76 - 90	13	2.7	62 %

Table 3: Results of vertigo treatment broken down by age groups.

\*One patient without improvement in symptoms was not considered in calculating the average values for each of these two age groups.

\*\*One patient with spontaneous remission and one patient without improvement in symptoms were omitted from calculations here.

In conclusion, it can be added that the tolerance of all patients to Vertigoheel could be characterized as good. There was no observation among any patients of side effects, negative medication interaction, or intolerance. Vertigoheel can therefore be recommended without reservation for all age groups for the therapy of vertigo symptoms of various origins.

#### Literature:

1. Neundörfer B. Schwindel, Therapiewoche 1984, 34:1223-1224.
2. Boeninghaus H.-G. Die Abgrenzung des vestibulären Schwindels, Deutsches Ärzteblatt 1984, 8:513 ff Becker W, Naumann H.-H, Pfaltz.
3. C.-R. Hals-Nasen-Ohren-Heilkunde 1983, Thieme Verlag, 2.Auflage: 58 ff.
4. Boeninghaus H.-G. Hals-Nasen-Ohren-Heilkunde 1977, Springer-Verlag, 4. Auflage: 51 ff.
5. Stoidner B. Neuere Therapieerfahrungen mit Vertigoheel, speziell in der Tropfenform? Biol. Medizin 1983, 12:4, 461.
6. Medical-scientific Department Heel Vertigoheel-Erfahrungen aus der Praxis, Biol. Medizin 1984, 13:5, 219-225.
7. Claussen C.-F. Der Schwindel und seine biologische Behandlung mit Vertigoheel - Ergebnisse von klinisch-experimentellen Untersuchungen, Biol. Medizin 1983, 12:6, 531.
8. Claussen C.-F. Die Behandlung des Syndroms des verlangsamten Hirnstammes mit Vertigoheel, Biol. Medizin 14:4, 510-514.

#### Address of the author:

L. Mohr-Remacle, M.D.  
General Practitioner  
Barthel Bruyn Str. 27  
4300 Essen 1, Germany

Diagnosis	Number of patients	Average age in years	Average length of time since beginning of medication (in days)	Percent share of patients for whom complete remission was achieved
Vertigo associated with circulatory disorders	30	49.8	2.1*	86 %
Cerebral sclerosis	18	76.7	2.7	61 %
Cervical-spine syndrome	6	58.8	1.9	83 %
Commotio cerebri	3	35.3	5.7	100 %
Miscellaneous	8	55.6	3.3**	37 %

Table 2: Results of vertigo treatment broken down by diagnosis groups.

\*Two patients without improvement of symptoms were not considered in calculating the average value here.

\*\*One patient with spontaneous remission and one patient without improvement in symptoms were omitted from calculations here.

In order to obtain a detailed assessment of the significance of the role played by the accompanying medication in these results, the patient data has been depicted again in Figures 2 and 3, with representation of patients who received only Vertigoheel, and of patients who received Vertigoheel with accompanying medication. It can be seen that the success rates differ only slightly between these two patient groups. It can therefore be concluded that the accompanying medication played an insignificant role in the success of therapy conducted for vertigo.

Despite the difficulties involved in a general practitioner obtaining an exact diagnosis among vertigo patients, data

was also broken down according to diagnosis groups: see Table 2. The indication areas are especially interesting for administration of Vertigoheel in the treatment of vertigo with cervical-spine syndrome, and of vertigo associated with circulatory disorders. Significant success was also achieved with this homeopathic agent in therapy of vertigo associated with cerebral sclerosis.

In addition, the patients treated were also broken down into age groups, with representation of therapeutic success among the respective groups: see Table 3. As can be seen here, there were no significant differences among the age groups with respect to therapeutic success.