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STUDY OF EFFICACY OF HOMOEOPATHIC MANAGEMENT OF DIABETIC FOOT

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ABSTRACT:

The consequences of diabetic foots can spread to several physiological systems. A very high prevalence of diabetic foot in patients with diabetes and its frequent serious wailing is the diabetic foot.

It has been reported that more than 50% of patients with a history of diabetes have been reported for more than 25 years, making it one of the most common diseases affecting the nervous system. Depending on the definition of diabetic foot, the prevalence shows from 5% to 60- 100% in the absence of symptoms. It can be because most patients with diabetic foot are asymptomatic. Diabetic foot complications occur in the same type 1, type 2 and obtained cause of diabetes.

KEYWORDS: Diabetic Foot, Diabetes Mellitus, Homeopathy and Homeopathic Medicine.

INTRODUCTION:

The spread of the epidemic of diabetes is the main health threat to the Indians and threatens to fail our humanity. From the report on Who India, the huge increase in diabetes prevalence shows that India is the top world with the largest number of diabetic entities. According to recent statistics that estimates that India currently has 32 million diabetic entities and is expected to increase 100 million by 2035, ie by 250%.

Neuropathic complication

Neuropathic complications predominate the features of Indian diabetics due to delayed diagnosis and late presentation of the syndrome. The diabetic foot is responsible for one of the largest patient confessions. Diabetic nerve -related disorders directly and indirectly contribute to morbidity and mortality in a huge way. Simple visual leg control and foot care can save and save your legs endangered.

Many times it is observed that strict control of sugar levels and diet does not help the patient completely recover from complications such as diabetic diabetic foot; Suffering continues together to the end of his life.

While diabetic patients and their suffering are well treated with homeopathic treatment as a diabetic foot, the standard of life improves much better. During the research projects, retinopathy, hypertension, diabetic foot, neuralgia, palm burning and feet have a good clinical improvement with homeopathic management. Those depending on allopathic treatment, some of them have stopped allopathic treatment. Even in some cases allopathic

Like homeopathic treatment, the patient is well without drugs and a reduction in BSL towards normal. Such a situation is only possible when your constitutional selection of medicines is perfect with the right effectiveness, repetition and fraud is well -followed without any disturbance, and then the work in the treatment of such cases is easier.

From this research work, I tried to give homeopathic treatment to the medical field for dealing with Diabetes mellitus diabetic foots. The study of diabetes mellitus and the relationship of diabetic foots with foreclinical, para clinical, clinical subjects with organon medicine explain the scientific approach of homeopathy to diabetes mellitus in the diabetic foot.

REVIEW OF LITERATURE:

Diabetes mellitus

Diabetes mellitus is syndrome characterized by chronic hyperglycaemia and disorders of carbohydrate, fat and proteins associated with absolute or relative deficiencies in insulin and insulin secretion.

Diabetes mellitus can be suspicious or clinically recognized by the presence of characteristic symptoms such as excessive thirst, polyphage polyuria, pruritus, otherwise weight loss or one or more complications associated with disease or credible.

Diabetic foot

This is a relatively early and common complication in diabetic patients and occurs secondary to metabolic disorders and prevalence is related to the duration of diabetes and the degree of metabolic control. Although there is evidence that the central nervous system is affected by long -term diabetes, the clinical impact of diabetes is mainly the manifestation of the peripheral nervous system

Diabetic foot

The diabetic ulcer of the foot is one of the main complications of diabetes mellitus. It occurs in 15% of all patients with diabetes and precedes 84% of all amputations of the lower legs. Diabetics are susceptible to leg ulcerations due to neurological and vascular complications.

Classification of Diabetes mellitus

1. Diabetes 1. Type (IDDM)

A. Immune mediated (type 1a)

B. Idiopathic

2. Type 2 diabetes (NIDDM)

A.Obese

3. Malnutrition - related diabetes mellitus

4. Another specific type of diabetes

A. Genetic defect - cell function characterized by mutations in nuclear transcription factor of hepatocytes (HNF) 4

Glookinase

Nuclear transcription factor of hepatocytes l Factor of insulin promoter

B. Genetic defect in the effect of insulin type of insulin resistance leprechaunism Rabson - Mendelhall syndrome liporatrophic diabetes

C. Disease of exocrine pancreas: pancreatitis, pancreactomy, neoplasia, cystic fibrosis, hemochromatosis.

D. Endocrinopathy: Cushing's syndrome, acromegaly, pheochromocytoma, hyperthyroidism, glucagonomist.

E. Drugs or chemicals: glucocorticoids, thiazids, beta blockers

F. Infection: Congenital Cut, Cytomegalovirus, Coxsackievirus

G. Unusual forms of immune -mediated diabetes syndrome "rigid person", anti -

Insulin receptor antibodies

H. Another genetic syndrome associated with diabetes: Down syndrome, Kleinfelter syndrome, Furers syndrome, Wolfranis syndrome, Huutington chorea

5. Gestational Diabetes mellitus.

Clinical findings

The 1DM patient represents a complex of characteristic symptoms. Absolute lack of insulin results in accumulation of circulating glucose and fatty acids with subsequent hyperosmolality and hyper -concrete.

Patient with diabetes 2. The type may or may not be present with characteristic features. The presence of obesity or strongly family history for mild diabetes indicates a high risk of developing type 2 diabetes.

Main features of diabetes mellitus

Diabetes mellitus type 1 (immune diabetes, formerly) called insulin dependent d.m.)

Most server forms of diabetes.

Immune dependent in 90% and idiopathic in 10% of cases causing the destruction of pancreatic B cells, leading to an absolute absence of insulin.

Sudden onset.

Looking for less than 30 years. Age, the most common in children. Body wt. normal or low.

Insulin car antibody is present.

Diabetic complications are missing in diagnosis. Family history of diabetes unusual.

Fast death without insulin treatment.

Diabetes mellitus type 2 (without immune diabetes, formerly called d.m.

The most common form of diabetes mellitus.

They play genetic and environmental factors in an important role. Gradual onset.

Looking at middle -aged and older people, but now also see in the younger age group. Obese in the body WT.

Insulin car antibody is missing.

Diabetic complications in the presence of diagnosis. Family history Diabetes Common.

No quick death without treatment of insulin.

As in type-1, there is an absolute lack of insulin, we must supply insulin from an exogenous source, so in these cases there is a very small range of homeopathy. (Because it's an irreversible state.)

On the other hand, in type 2, where there is a relative lack of insulin either due to a defect in cell or peripheral insulin resistance or both (which may be reversible), there is sufficient extent in homeopathy, not only for treatment but for the treatment of these types of cases that are most common.

Complications of acute complications Diabetes mellitus:

Diabetic ketoacidosis (DKA) and non -cycle hyperosmolar condition (NKHS) are an acute complication of diabetes. DKA can be seen in individuals with DM 1 and NKHS in individuals with type 2. Both disorders are associated with an absolute or relative insulin deficiency, exhaustion and a change in the mental state, DKA and NKHS are together with or without ketosis.

Chronic complications diabetes mellitus microvascular

Eye disease

Retinopathy (non -differential/proliferative) macular edema

Glaucoma cataract

Diabetic foot
Sensory and motor (mono and polydiabetic foot) autonomic
Nephropathy macrovascular
Disease of coronary arteries peripheral vascular disease cerebrovascular disease.
Gastro
Diameter gastro parasis.
Urine
Uroph
Sexual dysfunction
Neurological complications of diabetes
Introduction
The diabetic foot is the most common symptomatic complication of diabetes and potentially one of the most delayed. Most neurological complications with diabetes include the peripheral and autonomic nervous system.
The most important risk factors for the development of diabetic foots are a long time and increased severity of hyperglycemia. Other factors involved are male sex, increased height, smoking, retinopathy, microalbuminuria and alcoholism.
Main risk factors less risk factor
Long duration of diabetes male sex increased the severity of diabetes increased smoking height of retinopathy
Microalbuminuria alcoholism
The prevalence of the diabetic foot at the time of diagnosis-diabetes type 1 is 1-2% and 2-diabetes type is 10%. The presence of a diabetic foot significantly increases the risk of ulceration and infection of the legs, which can lead to amputation. Associated morbidity orders the need for routine, a thorough screening of a primary care physician and a possible timely detection.
Classification
These are numerous schemes for classification of diabetic diabetic foots. But none of them is complete. This is because most patients do not fit neatly in any individual category, but instead they have several overlapping clinical traits. Usually in the form of vasomotor interference in the limbs and abnormalities of sweating.
Diabetic foot can be classified as symmetrical/ asymmetric diffuse/ focal
Progressive / reversible
Symmetrical
1. Distal, primarily sensory polydiabetic foots mainly affected by large fibers
Mixed
Mainly affected small fibers
2. Autonomous diabetic foot
Chronically developing proximal motor diabetic foot
Asymmetric
1 .. Acute or sub -acute proximal diabetic foot
2. Skull monodiabetic foot
3 .. Truncal Diabetic Foot
1. Distal symmetrical sensorimotoric diabetic foot
2. Autonomous diabetic foot sudomotor
Cardiovascular gastrointestinal genitourinar
3. Symmetrical proximal limb motor diabetic foot (Amy trophy)
Focus
1. A skull diabetic foot
2. Radikulopathy/ plexopathy
3. Diabetic foot
4. Asymmetric limb Motor diabetic foot (Amy trophy)
Progressive
1. Distal symmetrical polydiabetic foot mostly sensory
Autonomic connection of common (asymptomatic) motor rare engine
2. Small fibers diabetic foot
Autonomous connection of common (symptomatic)
Reversible
1. Monodiabetic foot femoral
Cranial nervous palsy (III and VI) Truncal Radiculopathies
2. Medium pressure palsy
Ulnar
Lateral popliteal nerve
Pathogenesis

The pathogenesis of diabetic diabetic foots is multifactorial. Different pathogenic factors are interconnected and together contribute to the development and progression of syndrome. The real process of neuropathic progression is dynamic, with degeneration and nervous regeneration occurs spontaneously and at the same time. The pure balance between these processes determines whether the diabetic foot is progressing, receding or stabilizing.

It seems that in diabetic patients three mechanisms cause peripheral nerves degeneration. They are hyperglycemia

Local nerve ischemia neurotrophic factor by lack of hyperglycemia

The results of an attempt to control and complications of diabetes (DCCT) have convincingly showed that hyperglycaemia and insulin lack of diabetic feet contribute to the development of diabetic diabetic foots. The effects of hyperglycemia, diabetic diabetic foots focus on changes in the polyol track. In diabetics

Animals, the accumulation of sorbitol in the nerves in the presence of hyperglycaemia, results from increased provision of hyperglycaemia results from increased glucose provision, Aldos substrate.

The accumulation of sorbitol intracellularly causes reciprocal reduction of myoinositol and taurine levels to the extent that they become insufficient for normal intracellular metabolism. Myoinositol and taurine depletion was associated with reduced Na+/ K+ adenosine triphosphatase activity and slowed the speed of nervous conductivity in diabetic rats. The accumulation of sorbitol also leads to a decrease in nicotinamide-adenine of dinucleotide phosphate (NADPH) and glutathions in the cell. This may disrupt the ability of the cell to detoxify reactive oxygen types. Hyperglycaemia can also promote the formation of reactive oxygen species Auto by glucose oxidation and the formation of advanced glyce terminal products.

Local nerve ischemia

The role of local nerve ischemia in the development of diabetic diabetic foots is unclear. Nervous nerve biopsy from diabetic patients reveal many changes indicating local vascular disease, including the reinforcement of the basement membrane, proliferation of endothelial cells and vascular occlusion. In diabetic rats, nervous blood flow is reduced. Some studies have shown a reduction in nerve blood flow in diabetic patients, but others stressed in the nerve, increasing the production of reactive oxygen species, including nerve damage.

Neuropathic factor deficit

Neuropathic factors are involved in the development, maintenance and regeneration of sensitive elements of the nervous system. The best studied of them is a nerve growth factor (NGF), a protein that promotes survival

Sympathetic and sympathetic and sensory neurons derived from nerve elements in the peripheral nervous system. In diabetic animal models, it seems that NGF production and retrograde transport are disturbed. In a human study, the abnormal expression of NGF correlates in skin keratinocytes with an early manifestation of sensory diabetic foots with small fibers. Lack of diabetic foot factor can also reduce cell resistance to damage by oxidative stress. All these three mechanisms work together in a complex way and their understanding gives us more opportunities to intervene. In addition to the above mechanisms, an immune mechanism is recently recognized.

Classification of diabetic diabetic foots

(1) somatic - polydiabetic foot.Lt is symmetrical, mainly sensory and distal.

Asymmetrical, mainly motor and proximal. Monodiabetic foot (including mononeuritis multiplex) (1) Viscerar (autonomous) cardiovascular, gastrointestinal, genitourinary, sudomotor, vasomotor, primrose.

Clinical traits

A symmetrical sensory polydiabetic foot

This is often asymptomatic. The most common symptoms found in physical examination are the loss of tendon reflexes in the lower limbs, reduced perception of vibration distal and deterioration of gloves and storage of all other ways of feeling. Symptoms include paraesthesia in the legs sometimes in the hands, pain in the lower limbs (dull pain, worse at night mainly from the front aspect), a feeling of burning in the feet and abnormal walking (commonly widely based) often associated with a sense of insensitivity in the legs. Weakness and wasting of muscle and waste only develop in advanced cases, can be perforated, painless ulcers in the legs and painless distal arthropathy characterized by joint disorganization (Charcot joints).

Asymmetric motor diabetic diabetic foot

Sometimes it is called diabetic amyotrophy, which represents itself as a serious and progressive weakness and wasting of the proximal muscles of the lower limbs. It is commonly accompanied by severe pain, mainly felt on the front of the legs and hyperestezia and paraeshesia, are common. Sometimes weight loss may occur (neuropathic cachexia). Hypereeshesia and paraasthesia are also common. The patient may look sick and may not be able to get out of bed.

On the affected side may be missing reflexes of tendons.

Mono diabetic foot: The engine or sensory function can be affected within a single peripheral or skull nerve. The most commonly affected nerves are: the third and sixth cranial nerves that result in diplopia; Ulnar and the middle nerves leading to the clinical picture of the carpal tunnel compression syndrome and femoral, seating and lateral popliteal nerves leading to the foot drop.

Autonomic diabetic foot: This is not necessarily associated with a peripheral somatic diabetic foot. Parasympathetic or sympathetic nerves can be affected mainly in one or more systems. Although the autonomous diabetic foot can affect virtually all body systems in each patient, the connection of the system tends to be uneven.

Clinical features of autonomous diabetic foots

Cardio-vascular: Postural hypotension, resting tachycardia,

Fixed heart rate, sudden cardiorespiic arrest.

Gastrointestinal: dysphagia, abdominal fullness, nausea and

Vomiting, night diarrhea with or without faecal incontinence, constipation due to the aton of the large intestine.

Genitorinary: problems with sweatshirt, urinary incontinence,

and recurring infections caused by atonic bladder, impotence and retrograde ejaculation.

Sudomotor: Gustator sweating, night sweating without

Hypoglyceamia. Anhidrosis of cracks in the legs.

Vazomotorium: The legs feel constantly cool due to the loss of the skin
vasomotor reactions. Dependent edema due to loss of vasomotor tone and increased vascular permeability. Bullous formation.
Pupillary: reduced pupil size. Resistance to mydriatry.
Delayed or absent response to light.
Peripheral vascular disease and introduction of diabetic foot syndrome
The diabetic foot is one of the most common complications of diabetes. It is a leading hint for admission to the hospital and is associated with prolonged stay in the hospital. The amputation of the main limb is the end point of the legs of lesions in diabetics and is therefore the most feared complication of diabetes. It is interesting to note that many principles of etiology, treatment and prevention of diabetic foots have been determined by the pioneering work of Paul Brand.
In view of the current estimate of 25 million diabetics in India, it would not be exaggerated to claim that India could appear as a country with the highest amputations of diabetics in the coming years unless urgent preventive measures are taken.
The structured organization and facilities for the provision of diabetic foot care are remained. In order for such an approach to be successful, the focused efforts of all who work with diabetic patients are required. In addition, it is our responsibility to inform the National Health Department about the seriousness of the problem with the diabetic foots. Improvement of the result is possible if the correct strategies are performed at national level.

Diabetic foot care

Leg ulcers and amputation are the main cause of morbidity, disability and emotional and physical costs in patients with diabetes mellitus. Early recognition and management of independent risk factors for ulcers and amputation can prevent or delay the onset of unfavorable results. The following recommendations are for those diabetics who currently do not have foot ulcers and are to identify and manage risk factors before the legs or amputation becomes immediate.

Risk identification

The risk of ulcers or amputation increases in people who have diabetes for years, are men, have poor glycemic control or have cardiovascular, retinal or kidney complications. The following risk -related risk conditions are associated with an increased risk of amputation.
Peripheral diabetic foot with loss of protective feeling of changed biomechanics (in the presence of a diabetic foot)
Evidence of increased pressure (erythematical, haemorrhagic ulcer or callus) bone deformity
Peripheral vascular disease (reduced or missing pedal pulses) and history of ulcers or amputation
Nail pathology
Evaluation of the neurological state of low-risk foot should include a quantitative test of the somatosensory threshold using the Semmes-Weinstein5.07 (10) Monofilament.
Initial screening for peripheral vascular disease should include a medical history for claudication and evaluation of pedal pulses. The skin should be considered integrity, especially between the fingers and metatarsal heads. The presence of erythema, heat or calus formation may indicate the area of tissue damage with the upcoming decomposition. Bone deformities, restrictions in common mobility and walking and balance problems should be assessed.
Prevention of high -risk conditions
The distal symmetrical polydiabetic foot is one of the most important predictors of ulcers and amputation. The development of the diabetic foot can be significantly delayed by maintaining glycemic levels to as close as possible. Smoking should be encouraged to reduce the risk of complications of vascular diseases.
Management of high -risk conditions
People with a diabetic foot or evidence of increased plantar pressure can be sufficiently managed by a well -equipped walking shoe or athletic shoe. Patients should be educated about sensory loss and ways to replace other sensory modality (Visual Inspection) for supervision of early problems.
People with evidence of increased plantar pressure (eg erythema, heat, callus or measured pressure) should use shoes that pillows and redistribute pressure. Callus can be suppressed by a scalpel specialist in foot care or other medical staff with experience and training in foot care. People with bone deformities (eg Hammer Toes, prominent metatarsal heads, buunion) may need extra wide shoes or deep shoe. People with extreme bone deformations (Charcot's Foot), which cannot be accommodated with commercial feet, may need tailor -made shoes.
People with symptoms of Claudication should undergo full vascular assessment. People with the history of ulcers should be evaluated for the basic pathology that lead to nepets and will be adequately managed. Small skin conditions such as dryness, calluses, corn and tinea pedis should be treated to prevent more serious conditions.

Homeopathic approach:

Homeopathy can be defined as a medicine system - therapeutics based on law similar. The successful exercise of the right of similarity depends entirely on the concepts of individualization and sensitive institutes, which form the corner stone of homeopathic practice. The concept of individualization takes into account the overall reaction of the organism to an unfavorable environment. This overall reaction is observed through symptoms and symptoms on three levels: emotional; Intellectual and physical.
Homeopathic approach to diabetes mellitus
According to the classification of Hahnemann, diabetes mellitus decreases under chronic miasmatic disease, which falls under the disease with fully developed symptoms that are of chronic nature and has miasmatic effects. Either one -time disease such as psora, sycosis, sycosis or compound diseases.
Miasmatic classification of diabetes melitus
Let's take a look at endocrinopathy by the process of developing Hahnemann's pathology, which is the layout of diabetes determined by hereditary figures and individual susceptibility in the presence of an enemy environment. In clinical practice we will receive three categories of patients. Psoric diabetes are those called pre and potential diabetes. Where to group NidDM under the sycotic and IDDM are grouped under tubercular / syphilitic depending on the extent of reversible or irreversible changes that occurred in an individual.
Psor1c diabetes

Where blood sugar levels rises to stress and after stress is removed, it can fall to a normal level or may remain at a slightly higher or normal level, pre - or potential diabetes. It should be suspected whether there is a medical history of suppressed eruption of the skin and is related to the onset of diabetes. Exercise, diet and counseling will help keep these patients under normal musty and no medication may be required.

Sycotic Diabetes:

If the unstable states of blood sugar are not checked in time, the condition may proceed to a certain structural change and develop into the sycotic phase. One of the important symptoms could be symptoms gradually, such as polyuria, intense thirst with occasional nocturia, excessive appetite and weight loss, weakness, bibido and blurring vision.

Syphilitic and tubercular diabetes:

Usually IDDM is categorized under the tubercular combination of Psora and Syphilis. Reversibility, extent and type of tissue disability into complications decides on the syphilitic reverse fall of diabetes. Thanks to the overall failure of the metabolism of the pancreas, which he encounters in IDDM his irreversibility, he is more syphilitic.

In our o.p.d there are many cases that respond well to homeopathic treatment. I will introduce one such well -documented case.

Dr. N. L. Tiwari DINESH RAO

Joslin's Diabetes mellitus (1993) presents quite categorically; "When dealing with chronic diseases such as diabetes, our goals are aimed at maintaining well -being or affected individual and minimizing long -term complications". As a homeopathi, we have to ask ourselves: would Hahnemann be satisfied with this final point of the prescription of chronic diseases? Did not great care in underline the underlying cause of chronic disease, ie the state of impaired sensitivity that needs to be understood precisely, acted and the results thus obtained have been evaluated?

The presentation examines the problem of diabetes mellitus and integrates the homeopathic approach with advances registered in the clinical-pathological area of modern medicine. It outlines a definitive approach to studying the state based on the sound principles of homeopathy, see, generalization and individualization. It illustrates the way of analyzing the therapeutic action of the doctor to deduce the concepts on which they were founded. It recommends an evolutionary study of diabetes problem and a long -term monitoring strategy. The first six aphorisms of organon medicine form the basis of the studio. Patient, physician, at the age of 37 years of age belongs to the middle family. There is a strong family history of diabetes mellitus and hypertension. The father expired at the age of 52 years of acute myocardial infarction.

Homeopathic approach to NidDM:

Clinical range and restrictions-

From the homeopathic angle, diabetes mellitus syndrome is a chronic constitutional disorder. If it is uncontrolled for a longer period of time, it affects blood vessels and leads to micro and macro vascular complications, which can be life -threatening and certainly reduces the quality of life.

However, homeopathy affects the basic susceptibility of the system and corrects the basic disorganization of failures into the state of organization and the state of health, leading to normal functioning. Thus, thanks to homeopathic treatment, there is a better chance of returning the system to normal. Even more importantly, homeopathy approaches the illness and health holistic, with regard to the whole person and its environment and does not have the organ itself or system.

1) This has 2 consequences: in homeopathic care, the diabetic can achieve not only blood sugar levels, but also a pulsating sense of well -being.

2) The re -education of the patient and his family in terms of lifestyle, diet and exercise plays an essential role in the successful management of this disease. This research will investigate and test the validity of these claims.

Homeopathic approach to a diabetic foot

Secale Cor 30- Excellent diabetic gangrene remedy. Dry gangrene tip. Nitrate blue tinge. The skin feels cold, yet it covers that it is not tolerated. Deterioration

Album Arsenicum 30- diabetic gangrene. Burning and pain, relaxed with heat. Fetid fragrance from the wound. Unrest

API MELLIFICA 30-PREADING Cellulite with spicy stinging pain. Sensitive. Bleby is to see

Antimonium Crudum 30- calls are visible. Dry gangrene

Karbo vegetabis 30- Carbuns and cooking becomes gangrenous. Mokrý, purple and ice cold gangrena.moistical gangrene. There is a large prostrice

Hepar Sulph 30-Blebs are visible. Very sensitive to the touch

Lachesis 200- blueish purple surroundings around Gangrene. Traumatic

Rhus tox 30- spread of cellulite

Sulfuric acid-30-blue and purple surroundings of the gangrene. Skin -bleeding

Thiosinaminum 30-specific for callers. Dry gangrene

Tarentula Cub 30- painful and inflamed abscess with a tendency to gangrene

Echinacea q- emitting of a nasty fragrance from gangrene. 5 drops in a little water every 2 hours. Externally wash with Echinacea milk. It acts as a cleaning and antiseptic agent.

CONCLUSION:

My study with full devotion to the above approach can illuminate that homeopathy can do something for patients with a diabetic foot. However, there is a holistic responsibility for maintaining the stability of the external environment. It is necessary to be born that homeopathy based on the law on the birth of cure, but a person of unnatural habit cannot expect blessing of nature. There is also the extent of the future long -term research of homeopathy shutdowns, who can easily motivate patients and hold patients longer with confidence.

It should also be born that homeopathy is not for antiabetic treatment, but is based on antimiasmatic and institutional treatment. (ie homeopathy treats the patient and not the disease). There could be a chance of changing or modifying miasmatic expression, as the gene has been constantly influenced by exposed environmental mutagens and the effects of Miasm on the mutant gene may vary accordingly and it must be explored.

If this can happen and we cannot acknowledge that the altered or modified state of miasmatic expression, individualistic treatment of homeopathy will be futile.

Especially undesirable complications and adverse effects, which usually occur in modern treatment in the treatment of the patient with a diabetic foot, bears further loads in the drug of the disease.

This has not only that, but the complications of the disease without drugs, including simple control, have a long -term effect. Side effects.

Complications of strong medicinal products of non -nomoopathies have an immediate effect or sufficient to create an artificial chronic disease (most deplorable).

There is no doubt that homeopathic individualistic treatment is without such a life threatening condition; If cases are dealt with within the scope and restrictions.

Now it is time to prove that in addition to the primary primary, secondary and tertiary prevention; Homeopathic antimiasmatic / constitutional individualistic treatment can prevent the disease from generation to generation and has great support to reduce economic burden for our country as a whole.

There is a scope for other long -term research. I invite and greet research people to enroll in this aspect with the cooperation of a man of genetics (if necessary) to determine in this respect the effectiveness of individualistic medicine.

In this context I would like to quote the following -

Often it is "more important to know what patient has a disease than the type of disease" - according to Flanders Dunbar - a pioneer of psychosomatic medicine.

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