

## **Tuberculosis and Iridology**

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## 1. Introduction

This paper attempts to provide a conceptual framework for diagnosing and treating tuberculosis (TB) from an iridological perspective. Whereas the factual material presented in this article is obtained from interviews and a literature survey of material published in hardcopy and the web, the framework in which the factual material is presented represent the views of the author.

A key feature of this framework is the distinction between the clinical and miasmatic forms of TB.

### **TB – the disease**

Clinically tuberculosis is a disease caused by an infection with the bacteria *Mycobacterium tuberculosis*. The bacteria that cause the disease are normally inhaled by the victim in the form of microscopic droplets that are expelled into the air when a person with tuberculosis coughs, speaks or sneezes. Although the droplets dry out quickly the bacteria itself can remain airborne for hours. However, the tuberculosis bacteria are killed when exposed to ultraviolet light, including sunlight.

After the tuberculosis bacteria have been inhaled they reach the lungs and, within approximately six weeks, a small infection can appear that rarely gives any symptoms. This is called a primary infection. After this, the bacteria can then spread to all organs in the body through the blood. Although the lungs are the favourite place for the illness to strike you can develop tuberculosis in the pleura, in the bones, the urinary tract and sexual organs, the intestines and even in the skin. Lymph nodes in the lung root and on the throat can also get infected. Tuberculous meningitis is sometimes seen in newly infected children. This form of the disease is a life-threatening condition.

It is estimated that the TB bacteria is present but dormant in a third of the world's population.<sup>1</sup> It is kept in check by the immune system. When the immune system is compromised (as in the case of Aids, famine, war and poor public hygiene) the disease form of TB can develop. If you have a healthy immune system, in most cases the infection will remain dormant without doing any obvious harm. Months or even years later, however, the disease can become reactivated in different organs if the immune system is weakened. During the 19th century, up to 25 per cent of deaths in Europe were caused by this disease. The death toll began to fall as living standards improved at the start of the 20th century, and from the 1940s effective medicines to combat TB were developed. However there are now more people in the world with TB than there were in 1950. The disease is more common in areas of the world where poverty, malnutrition, poor general health and social disruption are present. In the UK, too, the number of TB cases is again rising. Alcoholics, HIV-positive individuals, some recent immigrants and healthcare workers are at increased risk. The disease is most commonly found in places such as hostels for the homeless, prisons, and centres for immigrants arriving from areas with high rates of HIV infection or inadequate health provision.

## **TB – the miasm**

A miasm can be seen as a pre-disposition to disease. This pre-disposition may or may not manifest itself in the clinical form of the disease. It can be of genetic origin possibly as a consequence of the full blown disease having occurred in one's ancestral line.

The theory of miasms originates in Hahnemann's book *The Chronic Diseases* which was published in 1828. He declared that the theory was the result of 12 years of the most painstaking work on difficult cases of a chronic character combined with his own historical research into the diseases of man. The three miasms given in that work – psoric, syphilitic and sycotic - are held to be responsible for all disease of a chronic nature and to form the foundation or basis for all disease in general.

The tubercular miasm is considered to be an offshoot of the psoric miasm. Whilst its portrait is somewhat similar to the psoric miasm it has its own completely unique features. The constitutional reactions of the TB miasm are not as dry, hot, and intense as the psoric one because the vital energy is more rapidly depleted. At the same time the pathological processes affect the deeper structures and cause rapid destruction of tissue.

The general nature of this miasm is changing symptomology, vague, weakness, shifting in location, depletion, dissatisfaction, lack of tolerance, careless "problem child", cravings that are not good for them. Physical expressions of this miasm are: offensive headswat, bleeding gums, long eyelashes, craving for salt, white spots on nails, nightmares, narrow chested. Its dermatological symptoms are ringworm, eczema, urticaria, herpes, re-occurring boils with pus and fever.

If allowed to progress the TB miasm can lead to tuberculosis as understood allopathically, i.e. a specific infectious disease caused by the germ mycobacterium tuberculosis. These individuals are affected by every kind of respiratory disorder and are prone to fevers. All these illnesses tend toward dangerous complications and are always made worse by suppressions. Suppression of the suppurations caused by the TB miasm often leads to respiratory distress and other dangerous sequels. For example, the suppression of a discharge from the ear in a tubercular child often causes nervous disorders and psychological changes in the individual. Sometimes it may even cause convulsions and death.

Diseases that develop from the tubercular miasm are bowel complaints, bronchitis, caries, colds, coughs, diabetes, emaciation, emphysema, epilepsy, fevers, fibrosis of the organs and tissues, glandular swelling, hay fever, head lice, hemorrhages, hydrocephalus, infection of the eyes, ears, nose, sinus, throat, and tonsils, meningitis, migraines, paralysis, hyperthyroid, laryngitis, lung abscesses, meningeal complications, pleurisy, pneumonia, pneumothorax, ringworm, spinal curvatures, and suppurative asthma.

Personalities with this miasm show the following symptoms: dissatisfaction, lack of tolerance, changes everything, does harmful thing to one's self.

## **Summary**

Keeping the distinction between the clinical and miasmatic forms of TB the rest of this paper looks at the diagnosis and treatment of TB both from a clinical and an iridological perspective. Tentative synergies between the two perspectives are suggested with a view to better diagnosis and treatment protocols.

It is important to note that the author has not clinically verified any of the hypotheses suggested in this paper.

## 2. Diagnosis

### **TB – the disease**

TB is mainly diagnosed clinically by making an assessment of the symptoms that are present. It can mimic many forms of disease and must always be considered if no firm diagnosis has been made.<sup>3</sup> Organs that can be affected are lungs, intestines, brain, gonads, kidneys and bones.

Typical signs of tuberculosis are:

- chronic or persistent cough and sputum production. If the disease is at an advanced stage the sputum will contain blood
- fatigue
- lack of appetite
- weight loss
- fever
- night sweats

Chronic low grade fever and raised ESR in the blood are warning symptoms of TB in general.

### **Pulmonary TB**

A persistent cough in conjunction with some of the above symptoms suggests the possibility of pulmonary TB. To confirm this diagnosis a sputum sample is subjected to a colour staining (AZT test). A positive result is achieved if the bacterial count is 10,000+/ml and confirms TB. A negative result does not rule out TB - bacterial counts may be diminished due to other medication or a strong immune response from the body. A more sensitive test - PCR (polymerase chain reaction) - can be used to identify the TB bacillus in lower concentrations. The top lobe of the right lung is the first pulmonary zone that is normally affected (because of the angle at which the trachea splits into the five lobes air flows into the top right lung with the least resistance). A chest X-Ray should reveal infiltration in this zone. Advanced TB will eventually spread to all the lobes.

In contrast pneumonia is associated with high fever and congestion in the lower lobes of the lungs.

From an iridological perspective the presence or absence of congestion in the upper lobe of the right lung is fairly straightforward to diagnose.

### **Intestinal TB**

Whilst TB can manifest itself anywhere along the small and large intestines the most common site tends to be the ileocecal region. The mesenteric lymph system and Peyer's patches tend to be involved. It is important to differentiate TB from Crohn's disease prior to commencing treatment. Colonoscopy can reveal TB nodules. A PCR test on a biopsy can reveal the TB bacillus.

From an iridological perspective atrophy or distension of the intestines can be seen in the shape of the collarette. Furthermore it is easy to see any inflammation of the mesenteric lymph system (flares around the collarette) or Peyer's patches (white marking in the appropriate zone).

### **Serous (brain) TB**

Symptoms of meningitis can be caused by the TB bacillus as well as pneumococci. A PCR test on a sample of the cerebrospinal fluid will reveal if TB is present. TB nodules in the brain can be mistaken for tumors.

From an iridological perspective one might see either bright or dark signs in the brain zone of the iris.

### **TB of the reproductive system**

TB can attack the reproductive system and lead to sterility in either sex. A PCR test on menstrual blood or a biopsy may reveal the presence of TB.

From an iridological perspective one might see either bright or dark signs in the reproductive zone of the iris.

### **TB of the Kidneys**

Pus or blood in the urine that has been analysed for bacterial infection and shown a negative result could be analysed for TB and show a positive result.

From an iridological perspective one might see either bright or dark signs in the kidney zone of the iris.

### **TB of the Bones**

Laboratory confirmation for a diagnosis of TB of the bones is hampered by the difficulty of getting an appropriate biopsy sample to test. The spine tends to be the most vulnerable region for TB of the bones followed by the hip joint and the knee joint. A diagnosis can be confirmed by a skilful interpretation of a MRI scan.

From an iridological perspective one might see either bright or dark signs in the spine zone of the iris.

### **TB – the miasm**

The TB miasm can be iridologically diagnosed from the following signs in the iris or pupil:

#### **Iris**

A large lacuna (open or closed) in the lung zone indicates a TB miasm.

When part of the ANW appears to float loosely across the pupil, or appear to be detached from the iris, a TB miasm is indicated with a tendency to respiratory weaknesses, eczema and inflammatory joint conditions.

A straw yellow stomach ruff indicates disturbed digestive processes due to abdominal TB.

White crystalline plaquing on the outer ciliary edge between 8-10 or 2-4 o'clock in either iris indicates a TB miasm – not necessarily in the respiratory system.

Calcification markings in the Hilus zone indicate a TB miasm.

#### **Pupils**

Threads across the pupil indicate a TB miasm. The shape of the thread helps us to locate the areas of the body where the miasm is most likely to manifest itself.

1. A waving thread that swings with the movement of the pupil indicates a Tubercular focus in the brain area.
2. A thread that spans the pupil with granular riders spaced along its length indicates a TB miasm in the abdominal area.

3. A short singular thread with the base end attached to the pupil ruff and the other end to a bubble or spot that floats in the pupil indicates a TB miasm affecting the lymphatic glands of the GI tract that can lead to ulcerative colitis, Crohn's disease and bowel cancer.
4. A crystalline formation in the lens in the shape of a grey bound propeller indicates a TB miasm affecting the mineral metabolism that can lead to hyperthyroidism and goitre which in turn could lead to bow legs, knock knees, abnormal curvature of the spine and spinal disc prolapse. A vitamin D deficiency is indicated.
5. Cataract pisciforms indicate a Tubercular influence on bone growth leading to a ricketic tendency. Check mineral & vitamin D status.
6. A retro-iridial pigment line indicates a TB process in the foetal stage leading to a tendency towards bone diseases – rickets & osteomalacia.

Dilated pupils can be a consequence of TB amongst other disorders.

Superior positioned pupils indicate indicate intestinal weakness – possibly from TB.

Although the tuberculinic disposition is not one of the classical iridological constitutions the Felke Institute (in Germany) defines this disposition as a combination of the above signs in an iris with a predominantly wavy fibre structure (like combed hair). This disposition has a tendency to all diseases related to and developing from tubercular toxins.

When a patient displays signs of the TB miasm in their irides it is important to examine the other zones pertaining to the immune system as well as their immune axis.<sup>7</sup> If the immune system is compromised then this patient is at greater risk of developing the disease form of TB.

## **Summary**

Whilst there are no specific signs in the iris for the clinical form of TB an iridologist can suspect it by piecing together evidence from the various body zones that the clinical form of TB is known to manifest itself in. There are specific signs in the iris for the miasmatic form of TB. Putting the two sets of signs together with the patient's symptoms an iridologist can be in a position to suspect clinical TB. In such a case a laboratory analysis should be undertaken to confirm or reject this suspicion.

## **3. Treatment**

### **TB – the disease**

Whilst there are a number of herbal remedies for the treatment of clinical TB it is important to note that TB is a notifiable disease in the UK. This means that by law the medical management of the full blown version of the disease must be undertaken in an allopathic environment in the UK.

Treatment involves three or four different kinds of antibiotics given in combination over six to nine months. Multiple medicines are necessary to prevent the emergence of resistance, which would lead to treatment failure and the nightmare of multiple drug-resistant organisms. Single medicines must never be added to a failing treatment regime. Therapy should be

directed by a physician who has specialist knowledge of the complications and side effects of TB medicines.

Attention to the details of treatment are vital. The main cause of treatment failure is non-compliance with what is perceived as a demanding and prolonged programme of therapy. Those patients who are microscopy or smear positive are infectious and, if possible, should avoid contact with other people for two weeks. Patients do not require hospital admission in order to start treatment. Other patients with a lower bacterial load are smear negative but culture positive on testing. These patients are not as infectious but should still have therapy along conventional lines. Pregnant women with TB must be treated urgently as the disease may progress rapidly with high risk to both mother and baby.

### **TB – the miasm**

The miasmatic aspect of TB can be treated homoeopathically. There are a number of remedies available to the practitioner like Tuberculinum, Bacillinum, Calc. Carb., Arsenicum Iodatum, Iodoformum and Phellandrium. Each case must be considered specifically when selecting a remedy. However the tubercular pre-disposition determines the therapeutic basis. In the experience of the Felke Institute (in Germany) the overall treatment becomes more effective when the tubercular basis is addressed.

It is important for the treatment protocol of patients with the TB miasm to take into account that the immune system is functioning healthily.

### **Summary**

Treatment of the clinical form of TB must be undertaken in an allopathic environment.

However the miasmatic form of TB can be treated homoeopathically. The treatment protocol for the miasmatic form of TB should pay specific attention to the immune system.

Clinical evidence needs to be gathered by taking patients with the miasmatic form of TB but without the disease form of TB and with chronic ailments in the zones that the disease form of TB is known to manifest itself, and treating the miasmatic form of TB to see if this is effective in reducing/eliminating their chronic ailments.

### **4. Conclusion**

Knowledge of the symptoms and likely paths of the clinical version of TB enables an iridologist to look in the appropriate zones of the irides to diagnose the disease form of TB. The presence or absence of any miasmatic signs of TB in the iris will strengthen or weaken any iridological diagnosis.

For example if an iridological inspection shows congestion in the upper lobe of the right lung then the possibility of TB can be kept in mind. If there is congestion in the lower lobes of the lungs and no congestion in the upper lobe of the right lung then the possibility of TB is reduced. If there is a floating ANW in addition to a congested upper lobe of the right lung then the possibility of TB increases.

Knowledge of the miasmatic influence of TB can permit early therapeutic intervention that may prevent the subsequent development of full blown TB. It can also provide a different therapeutic strategy that may not be obvious for chronic problems that are not responding to

the obvious remedies for those conditions e.g. infertility, intestinal and kidney disorders, spinal weakness, etc. If these problems can be resolved by treating the TB miasm then we have a clinical basis for concluding that this miasm can cause chronic problems that one might expect from the disease form of TB without actually experiencing the disease form clinically.

### **Next steps**

The conceptual framework outlined in this paper needs to be refined and corroborated or refuted by considering actual case histories. The author has started a database to collect this information and would appreciate any input from other iridologists. He can be contacted by email at:

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### **5. Sources**

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