History of this document:
- Guidelines elaborated by Dr S. Fayeton, Dr M. Van Wassenhoven and ECH Working Group on the topic were published by ECH years ago.
- Incorporating elements of the protocol used at the Central Council for Research in Homeopathy in India. Prof. Chaturbhuja Nayak May 2010.
- First draft presentation and first amendments of this new document: ECH G.A. Brussels, November 2010
- First edition draft submitted to all National Vice-presidents of the LMHI 2011.
- Second first edition draft presented to the 66th LMHI I.C.
- Call for amended second edition draft 2012
- Second edition presented to the 67th LMHI I.C. in NARA

Introduction:
Systematic clinical data collection must match contemporary reality as a whole. The aim of these guidelines is to promote convergence in the publications on verification of homeopathic symptoms. The proposed data collection system must be flexible and accessible manually or by information technology. The ultimate objective of this proposal is to use an automatic information system allowing collection, recording, extraction, processing, interpretation, evaluation and communication. This system must allow verification of symptoms from remedy provings as well as clinical symptoms which will never originate from pathogenetic trials. Clinical data collection and classification systems must respect the ‘essence’ of homeopathic practice, the law of similarity.

The importance of clinical verification of homeopathic is historical but even more important to validate “modern” homeopathic practice, the similarity law and the individualization rule including a global view on the patient. An unconfirmed proving symptom that never was verified by clinical data cannot yet be considered as useful for homeopathic practice.

We want to stress that this kind of research is meant first to improve homeopathy. Our proposal aims to gather data without interfering with daily practice accepting a lack of control mechanisms. Participants in this research should realize that biased observation has a negative influence on the quality of the data.
Scientific justification:

Is scientific research really what we hope it would be: the ultimate and indisputable answer our questions, like “will this patient be cured by this therapy”? This question is probably the most relevant one for each practitioner. An insurance company or government might have other prime questions like efficacy and cost-effectiveness. Shareholders of a pharmaceutical industry might be more interested in the question if the development of a specific medicine is profitable. The Randomised Controlled Trial (RCT) is considered the gold standard in clinical research, but – if the control is placebo – it says no more than that the real medicine performs better than the placebo at a specified certainty level. Possibly the verum works in 50% and the placebo in 40% of the cases. But would the practitioner consider prescribing a placebo? And what about the 50% not cured by the verum, or the patients that would be excluded for participating in RCTs because of age or concomitant diseases?

Do doctors commit themselves to the outcome of RCTs, e.g. in the most common cause of physician visits, the upper respiratory tract infection (URTI)?

There is strong RCT-evidence that antibiotics have no role in uncomplicated URTI according to the Cochrane Collaboration (risk ratio 0.95, 95% confidence interval [CI] 0.59 to 1.31). Antibiotics do reduce the risk of pneumonia after chest infections, but they are still prescribed in a majority of cases in ear infection, sore throat and common URTI where they are not helpful. So, doctors often prescribe antibiotics despite RCT-evidence against it risking multi-resistant bacteria. There are also indications for the opposite: not prescribing despite RCT evidence. A meta-analysis concluded that homeopathy had a ‘substantial beneficial effect’ (odds ratio 0.36, 95% CI 0.26-0.50) in URTI. The number of RCTs in this meta-analysis was sufficient with eight trials; 90% of all meta-analyses in the Cochrane database regarding respiratory diseases include eight or less RCTs. There was also no evidence of quality bias.

There may be numerous reasons why doctors do not follow the evidence, one of them if the possibility of bias, like incomplete reporting, ghost authorship and even fraud. This kind of bias and publication bias are usually more likely if the outcome is positive because huge financial interests may be involved. In the case of homeopathy plausibility is over-rated and

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8 Healy D. Did regulators fail over selective serotonin reuptake inhibitors? BMJ 2006;333:92-95
intermingled with questionable interpretation of the evidence. Bayesian philosophy is also not adequate to explain why the evidence is not followed and probably a paradigmatic shift is required.

But even if the evidence for homeopathy is taken seriously, it does not suffice to tell what homeopathic medicine will help the patient in front of you. If a doctor would like to exchange an antibiotic for a homeopathic medicine he will search in vain for RCT proof that, say, Mercurius (merc) cures throat infection. The costs to deliver this proof would be enormous because, among others, Merc will only cure a small proportion of throat infections. The result would be ‘adequate’ proof for a small proportion of only throat infections.

As Hahnemann said, every patient is new and singular, combination of symptoms in a sick person is quite often different and we cannot fix combinations of symptoms on before (individualization). In daily practice we are using a qualitative valorization of patient’s symptoms allowing the best homeopathic medicine choice. This traditional Hahnemannian approach can be assessed today mathematically (qualitative research methodology), it can tell us when to prescribe a homeopathic medicine knowing that probably several conditions should be met to expect a reasonable chance of success. Besides the one-to-one relationship between efficacy (certainty that the effect is not a placebo-effect) of a therapy and a specific condition, medicine is familiar with the multivariate relationship between signs/symptoms and diagnosis. This relationship is scientifically assessed in diagnosis research, but results in a probability that a specific diagnosis is correct.

Research in medicine divides the medical process in two, before and after the diagnosis. In the diagnostic part (before diagnosis) we assess the probability that a diagnosis is correct if the assessed diagnostic test (or symptom) is positive. The research question in the second part (after diagnosis) is quite different: the certainty (beyond a specified level) that the effect of the therapy differs from placebo. The reasoning in the first part is Bayesian, in the second part frequentistic.

<table>
<thead>
<tr>
<th>symptom A</th>
<th>diagnostic research</th>
<th>symptom B</th>
<th>RCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>test X</td>
<td>Diagnosis</td>
<td>test Y</td>
<td>result</td>
</tr>
<tr>
<td></td>
<td>probability of diagnosis</td>
<td></td>
<td>chances effect = placebo &lt; 0.05</td>
</tr>
</tbody>
</table>

The problem in homeopathy is the same as in the diagnosis of disease: a reliable outcome cannot be based on one fact. This is a Bayesian procedure that can be assessed the same way as diagnostic instruments. The outcome is a probability, not a yes or no statement about

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10 Rutten ALB. How can we change beliefs? A Bayesian perspective. Homeopathy 2008;97:214-219
effectiveness. In homeopathy the diagnosis can be used, but has the same (or less) value as other symptoms, see next figure. The research question in homeopathy is: How likely is cure when a symptom (or diagnosis) is positive?

The influence of different variables on outcome of therapy is known in epidemiology as ‘effect modification’; the presence of a specific variable influences chances of cure. The method is prognostic research. Prognostic research is therefore a suitable and sound scientific method for homeopathy.

**History:**
Internal Evidence was defined by Constantine Hering considering five steps to obtain a “evidence based” characteristic homeopathic symptom. (Ref. The Guiding Symptoms of our Materia Medica. Vol 1; 1879; Preface; page 3-4). Hering’s emphasis had progressively shifted from toxicological and proving symptoms to the verified symptoms: “Post hoc, ergo propter hoc” (After this, therefore because of this). It does not minimize the importance of provings, indeed without confirmed proving symptoms no clinical verification would be possible.

First step: **The possibility**, one substance provoked some symptoms which sometimes might even be toxic.
Second step: **The probability**, when this substance, diluted and dynamised, has provoked various symptoms on volunteers in good health.
Third step: **The confirmation**, when this same substance, diluted and dynamised, given to volunteers in good health, has confirmed some symptoms issued from a previous pathogenesis and provoked probable new symptoms.
Fourth step: **The corroboration**, this means the examination of the place taken by the probable symptom and its confirmation by the notions actually known of physiology and pathology.
Fifth step: **The Clinical Verification**, at the bed of the suffering/sick patient, the correspondence of the probable symptom, confirmed and corroborated is verified by the obtained clinical results.

To reach this goal three aspects must be considered:
A/ Data collection
B/ Data verification
C/ Data analysis

To Hering’s guidelines we can add more recent scientific developments, like qualification of results, causal relationship between medicine and effect, methodological specification like retrospective and prospective research and statistical analysis of results.
A/ Data collection of Homeopathic consultation

For clinical verification of homeopathic symptoms only a few administrative data are compulsory needed: a patient “number”, age and sex.

In daily practice patient’s symptoms are collected as the patient expresses them or as the MD observes them (clinical examination or patient comportment). After this first step, each collected symptom receives some classification in accordance with followed criteria:
(a) Factual: symptom originality; modalities and level of detail; global view of the patient; actuality (recent symptom) or anteriority (persistent old symptom); proving symptom or symptom not described in previous published provings or clinical symptoms.
(b) Anatomical (Mind, Head, Vertigo, Eye etc.)
(c) Keywords: for later comparison of gathered symptoms with each other.
(d) Grouping: symptoms will be grouped together in different sets; possible links between different symptoms are checked.
(e) Meaning: looking at these ‘sets of symptoms’ possible remedy ‘picture(s)’ can be proposed.
(f) Value: especially for new symptoms, the value of the symptom would be scrutinized (frequency of occurrence/accuracy/intensity) making possible, later on, an inclusion within the framework of knowledge of the remedy.

This preliminary part of data collection is common in daily practice in order to perform the best possible remedy search in repertories and/or clinical materia medica(s).

Another way of data collection is systematic application of questionnaires. Such questionnaires can be used to record frequently occurring homeopathic symptoms, like modalities and relations to food. These questionnaires can be filled in by patients apart from consultations and are helpful in determining the prevalence of symptoms in the whole population and in populations responding well to specific homeopathic medicines.

The prescribed homeopathic remedy is recorded accurately to avoid any possible confusion; therefore, it is important that the origin of the remedy (laboratory as example or registration number) is mentioned.
Intake frequency and dynamisation of the remedy are useful.
The concerned medicine must have been prescribed as a single remedy (unitary homeopathy) during a relevant period of time.
Information’s about the reasons for the initial choice of the medicine are relevant. Examples: proving’s symptoms list, keynote(s); etiologic circumstances; global or mind oriented repertorisation of symptoms; ‘meaning’ of patient’s problems (essence, spirit, remedy problem), etc.. More than one reason is possible for a case.

No other homeopathic medicine can be taken within at least one month before reporting of the cure. In case of possible doubt, reasons for acceptance must be justified. All possible concomitants must be mentioned (allopathic, psychotherapy, etc.), reports must be accompanied by a detailed description of the interventions (substance, dose, usage time (and/or period), timing).

At following consultations the reaction of the patient to the homeopathic remedy is recorded following a systematic pattern. It can be a personal scale but the best would be to use an international classification as the following scale.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Very spectacular changes in the total picture, all symptoms are disappearing and the general state of health is completely improved.</td>
</tr>
<tr>
<td>4</td>
<td>Spectacular disappearance of all symptoms with improved general state of health.</td>
</tr>
<tr>
<td>3</td>
<td>Disappearance of symptoms, start of a general health state improvement.</td>
</tr>
<tr>
<td>2</td>
<td>Good effect during the treatment but we are not convince it will improve the patient completely, other therapies are still needed</td>
</tr>
<tr>
<td>1</td>
<td>Some effect during the treatment but it could be due to other factors (like placebo)</td>
</tr>
<tr>
<td>0</td>
<td>No effect</td>
</tr>
<tr>
<td>-1</td>
<td>Some deterioration or aggravation during and/or after the treatment but it could due to other factors (like nocebo).</td>
</tr>
<tr>
<td>-2</td>
<td>Clear deterioration of the symptoms during and/or after the treatment.</td>
</tr>
<tr>
<td>-3</td>
<td>Deterioration of the symptoms and start of alteration of the general health state.</td>
</tr>
<tr>
<td>-4</td>
<td>Clear alteration of patient’s general state of health.</td>
</tr>
<tr>
<td>-5</td>
<td>Very spectacular alteration of complete patient’s health state.</td>
</tr>
</tbody>
</table>

An important question in this respect is: was the improvement really due to the homeopathic medicine. Other factors, like great successes in love or business, can give spectacular improvements of health. For assessing causal relationship in homeopathy we could use an algorithm, like Naranjo's algorithm. This algorithm is already available for adverse drug reactions.\(^{12,13}\) The next table is an adaptation of Naranjo’s algorithm; most homeopathic doctors will apply similar considerations intuitively if they select interesting cases to show how homeopathy works. This list is not yet validated and should be considered as a still developing tool. A total score of more than five helps to assess causal relationship between remedy reaction and remedy choice. The classification of result following the above scale should only be done if a causal relationship is likely. A zero effect should only be scored when it is certain that the medicine did not work, not after only one month in chronic conditions.


<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Was the case similar to other cases with this medicine?</td>
<td>+1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2. Did the effect appear after administration of the medicine?</td>
<td>+1</td>
<td>-1</td>
<td>0</td>
</tr>
<tr>
<td>3. Did the effect after one dose subside after a period of time?</td>
<td>+1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4. Was the improvement resumed after repeated administration of the medicine?</td>
<td>+2</td>
<td>-1</td>
<td>0</td>
</tr>
<tr>
<td>5. Was there an initial aggravation?</td>
<td>+1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6. Did the effect comprise more than the presented complaint, e.g. wellbeing and other complaints, like in the scale above?</td>
<td>+2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7. Did the course of improvement follow Hering's rule?</td>
<td>+2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>8. Did old symptoms reappear for a while in the course of the improvement?</td>
<td>+1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9. Are there alternate causes (other than the medicine) that solely could have caused the improvement?</td>
<td>-3</td>
<td>+1</td>
<td>0</td>
</tr>
<tr>
<td>10. Did the patient have the same response to other homeopathic medicines?</td>
<td>-1</td>
<td>+1</td>
<td>0</td>
</tr>
<tr>
<td>11. Was the effect confirmed by objective evidence?</td>
<td>+1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Other schools are looking to four parameters: evolution of patient’s subjective state; the movement of the symptoms of the first consultation; the miasmatic state and the fulfillment of Hering’s Law. The disappearance of a symptom without any other fundamental changes in the patient may indeed reveal a simple suppression that will not lead to a cure.

**Confirmation bias**

Confirmation bias is the tendency to favor information that confirms your preconceptions. If you prescribe Causticum, you tend to perceive that the patient has “sensitivity to injustice”. If you are very certain that a medicine must work, you value changes as related to the medicine. We must realize that the research we propose here has sensitivity for confirmation bias. Biased data, however, will have a negative influence on the reliability of our Materia Medica and Repertories.
B/ Homeopathic symptoms verification’s protocol

The hypothesis is that the selection of a Homeopathic remedy on basis of the existence of similar provings’ symptoms will induce a healing reaction in the patient; as secondary objective, additional symptoms could be observed and linked to the intake of the remedy.

Verification of homeopathic symptoms can be done retrospectively or prospectively. In **retrospective** verification of symptoms design, the databank can be **all cases** from a specific MD or from a centralized databank of clinical data coming from several MDs. If cases (symptoms) are recorded in sheet form there are limited facilities for analysis. This system is still suited for analysis of ‘best cases’ but data collection is better done using computerized technology.

The selection of a homeopathic remedy for verification must consider the amount of available patient’s files that have received a specific remedy in a same setting (etiologic circumstances; clinical indications; keynotes; global or mind oriented repertorisation of symptoms; ‘meaning’ of patient’s problems (essence, spirit, remedy problem). In retrospective research all symptoms are considered but of course not systematically checked in every patient during consultation.

In **prospective** verification of symptoms design possibly all **new cases** are used but they will be compared with the general population. Starting this design needs an agreement on a list of symptoms a group of MDs likes to verify. In prospective research a limited number of symptoms is considered, but these symptoms are checked in every patient (preliminary decision). Many reasons may be considered to make the choice of a symptom:

- prevalence in the population under study
- homeopathic relevance (keynotes as example)
- questioning the meaning of a homeopathic symptom
- questioning the link between a homeopathic symptom and a remedy
- systematic verification of repertory symptoms.

Questionnaires can also be useful to collect data prospectively by sending the questionnaire before the first consultation of give it to the patient at the first consultation to be filled in before the second consultation. This method enables us to investigate a larger number of symptoms prospectively compared to pre-specified symptoms verified during the first consultation.

A homeopathic medicine will be prescribed according the homeopathic principles of similarity and totality whatever the remedy will be.

It is important that each selected symptom has a defined meaning and setting:

- keynote
- etiological symptom
- **modalities of clinical symptom (anatomical: from mind to general)**
- mind oriented (but including a defined meaning)
- essence of patient’s problems (essence, spirit, remedy problem).
- the different symptoms in one research project should not be keynotes for the same medicine
Reaction of the patient on the intake of the remedy is recorded as defined before. Acute interventions during treatment for chronic illness should not be included. All symptoms presented by any of these patients will be studied further and classified according the very good reaction, the absence of significant reaction or bad obtained reaction. Retrospective research provides a quick overview of the relevance of all symptoms for respective homeopathic medicines, prospective research is more valid but for a limited number of symptoms.

C/ The analysis of collected data and publication.

In manual retrospective verification of symptoms design, using a sheet form, only clearly healed or failure cases are considered (5/4; 0 or -1/-2/-3/-4/-5 results). All symptoms presented by any of these patients will be studied and classified according the remedy very good reaction, the absence of significant reaction to the medicine or even bad obtained reaction. For each symptom the number of patients presenting a same reaction is calculated. This manual analysis of data is impossible for large remedies (too many times prescribed or when too much different symptoms are recorded).

In computerized retrospective verification of symptoms design, using information technology, all cases are considered (5/4/3/2/1/0/-1/-2/-3/-4/-5 results). All symptoms presented by any of these patients will be studied and classified according the remedy reaction. To perform this analysis automatically the population under study must be clearly defined and coherent about homeopathic setting (see above) and representatives of the whole population. For each symptom the number of patients presenting a same reaction is calculated. For this calculation we recommend to use the Likelihood method. This method is based on the “Bayes theorem” which studies the existing relation between two elements. It is commonly used in medicine, for example for the study of the relation between a method of diagnosis (or several associated) and the real diagnosis. The evaluation of results of a positive appendicitis echography and the real diagnosis allows asserting that the echography is not an absolute certitude for this diagnosis (8/10); but on the other hand the association of a positive echography and a positive biology allows a near certainty. In homeopathy, the similar law assigns the efficiency of a remedy to the presence (or the absence) of specific symptoms of a remedy. This method is thus perfectly adapted to the evaluation of this link. The gradient of likelihood which exists between the symptom and the efficiency of the prescribed remedy will be studied (Likelihood Ratio = LR).

- Based on data collection in daily practice.
- **LR+** is an indication that a remedy will be effective if the symptom is present, higher is better. LR+ must be >1.
- **LR-** is an indication that a remedy will not be effective if the patient does not have the symptom, more so if LR- is closer to zero. LR- must be <1.
- Reaching the level of « evidence ».
The positive gradient (LR+) is significant when it is upper than 1. It is an indication that the remedy will be effective for this symptom. Higher above 1, better it is, but we must take into account the confidence interval. If it is too broad, no final conclusion is possible. The negative gradient must be lower than 1, it is all the more significant that it is near 0. LR- lower than 1 is an indicator that the remedy would not be effective if the patient had not the symptom; this is more and more true if the value is near 0. A LR- higher than 1 means that the presence of this symptom by a patient will lead to another remedy than the one analyzed.

In a retrospective design, it considers the symptoms prevalence in a patient’s databank. The latter considered being representative of general population of people using homeopathy. The calculation can be done automatically using a mathematic formula explained in annex 4.

In prospective verification of symptoms design the same Bayesian methods can be applied. When results of clinical verification are published special attention is needed on the fact a verified symptom is coming from a proving or not, has been confirmed or not and has been already incorporated in repertories of symptoms or not. Finally, a new presentation of the symptom related to some remedy will be proposed to the homeopathic community. New questions could arise about the symptom and linked remedies and could be proposed for a further round of data collection and analysis. Our repertories and material medica will be updated accordingly to offer a better tool for the homeopathic MDs allowing better and better cure of all future patients.

To estimate the validity of LR values Confidence Intervals should be calculated. For these calculations we confine our outcome to populations where group “a” (group presenting a good reaction to the medicine and presenting the symptom) is larger than one. On the other hand, if a specific symptom occurs zero times or once in a population of 100 patients responding well to Sulphur but is existing in fact in 5% of the general population we can state that that symptom is no indication for Sulphur.

For the analysis of questionnaires regarding a larger set of symptoms, like modalities and relation to food, we could also apply modern statistical techniques like multivariate analysis.
CONCLUSIONS

The final aim of the clinical verification of homeopathic symptoms is to evaluate the strength of the link between a symptom and the efficiency of a remedy verifying at the same time the principle of similar and the totality rule.

As defined in another LMHI document, Homeopathic healing means healing according to the law of similar. All substances able to alter the state of health of a healthy subject, producing a pathogenesis of specific symptoms, when administrated to an ill living being that manifests similar symptoms to those evidenced in the healthy, work in a homeopathic way, i.e., effecting the reversibility of the morbid process.

This principle of similars says that a substance, capable of provoking symptoms in a healthy organism, acts as curative agent in a diseased organism in which the same symptoms are manifested: similia similibus curentur, or let likes be cured by likes. As it is mentioned in the Organon of Hahnemann, "to cure in a mild, prompt, safe, and durable manner, it is necessary to choose in each case a medicine that will excite an affection similar to that against which it is employed".

Clinical verification of symptoms is able to improve results in daily practice. Through a systematic clinical verification, an Evidence Based Repertory will be soon a reality, starting in your own office using your own daily results. It can also take into account results of local groups of colleagues or even of all homeopaths MDs in the world using an international databank of homeopathic clinical cases.

Previous publications have already demonstrated that these guidelines are able to reach these goals (see references).

Other Useful References
CCRH, Damiana – A Multicentric Clinical Verification Study. Indian Journal of Research in Homeopathy 2007 vol 1 n°1,17-23
Rutten A.L.B. Comparison of effectivenes of frequently and infrequently used homeopathic medicines Homeopathy (2011)
Annex 1

- Clinical verification of homeopathic symptoms -

Declaration of Intent

Name of organising group or individual:

Address:

We / I intend to perform a systematic data collection for clinical verification of:

Remedy:

If you are interested in collaboration, please ask us for the overview about the current knowledge on this remedy.

I am interested:

Name:

Address:

Phone/fax:

E-mail:
Annex 2

- Clinical verification of homeopathic symptoms -

Systematic clinical data collection form

Remedy : .......................................................  
Code : .......................................................  
Patient sex : .....................................................  
Birthday or age : .....................................................  
Concomitants : .....................................................  

Patient Curing level (make a choice following the adopted scale):

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>-1</th>
<th>-2</th>
<th>-3</th>
<th>-4</th>
<th>-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

O Symptom  O Syndrome  O General  
O Global  O Behavior

Explanation or comments: ........................................................................................................
.............................................................................................................................................
.............................................................................................................................................

Prescription purpose: O Keynote(s): .................................................................  
.............................................................................................................................................

O Repertorisation  O Etiologic  
O Clinical  
O Global  
O Mind  
O Other(s) ..............................................  
.............................................................................................................................................
.............................................................................................................................................

O Materia Medica .................................................................  
.................................................................................................................................

O Directly  
O Confirmation of repertory

O Remedy Meaning (essence—spirit—remedy problem)  
O Other .................................................................  
.............................................................................................................................................
.............................................................................................................................................

Explanation or comments: ........................................................................................................
.............................................................................................................................................
.............................................................................................................................................
.............................................................................................................................................

SYMPTOM number : ............  
SYMPTOM description : ........................................................................................................
.............................................................................................................................................
.............................................................................................................................................
.............................................................................................................................................
Annex 3

- Clinical verification of homeopathic symptoms -

Histopathography

Time period for symptom disappearance: ………………………………………
Possible recurrence(s) : ………………………………………………………
………………………………………………
………………………………………………
Result of second prescription : …………………………………………………
………………………………………………
………………………………………………

Type
O known (mentioned in the remedy overview, pp ………………………………….)
O known (personal source:…………………………………………………)
O new (not yet known within previous published provings or clinical drug feature)
O confirmed by other personal cases (how many?…………………………………)
O appearance during treatment:
O old (Hering)
O new (for the patient)

comments: ……………………………………………………………………………
………………………………………………………………………………
………………………………………………………………………………

Frame
O isolated
O part of a set of symptoms (please list)1 with other significant results
O general (all local symptoms together)
O global (well being)
O behavioral

Comments
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

1 Don’t forget to add a global list with all collected symptoms for the patient and your general comments (including possible link between symptoms - picture of the remedy - ‘meaning’).
Annex 4

Mathematic LR formula:

\[ LR_+ = \frac{a}{(a+c)} / \frac{b}{(b+d)} \]
\[ LR_- = \frac{c}{(a+c)} / \frac{d}{(d+b)} \]

Definitions:

**Medicine population:** the patients with a positive reaction to the medicine under study. **Remainder of the population:** all other patients, i.e. patients receiving no or other medicines plus patients receiving the medicine under study without positive reaction to that medicine.

\( a \) = number of patients presenting the symptom in the medicine population;
\( b \) = number of patients presenting the symptom in the remainder population;
\( c \) = number of patients not presenting the symptom in the medicine population;
\( d \) = number of patients not presenting the symptom in the remainder population