

Vaginal thrush is one of the most frequently encountered problems involving the female reproductive tract. It is caused by the yeast *Candida albicans*. Discuss the effects of *Candida* infection on the human organism, why or whether it may be considered an aspect of sycotic pathology, and suggest approaches for its control and eradication.

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‘CAUSES’ AND PREDISPOSING FACTORS

‘It is a saprophyte of the human and animal digestive tract, which may under some conditions (antibiotherapy, diabetes) prolifer and provoke some pathological manifestations of the skin, of mucous and of viscera.’ (Julian)

‘A yeast, *Candida albicans*, is the commonest fungus of medical importance. It is ubiquitous in the environment but it may also be transmitted between people directly. Candidosis is usually a superficial infection of skin, nails or mucous membrane with the yeast form of the fungus, causing mild inflammation. However, these tissues are rarely affected if they are entirely healthy. Factors that predispose to candidosis are:

Loss of integrity of skin and mucosæ

- Maceration of skin due to climate or obesity
- Eczema
- Dentures

Encouragement of local multiplication of *Candida*

- Alteration of mucosal flora: antibiotic treatment
- Hormonal: diabetes, pregnancy

Suppression of inflammatory and immune responses

- Specific congenital T lymphocyte deficiency
- Leucopænia of any cause
- Immunosuppressive drugs, including topical corticosteroids
- Malignancy
- Human immunodeficiency virus syndrome

A congenital immune deficiency of T lymphocytes predisposes to the syndrome of chronic mucocutaneous candidosis, while more severe, often iatrogenic, forms of immune suppression may permit systemic infection in which mycelia, as well as yeasts, invade tissue and form micro-abscesses.’ (Edwards et al, 1995. p144)

‘Candidiasis results from infection by *Candida albicans*, a budding yeast-like organism that can infect the skin and the mucosa of the mouth, intestine and genital tract. Young infants, pregnant women, diabetics, *people with prosthetic heart valves*, patients on broad-spectrum antibiotics and people immunocompromised by drugs or disease are especially susceptible to *Candida* infections ... Oral or genital candidiasis is often the first opportunistic infection to appear in HIV infection; if mucocutaneous candidiasis occurs in an adult patient who is neither diabetic nor taking an oral contraceptive preparation HIV infection is a likely underlying cause.’ (Forbes & Jackson, 1997. pp61-62, 98. Emphasis added)

Gascoigne (1995) points out that its appearance is associated with pregnancy, sugar intake, tight clothes, synthetic material, allergic reactions, prescribed drugs (corticosteroids, female sex hormones, immunosuppressant drugs), diabetes mellitus, AIDS and herpes simplex.

I also found reference to a curative action of DPT 30 in a case of candidiasis (Marlow, 1994). Pertussis vaccine has been implicated in the causation of juvenile onset diabetes as the vaccine acts directly on the islets of Langerhans, the insulin-secreting parts of the pancreas (Gaublomme, 1997). The pattern of progression is

hypoglycæmia followed by diabetes. This emphasises the link between candidiasis and diabetes, as does the fact that the organism is identified by the physiological character of its assimilation and fermentation of sugar. The use of Folliculinum successfully in candidiasis (Assilem, 1990) similarly underlines the connection with female sex hormones.

CLINICAL FEATURES & ASSOCIATED PATHOLOGY

The infection manifests most commonly where the skin is moist and in contact with itself (groin, perineum, breasts, axillæ). Nail infections start at the base, forming ridges, often accompanied by paronychia. On the mouth and genital mucosæ, white curd-like patches occur which, when scraped away, leave a bleeding base. Atrophy of the gums and angular stomatitis occur in the elderly. Vaginitis causes intense pruritus and a thick creamy leucorrhœa. Systemic candidiasis may present as septicæmia or with features of infection of the œsophageal and gastrointestinal tracts, heart, lungs, urinary tract or brain meninges. There may be an appearance of a skin rash similar to eczema with redness, soreness and some scaling.

‘Dr Orian Truss has written elaborately on this subject and believes that candidiasis is a commonly missed diagnosis that is responsible for many unusual and difficult to diagnose syndromes such as multiple allergies and generalised fatigue.’ (Shealy & Myss, 1993. p213.)

Other associated symptoms include lethargy and drowsiness, insomnia, poor memory, low body temperature, allergic symptoms, chronic diarrhœa, bladder infections, muscle and joint pain, menstrual problems, constipation and severe depression.

The proving of *Candida* shows connections with allergic asthma and polyarticular arthritis.

ESOTERIC VIEWPOINT

The various sources offering an interpretation of medical conditions from a more esoteric viewpoint offer a mixed bag of possibilities for consideration.

Page (1994) relates candidiasis to IBS as a sacral chakra infection, but also notes its association with ME in her chapter under heart chakra illnesses. The personalities susceptible to IBS are described as ‘caring, conscientious people who tend to keep their feelings inside whatever happens. They look after the needs of others before asking that their own needs will be met. However an inner resentment often develops which literally ‘screws them up inside’ leading to the spasms.’ (Page, 1994. p144) The personality type susceptible to ME is ‘those who are not walking on their own path. They are often pleasers, acting in accordance with the wishes of others. They are going in one direction miles away from their planned path. This disorientation leads to the tiredness and weakness as there is no real soul energy entering their body.’ (Page, 1994. p185)

Caroline Myss (1993) observes that ‘this disorder occurs mainly in people who have been psychologically, emotionally and physically over-active and in serious need of stabilising their lives. As in the mononucleosis virus, women are particularly susceptible, but for different reasons. Whereas the mononucleosis virus relates to issues of emotional safety, candidiasis corresponds to issues regarding the creation of a stabilised living situation, specifically what is known as the ‘nesting bug’. The stress emerging from the unfulfilled desire to lay down roots and establish a home and family is directly connected to this virus. Chronic candidiasis is a rather recently recognised disorder, and my opinion is that candidiasis, along with other contemporary epidemics such as mononucleosis, reflects very accurately our contemporary human stresses, lifestyles and concerns.’ (Shealy & Myss, 1993. p214)

Interestingly, Page seems to have linked the condition with more syphilitic manifestations of disease, while Myss paints the picture of a more sycotic personality.

CANDIDA AND THE SYCOTIC DIATHESIS

The closest correlation between candidiasis and the sycotic miasm I found in my research is noted by Cohen (1997). ‘Harris Coulter quotes the following words of Philip Hadley in his fourth volume of the *Divided Legacy*

(1994): “The truth we shall eventually come to is that the free-living microorganism is potentially a kaleidoscopic thing, in which the power of responding successfully to a changing environment by alterations in body state, both morphologic and biochemical — and even by self-destruction, if need be, in order to generate another and more stable type — stands as its one most important attribute.” If Philip Hadley is correct, and I think he is, then *N. gonorrhoea* and *Candida albicans* are the same organism, dissimilar only in their morphological states adapted to different environments.’ (Cohen, 1997. p701)

I could not find any other references to this theory so was unable to work through her reasoning, other than by noting the close correlation between *Candida* in potency and *Thuja* and *Medorrhinum* (Julian), and the fact that sycotic remedies predominate in the repertory in specific reference to candidiasis. To take her final statement further would be the equivalent of stating that polar bears and black bears are the same organism. Perhaps on some level they are, but we do not view them as such. She leads into her theory by reference to anthropologist Mark Nathan Cohen’s work *Health and Rise of Civilisation* where he describes the similarity of venereal syphilis, endemic syphilis and yaws which differ in their manifestations in response to environmental factors. This is likely to be derived from the lifetime’s research on the subject by Ellis Herndon Hudson begun during the 1920s and still continuing in 1965. However, Hudson noted that *Treponema pallidum*, *T. pertenue* and *T. carateum* differ only in their symptomatic manifestations — there are no morphological differences between the organisms, so the question of changing morphological state in the microorganism does not arise.

I found considerably more evidence to support the assertion that *Candida* is, if anything, more syphilitic than sycotic. If we look at conditions associated with candidiasis (AIDS and autoimmune syndromes, immunocompromised individuals), these appear far more syphilitic in expression. Page noted the connection with ME which she links to the heart chakra. Heart chakra diseases include heart disease, diseases of the immune system, allergies and hypersensitivity, cancer, AIDS and auto-immune diseases, all of which are highly syphilitic. All of these conditions have been associated with candidiasis. Note also that individuals with prosthetic heart valves commonly manifest the condition (see above). *Candida*’s current prevalence could be seen as an aspect of humanity’s present focus on heart chakra issues (seen all around us throughout western society), also picked up on in part by Myss above. The endocrine gland associated with this chakra is the thymus which is responsible for T-lymphocyte production. It has already been noted above that congenital immunodeficiency of T-lymphocytes predisposes to the syndrome of chronic mucocutaneous candidiasis. Coulter (1990) notes that ‘*T. pallidum* acts specifically against the thymus gland. The thymus-dependent parts of the lymphatic system deteriorate and there is a consequent decline in the number of T-lymphocytes ... Consequently, a long-term effect of syphilis is decline in, or loss of, the individual’s capacity to defend himself against other infections.’ (Coulter, 1990. p41) and again, ‘AIDS is marked by deterioration, destruction, or collapse of the thymus gland and a decrease in the T-lymphocyte populations. The ordinary ratio of 1:1 or 2:1 between T-helper and T-suppressor cells drops to 1:2 or lower. The immune system lapses into not-so-benevolent neutrality, opening the body to invasion by a host of ordinarily ‘commensal’ microorganisms.’ (Coulter, 1990. p43).

To give further weight to the syphilitic, as opposed to sycotic, connection, and in apparent opposition to Cohen’s assertion, I found the following: ‘The nearest relatives of the treponemes are saprophytes, microorganisms that flourish in decaying organic matter, and such was perhaps the original habitat of *T. pallidum*.’ (Hudson, 1965. p890) *Candida* is a saprophytic fungus: ie, *Candida* is morphologically closer to *Treponema pallidum* (syphilis) than *Neisseria gonorrhoea* (*gonorrhoea*), and as saprophytic fungi flourish in decaying organic matter, this points also to the syphilitic diathesis.

However, where apparent oppositions appear, then it is appropriate to consider that what is being reflected are two facets of the same issue. Sycosis and syphilis as categorisations (and, at the end of the day, that is *all* they are — models or constructs) may represent just this. Interestingly, syphilis and *gonorrhoea* were thought to be the same disease until Neisser isolated the gonococcal bacillus in 1879 (though the postulate had been advanced nearly a century earlier). It was first cultured in 1882 by Ernst von Bumm.

Perhaps a more credible hypothesis is this: a person with susceptibilities to pathology in the sexual sphere (B) comes into intimate contact with a similar person with active pathology (A). The strength of the morphogenic field of

A acts as a trigger to B, initiating their own pathology if they are already under some stress. If B has an underlying predisposition to a predominantly 'explosive' expression, their symptoms will be mainly exudative and provide the perfect environment for an explosive increase in the commensal *N. gonorrhoea* population. Should A come into intimate contact with a person of more 'implosive' energies (C), their aura of decay will result in symptoms including the presence of a large *T. pallidum* population (which, between the stages of syphilis, rather than hiding in some undetectable area of the body, simply isn't there). And if A has an affair with someone who is already severely immunocompromised by long-term iatrogenic damage (D), then D will be more likely to develop symptoms including the presence of HIV antibody and a proliferation in their resident *C. albicans* population.

This is not to say that the microorganisms themselves have no effect. The population explosion (in whatever microbe(s) for which the person provides the optimum environment) causes the host organism to produce further symptoms as it places it under further stress (common symptoms of disease). This also explains why the allopathic approach of targeting the overpopulation brings some relief of symptoms, and why the nosodes are so effective in addressing the underlying predisposition to the disease process they represent.

As like has a tendency to attract like, the assumption that the phased appearance of (essentially) the same microorganism in two similar individuals reflects *the passage of the microorganism between them*, and that this is therefore the *sole* route of disease transmission, is understandable; hence the germ theory of disease. Once this idea takes hold, the probably equally numerous instances where the detected microorganism in one party is not the same as that evidenced in their present partner, have likely been explained away as 'infection' from another source, even if the patients themselves cannot trace this. Hadley, Hudson and Cohen above who have observed that symptoms change according to (external) environment, have based their assumptions on the view that the germ theory remains valid and that therefore the only explanation is that the germs themselves mutate. If our individual morphogenic fields determine the precise form of our pathogens, then they could be seen as 'mutating', the apparent 'mutations' being reflections of the subtly different environments in which they take form.

If this is the case, it may account for some of the confusion, differing opinion and general doubt surrounding both the germ theory of disease and Hahnemann's miasmatic theory. What seems to be required is a recognition that the germ theory of disease is the medical equivalent of Newtonian physics, and an energetic (in all senses of the word) reclassification of disease predisposition based on parameters synthesised from multiple models of health and disease which in some aspect reflects them all (and which is well beyond the scope of this assignment!). In terms of miasmatic theory, candidiasis could therefore be classified as syco-syphilitic (if the primary tripartite division is used), belonging to the cancer and/or AIDS miasms if later authors' classifications are considered, or primarily syphilitic if AIDS and similar immune-deficient syndromes are seen as syphilitic in origin. There is also a psoric dimension to the condition (see below).

CONTROL AND ERADICATION

Candidiasis has an apparently close association with conditions involving some degree of compromise to the proper functioning of the immune system in affected individuals, most frequently of iatrogenic origin. Effective treatment regimes should therefore concentrate on restoring the integrity of the immune response as well as the fundamental predisposition to impaired immune functioning. This could be seen as revolving around heart chakra issues of self-love and self-worth which are central to many syctic, syphilitic and autoimmune syndromes.

Self-help regimes such as careful attention to bodily cleanliness, special diets and dietary supplementation, either of vitamins and/or beneficial bacteria such as *Lactobacillus acidophilus*, have been of benefit to sufferers. Aside from affecting the microenvironment in which *Candida* flourishes, such approaches allow the patient to devote some care and attention to themselves, and to feel the benefit of that nurture. The issue with high carbohydrate diets which are associated with the proliferation of *Candida*, and with diabetes, indicate the role of sugar as substitute for the sweetness of the self-love which has been denied.

Homœopathic remedies which mirror the primary delusion as well as the physical pathology are likely to be helpful. The repertories do not contain many remedies under the specific heading of *Candida* infection. These are

Pulsatilla, Calc-carb, Calc-phos, Helonias, Nit-ac, Sepia, Medorrhinum, Thuja, Nat-phos, Lycopodium and China. Interestingly, *Calc-carb* is a prominent remedy particularly in childhood infection with candidiasis. This brings a psoric dimension to the condition, making the miasmatic model of less value in understanding the complaint. However, taking the non-sexual manifestation of candidiasis, thrush, yields remedies much more in tune with the generalised psychological states reflecting lack of self-worth. Minerals dominate the list with the balance weighted slightly more to the syphilitic than the sycotic. Halogens, kalis and acids feature prominently. *Psorinum* and *Sulphur* are also listed. Instead of taking specific thrush rubrics, I looked through *materia medicæ* to find the most frequently mentioned remedies in relation to thrush. These were: *Arg-n, Ars, Borax, But-ac, Calc, Canth, Carb-ac, Carb-v, Caul, Chlorpr, Foll, Hep, Kali-br, Kali-i, Kali-m, Lac-c, Merc, Nat-c, Nat-m, Nit-ac, Phos, Psor, Staph, Sul-ac, Sulo-ac, Sulph, Thuj, Urin.*

In homœopathic terms, the delusion that ‘there is something so wrong with me that if I show it to you you’ll never come near me again’ (*Thuja*) together with the excessive self-indulgence needed to compensate this inner feeling, are a sycotic expression. The syphilitic who, because he believes all hope is lost and all around him is destruction and decay, sublimates his generative drive into sexual appetite, is equally susceptible. The widespread unquestioning abrogation of individual responsibility for health to the depersonalising conveyor belt of modern medicine (and its short-sighted application of a harmful pharmacopœia) appears to have resulted a possible separate categorisation where immunosuppression is the primary symptom, reflecting the lack of self-respect in the sufferer which may be seen as both sycotic and/or syphilitic.

In any case, since the yeast is ubiquitous in the environment, it does not need to be eradicated, but rather, individual susceptibility to hosting population explosions of the organism needs to be addressed. The expressions which give rise to this are so much a core of our present society that it would be reasonable to assume that complaints such as candidiasis are unlikely to be ‘eradicated’ without a fundamental expansion and realignment in society’s conception of itself and its members.

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WEB SITES

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