

A homœopathic perspective on the treatment of ‘White Spot’, with particular reference to the Sycotic miasm.

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As homœopaths we understand that cases needing a Sycotic approach are those with a preponderance of symptoms denoting excess of some kind. Hyperplasia and hypertrophy are grand keynotes, as are catarrhal discharges which often have a briny odour. Painful, localised irritations may accompany the discharges, and these may be better for pressure. More generalised inflammatory conditions, however, tend to target either the sexual organs or the joints. The main skin symptoms include warts, papillomas and moles. Fibroids and polyps may proliferate along the mucous membranes.¹

How is this relevant to “white spot” and what is it? While there are many references in the lactation literature, a definitive explanation of the condition is elusive. It was first described by Gunther as a “milk blister”.² Current authors such as Lawrence describe it as a “solitary bleb on the surface of the nipple usually at the opening of a duct, which has a shiny, smooth surface, and is a millimetre or less in diameter....[it is associated with] exquisite, pinpoint pain when the baby nurses ... and is “cured” when the health professional opens it with a sterile needle....[it] probably represents a small pressure cyst formed at the end of the duct from milk seeping into this very elastic tissue.”³

Brodrigg adds that it may be associated with a blocked duct and/or mastitis. As this area is prevented from draining well, the milk near the surface may become thickened. She calls it “milk under the skin” because of its’ association with a fine layer of skin which grows over the pore thus preventing the duct from emptying. She describes a small blister which may burst during the feed thus affording the mother rapid relief. She also recommends soaking the breast in warm salty water or gently lifting the layer of skin with a sterile needle if the baby’s sucking does not dislodge it.⁴

Noble also cautions against ignoring the condition because of its association with repeated breast infections due to blocked ducts. Along with the usual suggestions for its treatment, she refers to the effective use of a rough towel to abrade the surface of the nipple after softening the skin well in a long soaking bath.⁵

The Nursing Mothers Association of Australia (NMAA) adds that the area around the blister is usually red and inflamed and may be painful throughout the feed. It suggests trying to alter the baby’s feeding position to minimise pressure on the painful area and perhaps to entice a resolution by placing pressure on a different area of the nipple.⁶ Because of the restrictions placed on NMAA Breastfeeding Counsellors by their Code of Ethics, all cases, which come their way, are referred on to doctors for treatment by removing the bleb with a scalpel.

An interesting case study⁷ describes white granules or discrete lumps that could be expressed from an offending breast, histological examination suggesting “amorphous debris which is probably proteinaceous in origin”. This is consistent with the description of a “plugged duct” that is referred to by Riordan and Auerbach as a “local accumulation of dead cells that have been shed.”⁸

Minchin explores the possibility that, in some women, the presence of such a bleb may well be due to thrush, the excessive use of nipple creams or a fatty plug. When it is associated with mastitis, she describes it as a type of “obstructive mastitis”.⁹ In her capacity as sometime editor of *ALCA News*, (the professional journal of the Australian Lactation Consultants Association) she advises that the condition may well be that of *Corpora Amylacea*.

“[These] are concretions often present in the mammary gland. Recent ultrastructural studies ...have shown that their initial stage of formation in the alveoli involves aggregation and fusion of casein micelles; further materials then become added to this nucleus and the body becomes hard and crystalline, the crystalline material being hydroxyapatite.”¹⁰ This possible explanation does not sit well with me as it is not consistent with other medical definitions which describe these as being particularly “small hyaline masses of degenerate cells.....the product of amyloid degeneration..... a complex starch-like material (probably a glycoprotein).”¹¹

A closer look at the anatomy and physiology of the lactating breast can, I believe, provide a more precise understanding of a possible aetiology for this condition. Generally, under the influence of hormones, tissue proliferation abounds in the pregnant and lactating breast. Approximately 15-25 lobes are arranged in spoke-like formation around the breast. Each lobe is divided into some 20-40 lobules with each of these containing from 10-100 alveoli, which act as the secretory units that deposit their contents into the lactiferous ducts which elongate during pregnancy. These ducts drain the lobes through the nipple pores. The lining of these ducts consists of eight to ten-cell layered squamous epithelium, which, by its very nature, may produce a preponderance of cellular debris when in the quiescent state. This fact becomes significant, as mothers tend to report the development of these blebs in between, and not during, feeds.

The histological state of the alveolar gland varies, but is similarly significant. The functional state appears to vary from dilated thin-walled lumen to narrow-lumened, thick-walled glandular tissue. Epithelial cells vary, being flat to low columnar in shape with indistinct boundaries. Some cells protrude into the lumen of the alveoli, others are short and smooth. The lumen of the alveolus is crowded with fine granular material and lipid droplets similar to those protruding from the cells. Research into sanguineous nipple discharge, has indicated increased cellularity with epithelial cell clusters and capillary groupings forming spurs or invaginations into the duct and alveolar lumina.¹² These are often associated clinically with intraductal papilloma of the breast.

The proteinaceous component of the mammary secretion is that of merocrine secretion. This means that secretory materials pass out through the cell apex into the lumen without appreciable loss of cytoplasm. However, the fatty components of milk arise as lipid droplets in the cytoplasmic matrix of the milk cell. These increase in size and move to the apex of the cell where they project into the lumen, covered by a thin layer of cytoplasm. The droplets eventually break off, enveloped by a detached portion of the cell membrane and a thin rim of subjacent cytoplasm.¹³ Such a process may well explain those instances of plugging with fatty debris, which may be forcibly extruded by means of nipple compression or excavation. However, it does little to explain why it is that in some women, a definite layer of epithelium grows and occludes a nipple pore in between episodes of feeding.

The answer to that lies, I think, in the afore-mentioned research of Kline et al, which, is entirely consistent with our understanding of the particular philosophical and clinical aspects of the Sycotic miasm. It has been my clinical experience that women who present with this condition are often in need of *Thuja*. This is not an absolute rule, and remedies vary as the woman proceeds to cure.

However, a Sycotic picture always predominates, consistent with the clinical picture of tissue dysplasia and *Medorrhinum* is always necessitated at some point during the treatment. In all cases of true “milk under the skin” a thin membrane of tissue occludes a nipple pore and prevents drainage of that section of the breast leading to local pain and possible inflammation. A close perusal of the Repertory reveals an interesting clue. [Warts, nipple, on: *thuja*].¹⁴

From an allopathic medical perspective, “white spot” is, therefore, in my opinion, a benign expression of human papilloma virus. In Homœopathy we would view it as another expression of the Sycotic miasm.

The following case is a typical one and was chosen for its complexity consistent with a Sycotic miasmatic picture involving all of the female sexual organs. This case is particularly interesting because it is interspersed with a host of suppressions due to the allopathic background of the patient. She had never used homœopathic treatment before and was very unsure of its efficacy and had a great deal of trouble understanding and accepting the concept of *Law of Cure*. Management of such conditions is always dynamic and complex as the Vital Force attempts to zigzag towards resolution.

“Sheila” age 31 was referred by another Lactation Consultant for ongoing difficulty with respect to the condition of “white spot” and thrush.

She grew up in the country and had a healthy childhood. She had chicken pox and mumps and was vaccinated against tetanus and rubella. Menarche occurred at age 13 and a mild case of glandular fever was encountered at 15. After high school she undertook a nursing career, and although she became a social smoker and drinker she took no other drugs. However, her husband has been a marijuana smoker.

She had regular periods although they were painful so she went on the OCP in her late teens. She began to suffer sharp pain on penetration during intercourse and was subsequently diagnosed as having endometriosis. She had laser ablation of the endometrial lining twice in her late 20s and had trouble conceiving so went on IVF. She took Clomed for 5 cycles and fell pregnant. She says it was a good pregnancy.

She breastfed for six and a half months only as she suffered continually from breast problems and post-natal depression. She reported episodes of inconsolable crying and continual engorged, blocked breasts, which settled after hand expressing which she found painful and unpleasant due to inflammation of the ducts. She suffered from “vaginal dermatitis”, the main presenting symptom being extreme dryness < penetration for which her gynaecologist prescribed Ovestin cream. She was on the mini-pill.

This second baby was 8 weeks old at the time of consultation. The feeding had again, not been going well. The baby had been diagnosed with reflux and was prescribed Zantac by the paediatrician. She had a caesarean section for which she was prescribed antibiotic cover. She subsequently developed thrush again and had very persistently sore nipples for which Nilstat and Daktarin were prescribed.

At the time of consultation the right breast is the most troublesome. However, both nipples continually develop “blebs of tissue”, which she removes with a sterile needle in order to release the engorged, blocked ducts prevented from draining by the tissue occlusion.

She describes herself as “a shocking nail biter” and picks at her toenails, which crack easily. She suffered from heartburn during both pregnancies and has a preference for tasty foods. She particularly likes Thai cuisine and enjoys balsamic vinegar on her salads. She likes gin and tonic with bitter lemon and Earl Grey tea. She hates peas.

Since her marriage she has endured an almost constant catarrh, which she has to hawk up daily. This can be at anytime and she describes it as being thick and yellowish She is covered with moles and had warts on her left knee as a child. As a nurse her vaccination status is current; her last one being the HepB in 1990. She sero-converted.

As a nurse she has worked a lot with death and says she has bizarre dreams. She describes one where her best friend’s dead brother visited her in her dream, as a disembodied head.

She says she has a fear of being attacked and has had dreams of being chased. She has issues about lack of money now that she has two small children and her career is on hold.

Rx 25/8/1999 *Medorrhinum* 200C to be followed in five days with a divided dose of
Sepia 30C (night/morning/night)
Diet to follow normal “anti-thrush” guidelines; ie: no sugars or yeasts

She phoned a week later to report that immediately following the *Medorrhinum*, the bleb on the left nipple popped during the next feed. One on the right nipple popped three days later during a feed. Another skin tag then formed in a new area on the left nipple (inner quadrant rather than outer). It cleared the next day; again during a feed. She was pleased that she hadn't had to resort to using a needle to shift the blebs.

She phoned the next day to report a painful red area on the left breast. Feeding was painful and the whole breast felt tense. She'd taken Nurofen and was applying cabbage leaves to the area and encouraging the baby to feed often from that breast. I reassured her that it was probably a return of old symptoms and that it was a good sign. I suggested she continue with her self-prescribed regime and add several grams of vitamin C.

The breast settled completely the following day.

I phoned her 15/9/1999 to check progress. She reported that the blockages continued to come and go for the next several days and that she was able to clear them manually by soaking the offending breast in Epsom Salts and then using a sterile needle. Some had a “chalky, gritty” plug.

She reported some signs of vaginal thrush, which she had unfortunately suppressed with steroidal cream and Caneston. She subsequently experienced some “razor-sharp” pains in the breast and sore nipples, which she treated with Gentian Violet.

She returned early in November, to report some areas deep in the left breast aching and hard. She had successfully cleared them by using a hand pump, which dislodged another encrusted plug.

In June (before her first consultation) she had undergone an ultrasound to check out a series of re-occurring lumps, which had been appearing in either axilla. She had another ultrasound two weeks before this visit, which showed that the area had cleared and was now free of lumps. Her postnasal drip had completely settled for several weeks. However, since the suppression of the vaginal thrush it has returned and she is waking with a sore throat.

She has not been so consistent with her yeast-free diet. She still enjoys balsamic vinegar. Her bowels are moving twice a day and the haemorrhoid she had following the pregnancy has stopped bleeding. She reports that her pelvic floor tone is improving and that her libido is good. However, sex is painful (“like a paper-cut”). She reports that the vulval area is dry and sensitive. She describes it as being “raw, red and shiny”. There is a creamy discharge, which leaves a crusty stain. It has no odour and is not itchy.

Her dreams have been mostly happy. However, one night after a late-night cup of tea just before bed she had a horrific dream of someone shooting up with heroin. There's been no return of the post-natal depression. However, by late afternoon she is getting “short” with the children.

She describes the appearance of a series of red-brown little pin spots on the left breast and an area on the right nipple which looks “like a dead spot” which comes and goes.

Rx: 3/11/1999 *Thuja* LM 0/1; 4 drops to be taken in 15 mls water each morning 5 succussions.

Five days later she had “a massive attack of mastitis in the right breast.” She did not contact me and again suppressed the symptoms with antibiotics and Nurofen. She stopped the remedy.

She came to see me two weeks later and reported that during the mastitis the right breast was very red and hard in the inner upper quadrant. She described an ulcerated spot on the nipple, which crusted yellow and had a bloody scab. It was very tender all around the areola and the nipple was so sore that during feeds it felt as if the baby was biting. Associated symptoms included a “shocking frontal headache; < jar; movement; light; > rest in bed.” She described intense tension across the shoulders and high fevers with an internal sense of chills and shivers. She wanted warm showers. The fever resolved with a sweat.

She reported having “bizarre dreams” on the general theme of children in need of nurturing. Her ears have been itchy and she’s still biting her nails. She’s still craving strong tasting foods and she’s been putting balsamic vinegar on her tomatoes. The vulval area is painful and she has a bland creamy-yellow leucorrhoea. Since the antibiotics her nipples have been sore and she’s been washing them with bicarb soda (to balance out the pH) and occasionally using Gentian Violet.

Mentally she feels “down and defeated.” She’s irritated and short-tempered and upset with herself for losing control. She’s wanted to see less of her best friend lately; she sees her as being “possessive.”

Rx: 16/11/1999 *Sepia* LM 0/1 3 drops in 15 mls of water; AM; 5 succussions

She returned three weeks later to report that her breasts have been good and her vulval symptoms have deteriorated. She reported a swollen introitus and a creamy-white discharge, which causes “horrible itching.” She’s been using apple cider vinegar and says it helps. Today her eyes are red-rimmed and puffy. She has woken with bad breath and “feels contaminated.” Her tongue is covered with a thick white coating of thrush. She’s wanted sweet foods, especially chocolate. Her bowels have been runny this past week, so she’s been taking slippery elm bark. Her urine is darker than normal and slightly burns. Her right thumb joint is painful and she’s constantly hungry “eats all day”. Emotionally she feels good and has been having some flying dreams like she did when younger.

Rx: 3/12/1999 *Ant Crud* LM 0/2 5 drops in 10 mls water; AM; 5 succussions

She phoned on 9/12/99 to report that she’d taken the *Ant Crud* for three days and then went away for a few days holiday and inadvertently took the *Sepia* instead! All the vaginal symptoms have settled and she’s developed a lump in her the left axilla area of her breast today. I advised her to stop the remedy and to wait 24 hours to see what eventuated.

She presented the next day with a clear picture of the previous mastitic symptoms. When she woke, the left breast was full and hard and hot < jar. The baby was not able to drain the area well and it was becoming solid and ropy. The nipple had two white areas and the areola was very sensitive with a sensation during feeds as if the baby was biting. She cleared the area by using the breast pump and then encouraging the baby to have a good feed from that breast. Her neck was stiff and she had a frontal headache with heavy eyes (< movement) and an extreme thirst. Her tongue is “geographic” with much less thrush. Her stool is loose and her urine dark, scanty and hot. There is still some creamy discharge from the vagina but it is not uncomfortable. She’s teary and says, “I feel beaten!”

Rx: 10/12/99 *Bryonia* LM 0/2 5 drops in 15 mls of water 4 hourly with 5 succussions
alternating with
4 doses of *Strep* 200C to be taken away from the *Bryonia*.

(NB: whenever mastitis moves from one breast to another, it is a sign of strep B infection).

The infection subsided within 24 hours and I saw her again five weeks later. She menstruated just after the mastitis and again just before this visit. On this occasion she presents with a "swollen vagina". She describes it as a feeling of "fullness" inside and that the entrance looks red and swollen. "A gentle rub >." She reports that there's some creamy discharge, which has no odour and is not itchy. She reports that intercourse is a lot less painful and that vaginal dryness is much less of a problem. She's been to see her GP and has had a vaginal swab.

Dx: moderate thrush and strep B.

Her tongue is still patchy (red with thick, white areas). The nipples and areola are sore on and off. She describes it as being like a bruised feeling. She has white spots on her nails and the thumb joint remains painful. Her bowels are quite loose and she's windy (smelly). She says she can feel it move through her intestines "like a sharp cube." Mentally she feels good. Although she's light on sleep because of the baby, she's waking positive and planning her day well. She says her dreams have been assertive and she feels good about having spent New Years Eve at home with her husband and children rather than out and about at the beck and call of her friends. She had a confrontation with her friend over this and felt good afterwards... "like a weight had lifted."

Rx: 15/1/2000 *Nit Ac* LM 0/1 5 drops in 15 mls water; AM; 5 succussions.

I saw this lady again three weeks later, after having taken the *Nit Ac* for two weeks. Subsequent to taking the Rx, she has had a swelling on the right mastoid process, which was tender and swollen "like a blind pimple." The whole right side of her neck was stiff, and sore. Again, she returned to her GP who diagnosed "a subcutaneous cyst with no entry point" and put her on antibiotics for 5 days. The swelling subsided within two days.

During the time that her Vital Force presented with the acute picture in the neck, her vaginal symptoms totally settled. Now, since the suppression with the antibiotics, the area is generally tender and < coition when it feels "raw." She's been dreading intercourse and there's been some bleeding following. There is no leucorrhoea. She says she's waking with sore, dry eyes and that there's a sharp pain in her left ear like the after-pain experienced after popping an ear during flight. She again has post-nasal drip, which is clear to yellow and she has little thirst.

Earlier in the week the baby failed to drain the left breast well before bed and she noticed a white bleb on the nipple. She woke the next morning with a defined red, tender area in the quadrant below the nipple. She decided herself to take one dose of *Strep* 200C and the redness settled. Since the antibiotics she's had abdominal "colic" and lots of flatus. She says she's urinating every couple of hours. Mentally she feels calm and she's been having "fabulous dreams" where she's meeting challenges. She reports that during the last few days her breasts have been very "atrophied" and, on inspection it is obvious that they are lacking their usual state of fullness. They appear quite flaccid. She feels that her supply has dropped dramatically.

Rx: 10/2/2000 *Kreos* 30C (NMN; divided dose) to be followed by *Nit Ac* LM 0/2
This lady then remained well especially with respect to her breast symptoms and breastfeeding subsequently proceeded smoothly. Some nine months later I phoned her to check on progress and she reported a recent return of her old symptoms of endometriosis; namely sharp pain on penetration during intercourse.

I suggested that she come back for a follow-up appointment to address the return of this old layer. She said she would, but did not return to see me. As far as she is concerned she has been “cured” of her presenting problem and she’s happy about that. However, from a strictly classical homœopathic stance I consider that she still has a way to go. Her next lactation will be very interesting!

Other cases I have on file pertaining to this condition tell a similar story in that the symptoms eventually settle, often with a “healing crisis” of mastitis. In all cases a Sycotic miasm predominates and *Medorrhinum* has always been used. Sometimes *Thuja* also shows up during the course of treatment, and most episodes of mastitis respond well to *Bryonia*, although *Phytolacca* has featured. However, that’s where the comparison ends; as, in each individual case, the progress to cure as demonstrated in this particular case, is a unique expression of each woman’s Vital Force. Other remedies used by patients suffering from “white spot” include: *Helonias*; *Sepia*; *Chelidonium*; *Rhus Tox*; *Silica*; *Nat Mur*, *Nat Carb* and *Nat Sulph*. *Lycopodium* has been another commonly used remedy. Ladies for whom this is a simillimum usually need *Morg-g* at some stage of the treatment. Interestingly, this nosode is the only other remedy, which sits alongside *Thuja* under the rubric: [warts, nipple, on].

In conclusion I contend that this condition, which affects only a small portion of the lactating public (I only see a few cases each year), responds absolutely to good homœopathic treatment combined with sound breastfeeding management. Other Lactation Consultants often refer cases on to me, as conservative medical protocols have no real cure. At best they can give the woman a diagnosis and advice on how to clear the troublesome ducts, which may remain a problem through out the lactation. Often women with “white spot” wean early because of the pain and inconvenience.

This unusual condition, which presents as a unique expression of the Sycotic miasm, is therefore, most probably best defined medically as a variant of the human papilloma virus, as in all cases *Medorrhinum* is needed to close the miasm. However, the progress to resolution is, in every instance, variable and unique to each mother. It is this consistent clinical experience of the homœopath that helps to define our understanding and acceptance of “The Simillimum”. It is one of the cornerstones of homœopathic philosophy; and, for that reason is why most homœopathic research is really best suited to this qualitative approach.^{15,16,17} Documenting cases has always provided the most meaningful basis of homœopathic research, as the Similia Principle is always upheld. Furthermore the unique strength of Homœopathy in treating this or any other medically-defined condition, lies in the fact that it is the *individual* who is treated according the particular gestalt of symptomatology expressed at the time of the consultation, and assessed according the case-taking methods defined in *The Organon*¹⁸, and the wider homœopathic literature.

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