The New World Veterinary Repertory

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The Development Of The Repertory

As many remedies were studied, even in Hahnemann's time it was evident there needed to be a way to organize the information. Few people could keep in memory all the detail that was accumulating. The repertory was *invented* as an organizational tool. The flow of information then was like this: provings & poisonings → materia medica → repertory. You can see that by the time the information appeared in the repertory it had gone through three translations:

1. Perception/interpretation of the prover's symptoms as reported to the observer.
2. Organization of symptom information into sentences in the materia medica.
3. Fragmentation of materia medica into separate rubrics of a repertory.

Here is an example of how that is done, picking a proving at random, for Aconitum.

"19. Dr. Wurstl, aet. 39, sanguine temperament, suffered in former years frequently from articular rheumatism, toothache, and on the slightest chill diarrhoea, but has been quite well latterly. 22nd February, eight AM, 6 drops of tinct. Immediately slight scraping in throat, for 5 morning, nothing else. 23rd, nine AM, 12 drops. Somewhat more severe but transient scraping in throat. About 11 AM suddenly giddy when walking, thereafter slight throbbing in frontal region towards both eyes, for some morning. Otherwise well, as he was also the next 2 days, when he took 12 and 15 drops. 6th March, 8:30 AM, 15 drops. All day a slight coolness, which about six PM passed into chilliness, often recurring in course of evening; at same time rumbling in belly and itching in rectum compelling scratching. Next day no medicine; symptoms continued. 8th, nine AM, 20 drops; forenoon, frequent vertigo; noon, slight chilliness (lasting till evening); afternoon, a soft stool at night, frequent walking, without dreams. The chilly feeling, the loose bowels, and tickling in anus lasted 3 days; in addition three vesicles came on tip of tongue, which burnt for 4 days. 12th, eight AM, 30 drops. After 2 hours great confusion, throbbing and vertigo in head. After midday soup heat in head for 1/2 hours. After noon, again chilly; evening both knees are icy cold, with occasional transient stitches in them; night, frequent waking, but he soon goes to sleep again."[1]

Let's look at the information in this part of the proving:
"...forenoon, frequent vertigo; noon, slight chilliness (lasting till evening); afternoon, a soft stool at night, frequent waking, without dreams. The chilly feeling, the loose bowels, and tickling in anus lasted 3 days; in addition three vesicles came on tip of tongue, which burnt for 4 days."

We can see that there are a number of symptoms that occur together and it is obvious that a direct matching of proving report to a (new) patient would be most accurate if that patient

[1] *A Cyclopedia of Drug Pathogenesy*, Richard Hughes, MD, J. P. Dake, MD, Volume I, page 95. The date of the proving would seem to be 1843.

communicated the same pattern that was very much like this report — the vertigo, chilliness, soft stool, frequent waking, ticking in the anus and vesicles on the tip of the tongue. So if we saw a patient with all or most of this symptom complex we would know that Aconitum was the similar remedy.

It becomes immediately obvious that this is difficult to keep in memory, or even keep in this form in a materia medica (though some of the older ones did try to do that, as for example, that of Jahr or Knerr) especially considering this is just one fragment of many pages of provings from several people. The answer to this practical challenge is the repertory. Information is *extracted and grouped* for easy access but it is important to know that the *pattern is broken up* and the various parts are put in different places, scattered throughout the repertory.

In finding the remedy for the patient, the reverse is done — we find the separate parts of this pattern and *re-assemble* them for the patient at hand. You can see that the accuracy of this reassembly is critical.

As an example of how the information is entered, or not entered, let's take the selected phrase above and see where we can find it in Kent's Repertory.

Proving Symptom	Repertory Rubric	Comments
Forenoon, vertigo	Vertigo; FORENOON (25) : acon., agar., ambr., atro., bry., calc., camph., etc.	Aconitum present.
Frequent vertigo	Vertigo; VERTIGO (277) : abies-c., abies-n., absin., acet-ac., Acon., act-sp., etc.	Aconitum present in the general rubric for "vertigo" but there is no rubric for "frequent" or any similar words."
Noon, slight chilliness lasting to evening	Chill; CHILLINESS (128) : abrot., acon., aesc., aeth., agar., alum., am-c., am-m., etc.	Aconitum present in "chilliness" but there is no rubric for "slight" or for starting at noon and extending to evening.
Soft stool at night	Stool; SOFT (203) : acon., aesc., aeth., agar., agn., ail., all-c., all-s., aloe, etc.	Aconitum present for "soft stool" but no rubric for "soft at night."
Soft stool at night	Rectum; URGING, desire; night (11) : aloe, carl., coloc., graph., lyc., merc-i-r., nat-m., phys., Sulph., thuj., zinc.	A similar rubric that may apply is this urging at night but Aconitum not in it and there is no subrubric for "soft at night."

Proving Symptom	Repertory Rubric	Comments
Frequent waking without dreams	Sleep; WAKING; frequent (156) : acon., aeth., agar., agn., all-s., Alum., am-c., etc.	Aconitum found in “frequent waking” but there is no rubric for “waking without dreams.”
Tickling in anus (another prover’s description had it as “itching in anus lasting all day.”)	Rectum; ITCHING (153) : acon., Aesc., Agar., agn., all-c., Aloe, alum., alumn., etc.	Aconitum present in “rectum itching” but there is no rubric for “anus, tickling”and Kent cross references from the word “tickling” to this rubric.
Vesicles on tip of tongue with burning	Mouth; VESICLES; Tongue (73) : acon., Am-c., am-m., ant-c., Apis, arg., Ars., etc.	Aconitum in “tongue vesicles” but the rubric for “vesicles tip of tongue” does not include Aconitum.
Vesicles on tip of tongue with burning	Mouth; PAIN; burning; Tongue; tip (53) : acon., agar., am-c., am-m., arg., etc.	Aconitum present for “burning tip of tongue” but there is no rubric for “vesicles, burning, tip of tongue.”

So we can see that the proving symptoms are broken up and parts of the entire symptom are put in various sections of the repertory. As well, some of the detail that makes the proving most defined simply is not found there when we look for it — it was left behind. From this perusal of what has been included and what was left out, we can see that there was a decision by Kent as to what is important to the practitioner, what would be useful.

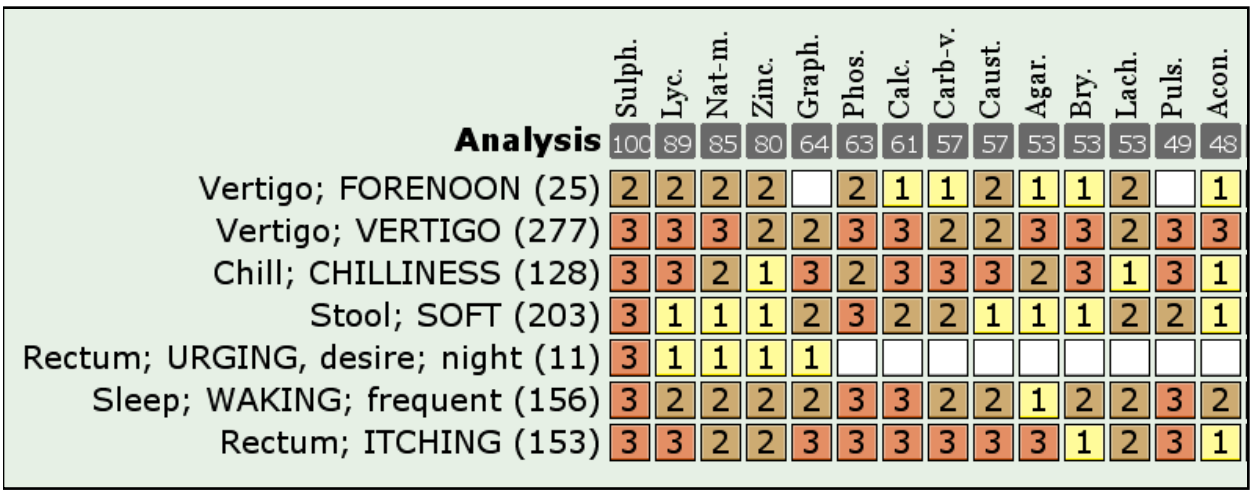
Let’s look at this from another angle. In this next table we list the symptom fragments that we are considering in the table above and see if we can find them in a number of representative repertories. If “yes” then there is such a rubric and aconitum is found in it. If “—” then either there is no such rubric or there is a rubric but aconitum not present in it.

Symptom	Kent	Boenninghausen (Boger edit)	Synthesis Edition 7	Complete 2009
Vertigo, forenoon	Yes	—	Yes	Yes
Vertigo, frequent	—	—	—	—
Vertigo, paroxysmal	—	—	—	—

Symptom	Kent	Boenninghausen (Boger edit)	Synthesis Edition 7	Complete 2009
Chilliness, noon	—	—	—	—
Chilliness, slight	—	—	—	—
Stools, soft at night	—	—	—	—
Stool, urging, night	—	—	—	—
Waking, frequent	Yes	Yes	Yes	Yes
Waking, not from dreams	—	—	—	—
Anus, tickling	—	—	—	—
Anus, itching	Yes	Yes	Yes	Yes
Anus, itching all day	—	—	—	—
Tongue vesicles with burning	Yes	—	Yes	—
Vesicles, at tip of tongue	—	—	Yes	—
Vesicles, at tip of tongue, burning	—	—	—	—
Tongue, burning	Yes	Yes	Yes	Yes
Tongue, burning, tip	Yes	—	Yes	Yes

We can see at a glance that only a minority of the information is included. This is practical — if every piece of information were included we could not lift the book or would be lost in the computer file — just too much there and it loses its purpose of easy symptom access. Nonetheless, if we were trying to find this remedy for a patient, and assuming that the patient was showing the exact concatenation as we are working with here, it would be difficult to clearly define aconitum as the match.

Here is how it would look as an analysis graph with what we have available to us in the Kent repertory. We see that Aconitum is in this analysis but certainly not prominent.



Analysis	Sulph. 100	Lyc. 89	Nat-m. 85	Zinc. 80	Graph. 64	Phos. 63	Calc. 61	Carb-v. 57	Caust. 57	Agar. 53	Bry. 53	Lach. 53	Puls. 49	Acon. 48
Vertigo; FORENOON (25)	2	2	2	2		2	1	1	2	1	1	2		1
Vertigo; VERTIGO (277)	3	3	3	2	2	3	3	2	2	3	3	2	3	3
Chill; CHILLINESS (128)	3	3	2	1	3	2	3	3	3	2	3	1	3	1
Stool; SOFT (203)	3	1	1	1	2	3	2	2	1	1	1	2	2	1
Rectum; URGING, desire; night (11)	3	1	1	1	1									
Sleep; WAKING; frequent (156)	3	2	2	2	2	3	3	2	2	1	2	2	3	2
Rectum; ITCHING (153)	3	3	2	2	3	3	3	3	3	3	1	2	3	1

Repertory Philosophy

Of necessity then all the repertories that have been produced have a *plan*, a way of organizing the information, certainly, but also *an expected way to access that information and reassemble the symptom*. There have been many repertories over the 200 years of homeopathic development and they vary considerably in how this is done. For our purpose in this presentation let us look primarily at the way two of the major repertories were constructed and used — Kent's General and the Boenninghausen Repertory as edited by C. M. Boger.

Kent's Method

The method of Kent is to emphasize the mental and the general symptoms, working from these into the modifying factors — the modalities — and when necessary using some particular symptoms with which to differentiate. There is understandably the inclusion of some details (subrubrics) of the mental and emotional state as well as sensations.

With animals these mental, emotional symptoms, and the sensations, are just not available. We can recognize emotions in animals but they are much more broadly categorized than in a person. We can say "fear" but not the details of the fear. We can say "anger" but not type of anger or really understand, for sure, the accuracy of calling it anger instead of fear or irritability or rage.

A common example is the dog that is afraid of thunder. There is a rubric that is specific for this fear of thunder and sometimes it seems to be accurate to apply it to the fearful dog in this situation. But in my experience, more often than not, the more accurate way to understand it is "fear of noise" of which thunder happens to be a more dramatic example.

Another difference in evaluating animal conditions is the difficulty in separating the general symptoms (affecting the whole individual) with the particular symptoms (affecting just a part). If it were a person he or she could tell us, but this must be inferred from observation of the animal.

So we see that the method of Kent, though very good, does not really work so well in animal cases because we just do not have the same accuracy of information, especially the information that his repertory is designed to use. If we couple this with, in our time, how often we homeopathic veterinarians are presented with cases of chronic disease — instead of acute

injuries, toxicities and infectious diseases — we can appreciate the challenge we face in doing this work.

These chronic cases are almost never presented to us in their nascent or unmodified form. Often, the homeopathic veterinarian is turned to only after other treatments, that have muddled the appearance of the patient's condition, make seeing the similar remedy even more difficult than it would be otherwise. As Kent has told us, with non-curative treatment the first symptoms to go are the *characteristic* ones, the most useful information and what we need to be certain of our remedy selection. These animals have pathology, often advanced pathology, and we also know that pathology is the *least useful guide* to finding the remedy that is needed.

The Newer Repertories Of The Kent Line

With time, other repertories came along as general interest in homeopathy developed, especially notable the *Synthetic Repertory* by Barthel and Kent's *General Repertory* edited by Künzli. These were very helpful and I used them quite a bit. Then even more expanded repertories began to appear, such as *Synthesis* by Frederik Shroyens and *The Complete* by Roger Van Zandvoort.

Somewhere along these development lines I began to feel a shift in my work. As the number of rubrics increased, along with much larger rubrics from added remedies, I could see my analyses were not as definitive as they had been and I had more trouble feeling satisfied with the outcome. Simply put there was too much information and it was confusing. I do find that these larger, more inclusive repertories are very useful in some cases, especially where I am searching for a *particular symptom* or a *detailed emotional state* but in most of my animal cases they are not advantageous. They are excellent repertories but more suitable for the patient in which the symptoms can be rather well defined.

When I began to study homeopathy with some seriousness, in 1978, I first learned to use the Kent repertory and that was my reference text for about ten years. This is a very good repertory, one that I still use, often on a daily basis. Yet if we ask "what is the best repertory for the veterinarian?" then we must refer to the types of patients that we encounter. Our homeopathic work, if to be successful, must be based on the information forthcoming from the patient — in this case animal patients.

I pondered the situation and came to the realization that there were two possible approaches in developing a repertory. One is to *expand it as much as possible*, adding in all possible information so that the repertory was almost as complete as the materia medica itself (the trend of those we have just considered).

The other possibility was the opposite. Rather than strive for completeness of the rubrics by putting in every possible remedy, the large available inventory of remedies is assessed, *through clinical application*, for usefulness and only the ones that are clinically confirmed as being most often needed, *the polychrests mostly*, are kept in the repertory and are used to construct the rubrics. After all, 200 years of clinical experience in which the most useful remedies are identified is an extraordinary resource.

As an example, consider that for a particular condition, such as the common cold, the materia medica medica contains hundreds remedies that would seem to have some similarity (the *Complete Repertory 2009* has 577 for this condition). However, as they are used in clinical

practice it becomes apparent that really only about 30 are usually needed, one of the others outside this group being occasionally applicable but rarely. In fact, it may be that only 8–10 remedies will handle 90% of what is commonly seen.

So in constructing a rubric for this condition, we have the choice of *a very large rubric* of hundreds of remedies — that will be difficult to narrow down to a small group for materia medica study — or we can start with *a limited rubric* of just the 30-40 most often needed ones, realizing that this will likely cover 98% of the cases we see.

The Boenninghausen Repertory

Coming from this latter perspective I spent some time using a variety of other repertories and came to the conclusion that the one repertory that best demonstrated this "winnowing" approach was the *Boenninghausen Repertory* as edited by Boger.

Before starting the search just described I had assumed that the rubrics in the *Boenninghausen* repertory were smaller because there was not enough information known at that time, or perhaps too few remedies, or not enough experience, etc., but as I used it, and understood the philosophical basis for it, I found it to be extraordinarily useful and accurate for all my cases — animal and even human surprisingly. I came to the realization that it had been *deliberately designed* to be a compilation of the most likely remedies in each rubric.

It may be more clear to put it like this: if we match a symptom from the patient, one that is important in the case (based on the corresponding intensity, persistence, or recurrence of that symptom) to the corresponding rubric, *there is a very high probability that the rubric will contain the remedy needed*. That in itself, it is a focus that is very practical. As a result of realizing this, the last 10 years or so the Boenninghausen repertory (edited by Boger) has been the reference I first turn to and which I use in the great majority of my cases.

Experience From Teaching

A parallel influence was that, from 1992 on, I had a post-graduate, year long, training program for veterinarians in the use of homeopathy. From this experience teaching I could appreciate the difficulty the students had in using the repertories arranged for working with human patients with much information that only a human being can report — sensations, types of pain, locations, detailed mental and emotional symptoms. One can, of course, learn to ignore this information (as I did) but I began to think how agreeable it would be to have a repertory re-edited towards veterinary use.

The Boenninghausen Method

So these two influences came together and I found the strategy of Boenninghausen to hold us in good stead in our animal work. The Boenninghausen "method" was developed early on, in the time of Hahnemann. Boenninghausen worked with both people *and animals* and as his experience grew he proposed a different way of using the symptoms of the patient, one closer to the way Hahnemann understood a case. He divided the symptoms like this, in order of importance:

- Location (the focus of the lesion or disturbance).

- Sensations.
- Modalities.
- Concomitants.
- General symptoms.
- Mentals.

The idea of concomitants

The introduction of the idea of concomitants also came from Boenninghausen and is an extremely useful tool, one he emphasized in his repertory. He recognized a pattern in both patients and in those doing provings, *an association of symptoms*, symptoms that would arise right before or at the same time as the main complaint. That association, the two symptoms together, was able to very much narrow the choice of remedies as there were fewer remedies that would have that association (think back to the proving fragment we have already discussed). He called these associated symptoms *concomitants*.[2]

Generalized modalities and concomitants

"If Boenninghausen had never done anything but give us his incomparable chapter on aggravations and ameliorations, this alone would have immortalized him. It seems to me, after profiting by them in a practice of over thirty years, it is impossible to over-estimate them."[3]

Another difference with Boenninghausen, one actually that Kent did not like, was his extending some of the symptoms, especially the modalities and concomitants, into the category of "generals" which could be applied to an entire section of the repertory.

If you look at the Respiratory section as an example, at the top of that section you will see rubric headings "Aggravation", "Amelioration", and "Concomitants". It is intended that these listings will apply to *all* the other symptoms in the Respiratory section of the repertory.

Why did Boenninghausen do this? He based this on the clinical observation that a modality that aggravated bronchitis would also aggravate other respiratory symptoms in the patient. He also observed the same in provings. He concluded this was a reliable rule — that modalities tended to be generalized in most patients, "general" not in that they would appear in the General Section of the repertory but that *they could be generalized to other conditions affecting the same part or function of the patient*, thus by analogy the same repertory section. Further investigation confirmed that same could be done with concomitant symptoms.

Examples of the Boenninghausen method

Here is an example of applying one of the modalities in the Respiratory section to the other listings that are there (the symptoms and conditions). In the "Aggravation" grouping there is the rubric:

Respiration; AGG.; Anger, vexation, etc.: Ign., ran-b., STAPH.

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[2] The dictionary meaning is "naturally accompanying or associated."

[3] E. B. Nash, MD, Expanded Work of Nash, B. Jain Publishers, New Delhi, 1995, page 572.

There are three remedies in this rubric and each of them could apply to any of the following symptoms. For example, if a patient had difficult breathing (one of the rubrics in the Respiratory section) and it was observed that they were made worse by getting upset, getting angry, then one could turn to the modality listed above and consider these three remedies: Ignatia, Ranunculus, and Staphysagria as a possible fit for this patient.

That this modality was seen in the patient, is a hint that one of these remedies could be the appropriate remedy. It does not always work out that it is one of these remedies, but is certainly worth considering the possibility. However, and here is what is different, the patient could, instead of having difficult breathing, have rattling of mucus (another rubric) and was also worse when emotionally upset by becoming angry. Then, again, the same modality rubric of the three remedies would apply and be worth perusing.

The same approach is used with concomitant symptoms. In the Respiratory section, there is a rubric "Concomitants" without any subrubrics — which is different than what we just discussed with the "Aggravation" modalities which *did* have an extensive listing.

It is interpreted like this. The respiratory condition in our patient is attended with other symptoms occurring right before or at the same time as the respiratory symptom of interest. The details of that concomitant symptom are not specified by this concomitant rubric, so the meaning is this: just having *any* concomitant symptom, regardless of what it is like, is enough to apply this rubric.

In some sections, the concomitants list is quite extensive. In the Cough section, for example, there are many detailed concomitants. A specific example for that section would be a patient with a hacking cough made worse by anxiety or fear (8 remedies).

So we see that Boenninghausen arranged the concomitant symptoms to be used in the same way as the modalities.

Summary of the Boenninghausen approach

We see the way that Boenninghausen arranged these groupings is by *moving the modalities and concomitants out of subrubrics* under specific rubrics/conditions and *put them into a more generalized grouping* for that repertory section.

At first look one would think this cannot be accurate as it is an assumption beyond the information that has been gathered in provings (and of course there are obvious exceptions). However, his observations were indeed based on clinical experience as well as on the study of provings, but Boenninghausen extended it further and used it to find his remedies in other cases.

One could have a patient with a respiratory condition affected by a modality, yet that relationship had never been described in a proving before. Nonetheless, the "generalized" modality rubric could still be applied to that patient with success in finding the suitable remedy.

I was not sure about this suggestion of Boenninghausen when I first starting using the Boger/Boenninghausen repertory but I found that my experience also confirmed this as a good approach, often solving cases for me that no other method did. Like any method it is not perfect, nonetheless, it is surprisingly useful and reliable.

Kent's Approach In Comparison

This is quite different than the way Kent structured his repertory. There you will find in the various repertory sections that the modalities are assigned to individual symptoms and you will see these modalities *listed as subrubrics under that symptom*. For example, in the Respiratory section of Kent, there is the rubric for accelerated respiration and under that, as a subrubric, there is "while lying down". So we understand, from the way it is arranged, that the modality of worse from lying down applies to *just the symptom of accelerated respiration*. There are many other places in the Respiratory section that this modality of worse lying is given, however always under specific headings, detailed symptoms like the accelerated respiration one. This is the way that Kent preferred it, thinking it more accurate, and it is indeed a very useful arrangement and likely more accurate in some cases.

Animal Cases

In working animal cases we find it a most useful method to use the Boenninghausen method and the way it is used in animals is similar to what is described above as the Boenninghausen method (the list of symptom types as to importance). However, we cannot include "sensations" though occasionally we can make a reasonable guess at one.

An example that comes to mind is the dog that will suddenly turn and begin to chew frantically at a place on the skin. They act just like bitten by a flea and sometimes it is accurate to use a skin rubric such as "biting sensation" or "stinging sensation". However, most of the time we have to work without this idea of semi-certainty. So our emphasis, by necessity, is on:

- Location.
- Modalities.
- Concomitants.
- Generals.

Mental symptoms can sometimes be used, as I described above, but most often *after other symptoms have narrowed down* to a remedy group and we are making our final differentiation by bringing in the mental/emotional behavior as a help in deciding our remedy choice.

The Editing Process

In using the Boger/Boenninghausen repertory as our foundation, Wendy Jensen and I went through an editing that retained the philosophical structure that Boenninghausen introduced (and developed further by Boger). We removed what was not useful to our work and also brought in information from Kent, Boger (primarily the Synoptic Key) and Jahr (the New Manual) as our primary sources, as well as useful information from other repertories such as Knerr, Boericke, Hering's Guiding Symptoms and Allen's Encyclopedia that would add remedies to some of the most important rubrics for us as veterinarians.

Cleaning up

So the first part of the editing process was "cleaning up" the Boger/Boenninghausen repertory by taking out information not useful to us in our veterinary work — the sensations, the details of pain, the symptoms that simply could not be recognized in animals.

Adding rubrics

Then, that done, we were especially interested in adding rubrics from other sources, especially Kent, that we would often want to find for our animal work.

An example that comes to mind is "a greenish discharge from the nose". Another is a rubric that characterizes the very frequent condition of "ear irritation with excessive oily wax production" in dogs (these days often diagnosed as "yeast infection"). So we searched for these rubrics or, if we could not find one, created them newly from the search of materia medica.

Enlarging some rubrics

In some instances a rubric of veterinary interest was already in Boenninghausen but the rubric could be enlarged from other sources to our advantage. There are a number of such rubrics frequently seen in practice for which we would love to have more information of possible remedies to consider, so based on our experience in practice we paid special attention to these.

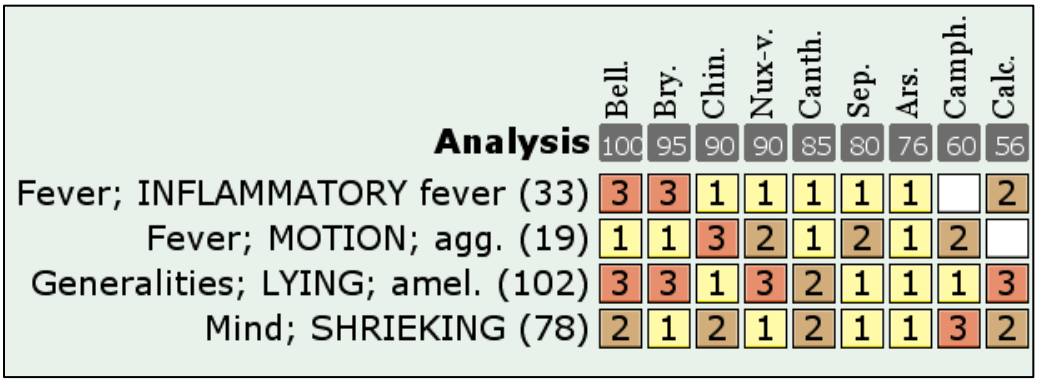
So when more than one rubric was found in other sources for the symptom of special interest, we would combine them including the remedies from two or more rubrics and *retaining the highest grading* for the remedies that were duplicated.

The addition of remedies from other sources has increased the range of remedies to consider for cases. The Boger/Boenninghausen repertory has 342 remedies while Kent has 624. So we will see in this new veterinary repertory some remedies that are not in the original Boger/ Boenninghausen.

A Case Example

Moses, a 5 year old male cat, has become recently ill. He is very lethargic and completely lost his appetite. If made to stand he cries out. He has not moved for 24 hours. There is a fever going from 103.5 F. (39.7 C) to 105 F. (40.6 C). Blood analysis shows a normal WBC count, normal neutrophil levels but very low lymphocyte and monocyte numbers—suggesting a marked migration of these cells to some extravascular site. These values are also elevated: SGOT, CPK (very high), direct bilirubin, & blood glucose. The SGPT is normal as are BUN and Creatinine. The remedy which cured this cat was **Bryonia 30c** given as single pellets on a four hourly schedule for four doses (until response evident). After this treatment he quickly went on to a full recovery that was confirmed at a follow-up appointment.

Let's start with a workup of the case using the Kent repertory.



	Bell.	Bry.	Chin.	Nux-v.	Canth.	Sep.	Ars.	Camph.	Calc.
Analysis	100	95	90	90	85	80	76	60	56
Fever; INFLAMMATORY fever (33)	3	3	1	1	1	1	1		2
Fever; MOTION; agg. (19)	1	1	3	2	1	2	1	2	
Generalities; LYING; amel. (102)	3	3	1	3	2	1	1	1	3
Mind; SHRIEKING (78)	2	1	2	1	2	1	1	3	2

We see that Bryonia is definitely in the top group for consideration. There are seven remedies that are similar enough to be in all of the rubrics chosen for the analysis. So it would not be difficult with a quick perusal of the materia medica (if even necessary) to choose Bryonia out of this group.

Just for comparison we can see the greater challenge if we were to use the Complete Repertory 2009.

Analysis	Nux-v. 100	Bry. 97	Ars. 94	Bell. 91	Chin. 91	Arn. 89	Sep. 89	Stann. 89	Camph. 86	Apis 83	Canth. 83	Stram. 83	Caust. 81	Ant-c. 78	Con. 75	Spig. 75	Spong. 75	Sul-ac. 73	Alum. 56
Fever, Heat; INFLAMMATORY fever (94)	4	4	3	4	1	1	1	1	2	3	1	1	1	1	1	1	1	1	
Fever, Heat; MOTION; Agg. (28)	4	3	3	1	4	3	3	4	3	1	1	1	1	1	1	1	1	1	1
Generalities; LYING; Amel.; during (367)	4	4	4	4	4	4	4	4	2	2	4	4	4	3	4	4	4	3	4
Mind; SHRIEKING, screaming, shouting (285)	4	4	4	4	4	4	4	3	4	4	4	4	3	3	1	1	1	1	3

Here we still have Bryonia in the second position but now the remedies for consideration has increased to 18. Doable, but more work.

Lastly, here is the analysis in the Boger/Boenninghausen repertory.

Analysis	Bry. 100	Nux-v. 81	Ars. 73	Bell. 71	Acon. 71	Cham. 63	Sep. 57	Stram. 51
Fever; PATHOLOGICAL TYPES; Inflammatory (55)	4	4	3	4	4	3	2	1
Fever; AGG.; Motion (22)	1	4	3	3			2	1
CONCOMITANTS; GENERALITIES; Lie down, inclination to (11)	3	4	4		3	2	2	
Fever; CONCOMITANTS; MIND; Shrieking (14)	1			3	2	2		3

Bryonia clearly is at the top of the list and the only remedy that is in all rubrics.

Note that this analysis started with the "inflammatory fever" but then *drew on a modality* from the Fever section as well as *two concomitants* (fever, with inclination to lie down, fever with shrieking, crying out). So you can see here how the method of generalized modalities and concomitants is used — and to advantage.

Repertory Use

In closing, here is a suggested way to use the *New World Veterinary Repertory*.

Identify the focus of the condition in your patient. Use that location as your base for starting your analysis. The "location" need not be an anatomical region, it could be a function such as fever in the example case above.

Then *bring in the modalities and the concomitants* that you have available. Use them to narrow the grouping of remedies for consideration.

If there is not a corresponding modality in the repertory section you are focusing on, then use *modalities from the Generals section* of the repertory.

Use few rubrics in your analysis. The more rubrics you use, the more likely the remedy needed will be lost in the listings. Pick them carefully.

The important symptoms to use are those that are *intense* (especially in acute conditions), that are *persistent or recurrent* (in chronic conditions), or are *unusual* in some way — either by appearance or in association with the rest of the case.

If you do not have the information needed — the modalities, concomitants, the generals — then *pick the one rubric that most accurately characterizes the chief complaint*. Assume it is highly likely that the remedy you need is in that list. Then work with the list by adding one other symptom, one that is affecting a different region or function. See if that more clearly defines the remedy choices.

You may need to add a second rubric, delete it, add another — back and forth until you are satisfied.

In some very difficult cases, there is no other option than considering carefully every remedy in the one rubric list.

Limiting the remedy choices

It does help, in the chronic cases, to limit remedy considerations to those suitable for chronic disease. This can bring the remedies under consideration to a reasonable number. We do this by using Hahnemann's and Boenninghausen's list of remedies suitable for treatment of the chronic miasmatic conditions. This list is from Hahnemann's book, *The Chronic Diseases*, and Boenninghausen's *A Systematic Alphabetic Repertory of Homeopathic Remedies*.

This limitation is not always appropriate but it can be a useful technique when it appears the patient we are dealing with is strongly affected by one or more miasms.

In Summary

So what we have is the first truly edited veterinary repertory, worked from the ground up, with the intention it would be of the most practical usefulness to those working with animals. It will serve you well to practice using it with some cases for which you already know the curative remedy. That way you can try various approaches in analysis, using different rubrics, and gain some familiarity with how cases are worked out with this approach.

Good luck with using this repertory. I think you will find it both interesting and very useful.