
BIOPATHOGRAPHICAL INTERPRETATION OF A CASE OF NON-SPECIFIC CERVICITIS WITH LUMBAR SPONDYLOSIS

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ABSTRACT

Background: Biopathography provides a longitudinal perspective on case-taking by examining the evolution of illness alongside significant life events, transitions and individual responses. It extends the conventional clinical history by considering how the patient's present state has developed over time.

Case presentation: A 39-year-old woman presented with lumbar pain radiating to the left lower limb, vaginal pricking pain, lower abdominal pain, urinary frequency and urinary incontinence. Pap smear examination reported non-specific cervicitis, with no evidence of intraepithelial lesion or malignancy. Her history included recurrent respiratory complaints during childhood, initially regular menstruation, profuse postpartum bleeding following her second delivery, recurrent heavy menstrual bleeding, severe anaemia requiring packed red-cell transfusion, and subsequent reduction and irregularity of menstrual flow. Pelvic and

urinary manifestations developed later. Her lumbar complaints were considered separately in relation to their chronology and the physical demands of her daily life.

Biopathographical interpretation: The case was examined through the chronological progression of symptoms, reproductive transitions, changes in menstrual expression, associated clinical findings and the patient's responses to family and personal circumstances. A parallel history of lumbar complaints was identified. The analysis emphasised temporal relationships without assuming direct causation.

Conclusion: Biopathographical interpretation may help organise multiple complaints into a coherent longitudinal account, supporting a more individualised understanding of the patient's clinical history. The approach complements, rather than replaces, diagnostic assessment and appropriate clinical investigation.

KEYWORDS: Biopathography; biographical history; case-taking; individualisation; non-specific cervicitis; lumbar spondylosis; clinical chronology.

INTRODUCTION

Clinical case-taking involves collecting information about present complaints, previous illnesses, investigations, treatment history and the patient's general health. A biopathographical approach extends this process by arranging significant health events and life experiences chronologically, thereby exploring how the present clinical state has evolved. Within homoeopathic literature, the importance of individual biography and the patient's response to life circumstances has been discussed by authors including Paschero and Eizayaga ^[1,2]. Historical analyses of homoeopathic case-taking have also described the development of approaches that consider the individual patient's account alongside the manifestations of disease ^[3]. The use of life histories in healthcare has further been discussed as a way of recognising patients' experiences and supporting a more person-centred understanding of illness ^[4].

Biopathography therefore addresses two related questions: What is the patient experiencing now? and How has the present state developed through the patient's life history? It does not establish that one event necessarily caused a later illness. Instead, it helps identify the sequence of events, changes in symptom expression and the personal context in which illness is experienced.

The present case of a 39-year-old woman with non-specific cervicitis and lumbar complaints is presented to demonstrate the application of this longitudinal approach.

AIM

To demonstrate the application of **biopathographical interpretation** in understanding the evolution of a case of non-specific cervicitis with lumbar spondylosis.

OBJECTIVES

1. To trace the *chronological evolution* of the patient's illness and significant life events.
2. To examine changes in disease expression in relation to the patient's biographical context and individual responses.
3. To demonstrate the *usefulness of biopathography* in developing an individualised clinical understanding.

METHOD OF BIOPATHOGRAPHICAL ANALYSIS

The analysis focused on four components:

1. Significant health events and life transitions.
2. Changes in symptoms and clinical manifestations over time.
3. The patient's reported responses to family, personal and physical circumstances.
4. The relationship between the present clinical state and the preceding course of illness.

The approach was informed by literature on biographical history and the reporting principles of the CARE case-report guidelines, which emphasise clear patient information, chronology, diagnostic assessment and transparent reporting [4,5].

CASE PRESENTATION

A 39-year-old woman presented with **lumbar pain, vaginal pricking pain, lower abdominal pain, frequent urination and urinary incontinence**. The lumbar pain radiated to the left leg up to the ankle and was aggravated by sitting on the floor, physical exertion and forward bending.

Pap smear examination reported *non-specific cervicitis* and was negative for intraepithelial lesion or malignancy. The case record also *noted L4–L5 involvement* in relation to the lumbar complaint.

Her earlier history included *recurrent respiratory complaints during childhood* and a continuing tendency to catch cold. Her reproductive history was initially characterised by regular menstruation. A significant change was reported **following her second delivery**, after which she *experienced profuse bleeding* and subsequently **recurrent heavy and frequent menstruation**. This was associated with anaemia, weakness and weight loss. Her

haemoglobin reportedly reached **7.1 g/dL**, and she received two units of packed red cells, following which the haemoglobin level **increased to 9.7 g/dL**.

In later years, menstrual flow became **reduced and irregular**. More recently, she experienced watery, white, non-offensive leucorrhoea before menstruation, occasional itching, vaginal pricking pain and lower abdominal pain. Urinary frequency, urgency, nocturnal disturbance and stress-associated incontinence were also reported.

The history of lumbar pain was examined as a parallel clinical course, alongside her reported physical responsibilities, including carrying drinking water and prolonged sitting while stitching.

BIOPATHOGRAPHICAL EVOLUTION OF THE CASE

Table 1. Chronological summary of the patient's biopathographical history.

Period or transition	Biographical and clinical events	Biopathographical significance
Childhood to approximately 15 years	Frequently unwell, with recurrent respiratory complaints and a reported history of treatment for tuberculosis.	Establishes the earliest reported pattern of recurrent illness. The past diagnosis and treatment require confirmation from available records if possible.
After approximately 15 years	Continued tendency to catch cold, particularly in cold or rainy weather, with coryza, hoarseness and cough.	Demonstrates persistence of respiratory complaints beyond childhood.
Reproductive baseline	Menarche at 15 years; initially regular cycles of approximately 30 days, lasting about five days. Married at 22 years; two normal vaginal deliveries.	Provides a baseline against which subsequent menstrual changes can be described.
Following second delivery	Profuse postpartum bleeding; dilatation and curettage reportedly performed for retained material.	Marks a major reported transition in reproductive health.
Subsequent years	Frequent and profuse menstruation, accompanied by weakness, weight loss and anaemia.	Documents persistence of heavy menstrual bleeding and associated systemic effects.
Severe anaemia phase	Haemoglobin reportedly reached 7.1 g/dL; two units of packed red cells were administered; later haemoglobin was 9.7 g/dL.	Represents a clinically important episode in the patient's longitudinal history.
Later menstrual phase	Menstrual flow became reduced and irregular; in June, July and August 2026, bleeding was reported to last approximately three days, one day of profuse bleeding after a missed first day, and one day, respectively.	Demonstrates a change from frequent/profuse bleeding to a reduced and irregular pattern.
Recent pelvic	Watery, white, non-offensive	Describes the current genital and

phase	leucorrhoea before menstruation, occasional itching, vaginal pricking pain and lower abdominal pain. Pap smear reported non-specific cervicitis.	pelvic manifestations.
Recent urinary phase	Frequency, urgency, nocturnal disturbance and urinary leakage during coughing, sneezing or loud talking.	Identifies an additional urinary component requiring clinical assessment.
Parallel lumbar course	Lumbar pain with radiation to the left leg up to the ankle; aggravated by sitting on the floor, exertion and forward bending. Physical responsibilities included carrying water and prolonged sitting while stitching.	Places the lumbar complaint within its own chronology and daily-life context without assuming a direct cause.
Life-space history	Increased family responsibilities, care of a bedridden father-in-law, perceived lack of concern from relatives, regret about discontinued education and concern for her children.	Adds the patient's reported experiences and responses to the clinical narrative.

Early life: recurrent illness

The patient recalled being frequently unwell during childhood and receiving considerable care from her family. Her history included recurrent respiratory complaints and breathlessness. She reported receiving treatment for **tuberculosis** until approximately 15 years of age; this past diagnosis was based on her account and should not be presented as independently verified unless supporting records are available.

After this period, she continued to experience a **tendency to catch cold**, particularly in cold or rainy weather, with recurrent coryza, hoarseness and cough. The biopathographical significance lies in the reported continuity of respiratory complaints over time.

Reproductive life: initial stability

Menarche occurred at 15 years. The patient described her menstrual cycles as initially regular, occurring approximately every 30 days and lasting about five days. She married at 22 years and had two pregnancies, both ending in normal vaginal deliveries.

This period provides the reproductive baseline before the subsequent change in menstrual pattern. The chronology is important because it distinguishes the patient's earlier menstrual history from the later period of excessive bleeding.

Major transition following the second delivery

Following her second delivery, the patient reportedly experienced profuse postpartum bleeding. **Dilatation and curettage** was performed for reported retained material. Subsequently, menstruation became frequent and profuse.

This sequence represents a major transition in the patient's reported reproductive history. However, the temporal relationship does not independently establish the cause of the subsequent menstrual abnormalities.

Persistent menstrual blood loss and anaemia

The patient described recurrent heavy menstrual bleeding over the subsequent period, accompanied by weakness and weight loss. Her haemoglobin reportedly **reached 7.1 g/dL**, for which she **received two units of packed red cells**. A later **haemoglobin value of 9.7 g/dL** was reported.

This episode is clinically significant and should be interpreted as part of the patient's medical history rather than solely as a biographical event. The recorded laboratory values and transfusion details should be checked against the original records. The World Health Organization's guidance on haemoglobin concentrations provides a reference framework for documenting and interpreting anaemia ^[6].

Subsequent change in menstrual expression

Following the period of frequent and profuse bleeding, the patient reported a reduction and irregularity in menstrual flow. In June 2026, bleeding lasted approximately three days. In July, bleeding was absent on the first day and was profuse for one day thereafter. In August, bleeding reportedly lasted one day.

This change is important to the longitudinal description because the menstrual pattern did not remain static. It shifted from initially regular menstruation to excessive bleeding and later to reduced and irregular flow. These observations do not, by themselves, establish the underlying cause of the menstrual changes.

Emergence of pelvic and genital manifestations

The more recent history included watery, white, non-offensive leucorrhoea before menstruation, occasional itching, vaginal pricking pain and lower abdominal pain. The vaginal pain had reportedly been present for approximately two months and was described as severe enough to make the patient bend double. Pressure was reported to provide relief.

Pap smear examination reported **non-specific cervicitis** and was negative for intraepithelial lesion or malignancy. These findings describe the documented cervical assessment but do not, by themselves, establish the cause of cervicitis. Further assessment should be based on

the clinical presentation and appropriate investigations. Standard guidance on cervicitis highlights the importance of evaluating relevant infectious and non-infectious causes [7].

Development of urinary manifestations

The patient also reported urinary frequency, urgency, nocturnal disturbance and leakage associated with coughing, sneezing or loud talking. These symptoms occurred alongside the pelvic complaints and form a distinct component of the current clinical picture.

Their inclusion is important because a longitudinal history should record associated manifestations without assuming that symptoms involving different systems necessarily share a single cause. The urinary symptoms require appropriate clinical assessment in their own right.

Parallel evolution of the lumbar complaint

The lumbar complaint was considered as a parallel course within the patient's history. She reported lumbar pain radiating to the left leg up to the ankle, aggravated by sitting on the floor, exertion and forward bending.

Her daily responsibilities included carrying drinking water on her hip for approximately 2 km, sometimes twice daily, and prolonged sitting while stitching. These details provide context regarding physical demands and posture.

Clinical assessment should consider alternative causes and relevant neurological features, consistent with guidance for low back pain and sciatica [8].

LIFE-SPACE AND INDIVIDUAL RESPONSE

The patient's history also included changes in responsibilities and family circumstances. Following marriage, she assumed increased domestic responsibilities and cared for her bedridden father-in-law. She described sadness, hurt and anger when she perceived a lack of concern from her husband's siblings. She reported weeping during anger and feeling better when consoled.

She also expressed regret about discontinuing her education and concern about what would happen to her sons if her health deteriorated.

These experiences add context to the patient's account of illness. Their value in the present analysis is descriptive: they record how she reports responding to responsibility, perceived neglect, interrupted aspirations and concern for her family. They should not be treated as proof that emotional experiences caused the physical conditions.

FLOWCHART OF BIOPATHOGRAPHICAL EVOLUTION

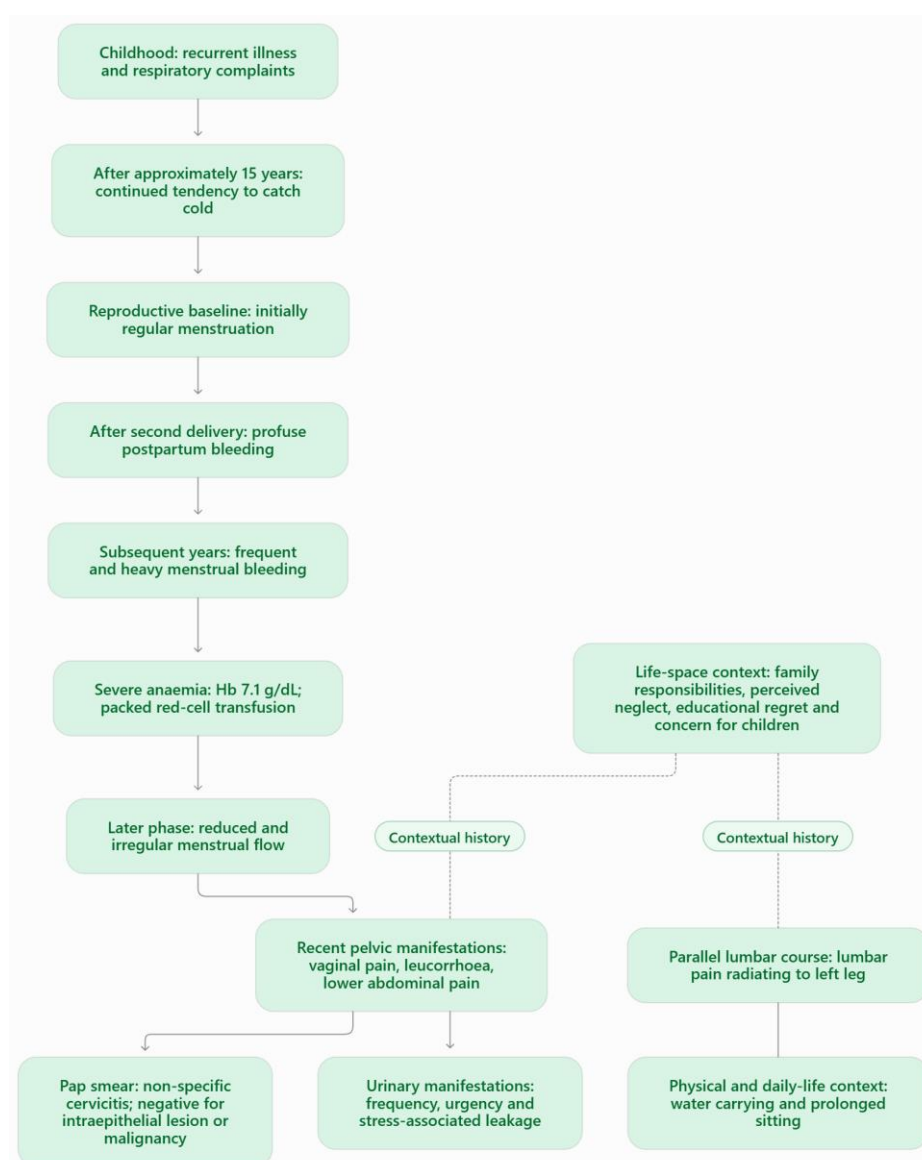


Figure 1. Chronological representation of the patient's reported clinical evolution.

BIOPATHOGRAPHICAL FINDINGS

The principal findings of the analysis are:

1. Continuity: Recurrent respiratory complaints were reported from childhood into later life.
2. Transition: The reproductive history changed from initially regular menstruation to postpartum bleeding and recurrent heavy menstrual loss.
3. Clinical consequence: The heavy bleeding period was associated with severe anaemia and transfusion, as reported in the clinical history.
4. Alteration: Menstrual expression later changed to reduced and irregular flow.
5. Expansion of the clinical picture: Pelvic and urinary manifestations were reported in the more recent period.

6. Parallel course: Lumbar pain developed within a separate musculoskeletal history and was considered alongside, but not attributed to, daily physical demands.

7. Individual context: The patient's reported responses to family responsibilities, perceived neglect, educational regret and concern for her children added depth to the clinical narrative.

DISCUSSION

The present case illustrates the value of biopathographical interpretation in understanding the progression of illness through significant clinical and personal transitions. Homoeopathic literature and life-history approaches in healthcare emphasise the importance of considering the individual's experiences alongside the presenting complaints [1–4].

The most significant clinical transition was the reported alteration in menstrual function following the second delivery. The progression from profuse postpartum bleeding and recurrent heavy menstrual loss to severe anaemia requiring transfusion, followed by reduced and irregular menstruation, highlights the importance of establishing a detailed reproductive and menstrual chronology. These events warrant correlation with relevant gynaecological findings and investigation records rather than assuming a direct causal relationship between successive symptoms.

The lumbar pain, radiation into the left leg and aggravating factors represent a distinct clinical problem requiring correlation with examination findings and documented investigations. Although the patient's physical responsibilities provide contextual information, they do not independently establish the cause of lumbar spondylosis [8]. Similarly, the patient's experiences of family responsibilities, perceived neglect and educational regret contribute to an understanding of her lived experience but should not be interpreted as proven causes of her physical conditions.

The chronological table and flowchart support transparent case reporting by distinguishing documented clinical events from their interpretive significance, consistent with the CARE guidelines [5]. Importantly, biopathographical interpretation complements rather than replaces clinical evaluation. Severe anaemia, abnormal uterine bleeding, cervical findings, urinary symptoms and radiating lumbar pain require appropriate diagnostic assessment. A cervical smear result alone cannot establish a specific infectious cause. Thus, the principal clinical contribution of this approach is to organise the patient's longitudinal history, identify important transitions and guide further assessment without overstating causal or diagnostic conclusions.

STRENGTHS AND LIMITATIONS

Strengths

- The case is presented chronologically, highlighting major transitions in the patient's health history.
- Reproductive, pelvic, urinary and lumbar complaints are documented within their respective clinical contexts.
- The patient's reported emotional responses and life circumstances are included without assuming that they caused physical disease.
- The table and flowchart provide a concise visual representation of the longitudinal history.

Limitations

- Some early medical events, including the reported childhood tuberculosis treatment and postpartum retained material, are based on the patient's account and may not be independently verified.
- The available information does not establish the cause of the menstrual abnormalities, cervicitis or lumbar pathology.
- The detailed diagnostic evidence supporting lumbar spondylosis, including the original imaging or clinical report, should be verified before submission.
- This is a single-case descriptive analysis. It cannot establish causation, demonstrate treatment effectiveness or support generalisation to other patients.
- The patient's perspective on the care experience and follow-up information should be added if available and appropriate for publication.

CONCLUSION

Biopathographical interpretation provides a longitudinal perspective on the evolution of an individual patient's clinical state. In this case, the approach brought together the history of recurrent respiratory complaints, reproductive transitions, heavy menstrual bleeding, severe anaemia, subsequent menstrual changes, pelvic and urinary manifestations, and a parallel course of lumbar pain.

The patient's life-space history further documented her responses to family responsibilities, perceived neglect, educational regret and concern for her children. These details enriched the clinical narrative without requiring assumptions that personal events caused the diagnosed conditions.

The case demonstrates that biopathography can help organise complex clinical histories into a coherent sequence of events, transitions and individual responses. It may support more comprehensive case perception and individualisation when used alongside appropriate diagnostic evaluation, transparent reporting and evidence-based clinical care.

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