WORLD JOURNAL OF PHARMACEUTICAL RESEARCH
SJIF Impact Factor 6.805
Volume 5, Issue 9, 699-704. Research Article ISSN 2277– 7105

ALTERNATIVE MEDICAL MANAGEMENT OF LOCALIZED SKIN HYPO-PIGMENTATION BY HOMEOPATHIC MEDICINE - A BREAKTHROUGH IN MEDICAL MANAGEMENT

Swami Shraddhamayananda*

Monk in Charge of Medical Unit at Belur Math. Ramakrishna Mission Charitable Dispensary, Belur Math, Howrah, West Bengal, India.

Article Received on
22 June 2016,

Revised on 13 July 2016,
Accepted on 02 Aug 2016

DOI: 10.20959/wjpr20169-6862

***Corresponding Author**
Dr. Swami Shraddhamayananda
Monk in Charge of Medical Unit at Belur Math. Ramakrishna Mission Charitable Dispensary, Belur Math, Howrah, West Bengal, India.

ABSTRACT

Hypo-pigmentation of skin, although is not a life threatening disease, but is considered to be a social stigma, so invariably associated with significant psychological trauma and social isolation. Vitiligo, post-burn leucoderma are the common causes of localised hypo-pigmentation. Although at present various treatment options are available, they are costly, so out of reach of most of the people of developing countries like India. So there had been always a search for a medicine, which will be cheap as well as less traumatic and easily available. Here in this study, we report the spectacular improvement of 400 cases of hypo-pigmentation, who were treated with homeopathic medicine from 2008 through 2015. In 85 % cases there was an over 99% improvement and this was supported by skin biopsy examinations showing melanocyte production and repigmentation in the affected skin lesions. Present state of knowledge regarding the mechanism of action of these medicines is not known. However, encouraging results in difficult to treat cases prompted me to expose these findings before scientific fraternity for appraisal.

KEYWORDS: Hypopigmentation, Homeopathic medicine, repigmentation.

INTRODUCTION

Hypopigmentation is the absence of normal amounts of melanin (the chemical that gives skin its color–produced by melanocyte cell in epidermis) caused by disease, injury, burns or other trauma to the skin. Although they are not life threatening conditions, they are still considered as social stigma and poses psychological trauma and social isolation. Hypopigmentation can

be classified into generalized and localized causes. Generalized hypopigmentation can be due to albinism and hypo-pituitary disease. Localized hypopigmentation can be due to vitiligo, piebaldism, pityriasis alba, chemical toxins, pityriasis versicolor, leprosy, tuberous sclerosis and post-inflammatory conditions. The prevalence of vitiligo is approximately 1% in the United States and 0.1-2% worldwide.[1]

Although various treatment options in the form of phototherapy and laser are available, there had been always a search for a 'magic' medicine which could modify the hypopigmentation process and produce re-pigmentation. Total 400 cases were initially enrolled amongst them vitiligo was present in 300 cases. All the cases were treated with homeopathic medicine, only oral single medicine, no external application; the result was very much promising.

The patients and the method of treatment

A total of 400 patients attended in this Institution for treatment of hypo -pigmentation during the period year 2008 through 2015. Patients presented with generalized skin hypo-pigmentation due to albinism – (characterized by colorless skin, hair, and eyes that occurs because skin cells produce little or no melanin) were excluded in this study. Skin hypo-pigmentation due to various infection like tinea versicolor (caused by fungal infection and characterized by scaly, itchy patches of lighter or pinkish skin) and pityriasis alba (affecting children and is characterized by colorless, scaly skin patches), lepromatous skin lesion were excluded in this study as these conditions could be treated with specific antibiotics and anti-fungal therapy. After these exclusion criteria, total 350 cases were finally included in this study. In all cases, informed consent was taken. Institutional Ethical Committee permission was taken as usual. The age ranges between 5 to 65 years (mean age 22), with slightly higher (56.4%) female patients. Most of them presented with vitiligo (300 Cases), post-burn hypopigmentation (50 Cases). In 246 cases (70%) there were multiple lesions and in 104 cases (30 %) the lesions were single. In 54 Cases lesions were found in upper limbs, in 56 cases in lower limbs, and lesions were involved in 20 cases over trunk region.

Medicines and their doses

The homeopathic medicine "Causticum 1000" (ultra diluted potassium hydroxide) and Graphites 200 were used for post-burn hypo-pigmentation. These medicines were prepared following Indian Pharmacopeia and were purchased from an authorized company "HAPCO". Causticum and Graphites were given once in 2 weeks period for a duration of 4 weeks, depending upon clinical response. This schedule of treatment was followed in all the

cases irrespective of differences of age, sex, degree of lesion, because these medicines are completely free of any side effects due to ultra dilutions. These medicines specifically selected for post burn cases were used in 20 vitiligo (10 cases graphitis + 10 cases Causticum) cases as a control study but in all the cases new lesions were seen and gradually increased within six months.

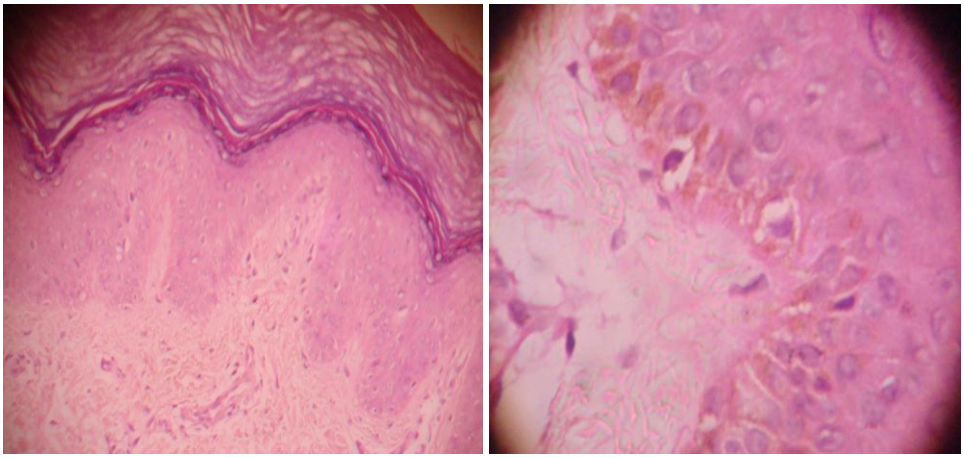
In vitiligo cases Lycopodium 200, Calc. carb 200 and Lachesis 200 were given weekly once (to avoid unusual aggravation) instead of 1000 dilution for the period of one month. Details of this treatment is given elsewhere (Vitiligo–A Treatise of Successful Homeopathic Treatment by the author, published by Lap Lambart Academic Publishing, Germany). These medicines which were given in vitiligo cases were given to 15 post burn hypo-pigmentation patients as a control study but no change was seen within two years.

RESULTS

Amongst 50 patients of post-burn hypo-pigmentation, there was complete remission in 40 (80%, Fig. 1 and Fig. 2) cases. More than 80% improvement was seen in 8 cases and 2 cases did not continue treatment after three months. Pre and Post treatment biopsy were done in 6 cases. In all these cases pretreatment biopsy showed no melanocytes while post treatment biopsy showed melanocytes and melanine (Fig.3). After beginning of treatment earliest reaction was noted within one month and complete remission which was observed in 40 cases which occurred in between 6 months 3 years. Out of 300 patients of vitiligo, complete remission was found in 210 cases; 50% remission was found in 75 patients who are continuing treatment and in 15 patients there was no response of treatment.

Fig 1: Showing complete remission of a case after treatment

Fig 2: Showing complete remission of a case after treatment



Before Therapy **After Therapy**

Fig. 3: Histological pictures of a patient before and after treatment showing intense melanin pigmentation with increased number of melanocytes after treatment.

DISCUSSION

Generalized hypo-pigmentation can be due to albinism and hypo-pituitary disease. Albinism is an inherited disorder caused by the absence of an enzyme that produces melanin, resulting in a complete lack of pigmentation in skin, hair, or eyes. There is no cure for albinism and thus was excluded in this study. Localized hypopigmentation can be due to vitiligo, piebaldism, pityriasis alba, chemical toxins, pityriasis versicolor, leprosy, tuberous sclerosis and post-inflammatory hypo-pigmentation. The most common cause of acquired hypo-pigmentation is damage or trauma to the skin. Burns, infections, pimples, blisters, scrapes, and any injuries that result in scarring can all lead to skin discoloration. Treatment of post-inflammatory hypo-pigmentation include topical corticosteroids, light or laser treatment, or surgical skin grafting.

Vitiligo causes smooth, white patches on the skin. In some people, these patches can appear all over the body. It is an autoimmune disorder in which the pigment-producing cells are

damaged. There is no cure for vitiligo, but there are several treatments options available as conventional management.

Phototherapy by ultraviolet light (UVB light from UVB lamps) is the most common treatment for vitiligo.[2] Narrowband ultraviolet B (UVB) phototherapy is now used more commonly than ultraviolet light A + psoralen(PUVA) as less dose is required and it is less damaging to the skin. Adding a psoralen, a photosensitizer, or an immunomodulant[3] that increases the effect of the UV light can aid in partial repigmentation. Although numerous lasers are available today only excimer lasers, and the Fraxel Restore laser are the only lasers that are approved for hypo-pigmentation treatment.[4] For hypopigmentation that is unresponsive to medications, camouflaging with cosmetic tattooing or permanent makeup may be the best option. Other options which are available includes melanocyte transplantation (taking pigmented skin from the patient's gluteal region and melanocytes were then separated and expanded in culture) into denuded hypo-pigmented areas. The longevity of the repigmentation differed from person to person with 70-85% success rate.[5] Main drawback of all these therapies are that they are costly, so beyond the reach of most of the poor people. So, there was always a search for a ‘magic medicine’ which can treat hypo-pigmentation by providing repigmentation.

This study shows very encouraging results by homoeopathic medicines, which is not only cost effective but also showing histolgically proven repigmentation in most of the cases. As this medical management is very much cheaper in comparison to other options, this could be very attractive therapy in various causes of hypo-pigmentation including vitiligo, post-traumatic, post-burn hypo-pigmentation particularly in developing country like India.

The exact mechanism of action of these medicines is still not known; but with this ‘very encouraging’ result we shall continue this study and we shall find out the exact mechanism of action in subsequent studies. According to International Academy of Classical Homeopathy, graphite belongs exclusively to the Homeopathic Pharmacopoeia. It was classed by Hahnemann among the "Antipsoric Remedies," as being more especially adapted to the treatment of chronic diseases. It was found that graphite has a very marked action on the skin lesions, specially eczema, impetigo, skin fissure or cracks and can be used for treating burning blisters on tongue, erysipelas and various skin infection and inflammation. But even after extensive literature search, not a single paper was found on the role of graphite in management of post-burn hypo-pigmentation and scar contracture.

These encouraging results in difficult complicated cases prompted us to expose these findings before scientific fraternity for appraisal**.** In this respect, this work could be considered as a break-through in medical management of post-burn patients**.**

ACKNOWLEDGEMENT

I hereby acknowledge The President, Ramakrishna Mission for giving me permission to publish this paper. I also thank all doctors and paramedical staff of our Medical Unit for helpful suggestions.

REFERENCES

1. Halder, RM; Chappell, JL. "Vitiligo update". Seminars in cutaneous medicine and surgery, 2009; 28(2): 86–92. doi:10.1016/j.sder.2009.04.008.
2. Whitton, ME; Ashcroft, DM; González, U. "Therapeutic interventions for vitiligo.". Journal of the American Academy of Dermatology, Oct 2008; 59(4): 713–7. doi:10.1016/j.jaad.2008.06.023..
3. Scherschun, L; Kim, JJ; Lim, HW. "Narrow-band ultraviolet B is a useful and well-tolerated treatment for vitiligo". Journal of the American Academy of Dermatology, 2001; 44(6): 999–1003. doi:10.1067/mjd.2001.114752.
4. Nisticò S, Chiricozzi A, Saraceno R, Schipani C, Chimenti S. "Vitiligo treatment with monochromatic excimer light and tacrolimus: results of an open randomized controlled study". Photomed Laser Surg, Jan, 2012; 30(1): 26–30. doi:10.1089/pho.2011.3029.
5. Olsson MJ, Juhlin L. "Long-term follow-up of leucoderma patients treated with transplants of autologous cultured melanocytes, ultrathin epidermal sheets and basal cell layer suspension". The British Journal of Dermatology, 2002; 147(5): 893–904. doi:10.1046/j.1365-2133.2002.04837.x.