

**BULLOUS PEMPHIGOID TREATED WITH HOMOEOPATHY: A
CASE REPORT*****Dr. Tushita Thakur**

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ABSTRACT

Bullous pemphigoid (BP) is a chronic, subepidermal autoimmune blistering skin disease that usually occurs in the elderly population.^[1-4]

Itching is often the first symptom followed by large tense blisters on erythematous base filled with clear or hemorrhagic fluid that don't easily rupture when touched.^[1-3,5] Its diagnosis can be confirmed by histology, direct and indirect immunofluorescence.^[1,6] The conventional treatment of BP involves systemic anti-inflammatory oral corticosteroids and immunosuppressive drugs.^[3,4] It usually resolves after 3-6 years without treatment; and in 1.5-5 years with conventional treatment. Lesions usually heal without scarring or milia formation. Patients who receive high-doses of corticosteroids and

immunosuppressive medications are at risk for side effects including peptic ulcers, GI bleeding, agranulocytosis and diabetes etc.^[4,7] Published literature indicates that most deaths associated with BP are secondary to adverse effects conventional treatment.^[4,7] A boy aged 7 years presented in the OPD with multiple pruritic tense blisters on the right leg for the previous 2.5 years. The patient had taken conventional treatment at a tertiary care public hospital for 2 years; itching was controlled and the blisters reduced in size and number; however the condition was not cured. The patient was not taking any medicines for the last 6 months. The homoeopathic medicine Rhus Venenata 30C was prescribed on the basis of totality of symptoms and repertorisation. Lesions were reduced considerably within 7 days and completely in 14 days. Three month post treatment follow up showed no recurrence. Skin lesion photographs before treatment and during follow-up visits have provided documentary evidence about the effectiveness of homoeopathic treatment in Bullous pemphigoid.

KEYWORDS: Case report, Bullous Pemphigoid, Rhus Venenata, Homoeopathy.

INTRODUCTION

Bullous pemphigoid (BP) is a chronic, subepidermal autoimmune blistering skin disease that usually occurs in the elderly population.^[1- 4] This disease most often involves only the skin, but the eyes, mouth and genitals also can be affected.^[2]

BP has been reported to occur throughout the world with no known ethnic, racial, or sexual predilection. The reported disease incidence is between 0.2 and 3 per 100,000 person years.^[1,4] It primarily affects elderly population in the fifth to seventh decade of life, the average age of onset being 65 years. Published literature however indicates that it may rarely be childhood onset.^[1- 4]

The exact etiology of bullous pemphigoid is unknown. Research suggests that immune system produces antibodies to the fibers that connect epidermis and dermis in BP. These auto-antibodies result in blister formation, itching and areas of inflammation on skin.^[2, 3 & 5] There are no obvious precipitating factors in most cases. However, precipitation of BP by UV light, radiation therapy, thermal burns etc has been reported in some cases. It may also be associated with other autoimmune diseases like diabetes mellitus and pernicious anemia, chronic inflammatory skin diseases such as lichen planus and psoriasis.^[1]

Often the first symptom to appear is itching followed by appearance of large tense blister that don't easily rupture when touched. These large blisters or bullae appear on erythematous base or on normal skin and are filled with clear or hemorrhagic fluid.^[1- 3, 5] These lesions are most common in the lower abdomen, inner or anterior thighs, back of knees, underarms, flexor forearms and groins; although they may occur anywhere in the body. Blistering on the palms and the soles can severely interfere with patients' daily activities. In about 10-25% of the patients BP may involve mucosa, resulting in limited oral intake secondary to dysphagia.^[1, 5]

The most common presentation is generalised bullous form which presents as tense bullae on flexural areas of the skin. Vesicular form is less common which presents as groups of small, tense blisters, often on an urticarial or erythematous base. Vegetating plaques are seen on intertriginous areas of the skin, such as neck, axillae and groin in very uncommon vegetative form of BP. Persistent urticarial lesions may be initial presentation in some patients that subsequently converts to bullae. Pemphigoid nodularis is a rare form of BP with blisters arising on nodular lesional or normal-appearing skin. In childhood-onset BP; the cutaneous

features may be clinically unique. In infants blisters generally occur on the palms, soles and face, rarely on genital areas.^[1 & 4]

The pathogenesis of BP is characterized by the presence of immunoglobulin G (IgG) autoantibodies specific for the hemidesmosomal bullous pemphigoid antigens BP230 and BP180.^[1,4] The diagnosis can be confirmed by histology, direct and indirect immunofluorescence.^[1,6]

The conventional treatment of BP involves systemic anti-inflammatory and immunosuppressive agents, oral corticosteroids being the usual prescription.^[3,4] Antibiotics are given to treat infection in ruptured blisters. Dressing is often required to protect raw, oozing areas. If the disease is controlled, dosage of corticosteroids is gradually tapered. However, if patient does not respond to treatment or the disease flares up as the dose is tapered; immunosuppressive drugs are prescribed.^[4] BP usually resolves after 3-6 years without treatment; and in 1.5-5 years with conventional treatment. However, many patients with aggressive or generalised BP require treatment for many more years. Lesions usually heal without scarring or milia formation. Patients who receive high-doses of corticosteroids and immunosuppressive medications are at risk for side effects of these medications which include peptic ulcers, gastrointestinal bleeding, agranulocytosis, and diabetes etc.^[4, 7]

BP can be fatal in about one third of older, debilitated people who are not under medication usually due to sepsis in ruptured bullae. However, published literature indicates that most deaths occurs secondary to the adverse effects of corticosteroid and immunosuppressant medications.^[4,7]

In homoeopathic texts various medicines are mentioned for blistering diseases; however there is a lack of published case report or a case study with documentary evidence. A case report presented with photographs during follow up visits has provided documentary evidence about the effectiveness of homoeopathic treatment in bullous pemphigoid.

CASE REPORT

A boy aged 7 years presented in the OPD with multiple pruritic tense blisters on the right leg for the previous 2.5 years. The physical examination of the patient revealed that bullae developed on an erythematous base on right leg (Fig.1). One ruptured lesion and one healed

lesion was observed on leg (Fig.1). The hairs, nails and mucous membranes were intact. His lesions and itching was aggravated by summer heat and warm covering in winters.

History of present illness

There was no history of any injury/ burns or drug intake prior to the onset of blistering. There was no past history of upper respiratory tract infections in the patient. The patient had been diagnosed as Bullous pemphigoid and taken conventional treatment at a tertiary care public hospital for 2 years. The itching in lesions was controlled with medicines and the blisters reduced in size and number; however the condition was not cured. The patient was not taking any medicines for the last 6 months.

Past history

The patient did not suffer from any other dermatological ailment before this complaint started. His milestones were normal. Vaccination was done on time and uneventful. Past perinatal and drug history were uneventful.

Family History

There was no family history of similar illness. Grandfather had type 2 diabetes.

Physical Generals

Thermal reaction- Ambithermal

Appetite- Normal

Thirst- Increased

Tongue- Triangular red tip with whitish coating posteriorly

Stool- Regular bowel movements, satisfactory

Urine- Normal

Sleep- Itching aggravated at night. Patient was restless, irritated and unable to sleep.

Sweat- Sweat was normal, inodorous.

Laboratory reports

As this was a diagnosed case, further laboratory investigations were not advised.

Treatment protocol

A single suitable homeopathic remedy was prescribed on basis of totality of symptoms after consulting homoeopathic repertories and material medicae.

Medicine prescribed

Rhus Venenata 30C was prescribed once daily five pills early morning empty stomach. The patient was advised to follow up on a weekly basis.

Follow up and outcome

The lesions completely resolved within two weeks of starting treatment. The patient was now put on placebo and follow up was continued. Over the next 3 month following treatment, the lesions did not recur.



Figure 1. At start of treatment



Figure 2. One week after starting treatment



Figure 3. Two week after starting treatment

DISCUSSION

Homoeopathic material medica and repertories were extensively studied to find the “Homoeopathic similimum” suitable for this case. The medicines mentioned for blistering diseases in Boger Repertory were as follows with their gradation^[10]:

Chapter- Skin

Rubric- Skin, eruptions, pemphigus

Grade 3 remedies: Aru-t., Dulc., Hep., Rhus-t.

Grade 4 remedies: Ars., Canth., Ran-b.,

Chapter- Skin

Rubric- Skin, eruptions, vesicular, blisters, etc.

Grade 3 remedies: Ars., Aru-t., Canth., Crot-t., Nat-m., Ran-b., Rhus-t.

Grade 4 remedies: Caust., Dulc., Grap., Lach., Merc., Pho., Sep., Sul.

Out of above medicines, Rhus toxicodendron was most similar to this case. Homoeopathic texts describe Rhus toxicodendron for Eruptions, generally vesicular; vesicles are large with ‘tensive or tight feeling’ in blisters. Sometimes these blisters spread up the limb and are sometimes circular in form, spreading with a red edge in the advance, which gradually turns to a blister, the red border still keeping in advance. Lesions are intensely pruritic; with itching aggravated by after scratching. Stinging and tingling on skin, burning after scratching. The right side is affected more than the left. Thirst increased with dry tongue, mouth and throat. Vesicular skin complaints accompanied with burning, intense itching, stinging. Patient

is extremely restlessness, with continued change of position. Rhus tox symptoms as described by Dr. H.C. Allen and Dr. J. H. Clarke match with the patient.^[11,12] However, the aggravating and ameliorating modalities of Rhus toxicodendron did not match with the patient. Rhus toxicodendron is generally aggravated by cold, wet rainy weather and at night; and better by warm, dry weather, warm applications.^[11,12]

Rhus Venenata was considered next as homoeopathic texts describe Rhus ven. for most severe skin symptoms than any other Rhus species. It has vesicular eruptions or clusters of vesicles on an inflamed base and accompanied with most intolerable itching. Itching is aggravated in evening in a warm room and at night in bed. Therefore, Rhus ven. was considered more suitable for prescription on basis of totality of symptoms. The medicine was given in 30C potency and repeated one dose every day, early morning empty stomach. The lesions completely resolved within two weeks of starting treatment (Fig.2 and Fig.3). The patient was now put on placebo and follow up was continued. Over the next 3 month following treatment, the lesions did not recur.

CONCLUSION

This case provides documentary evidence about the effectiveness of homoeopathic treatment in Bullous Pemphigoid. However, suitably designed study with bigger sample size for extended time period is suggested for further validation of above findings.

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