

A Case of Ankylosing Spondylitis

PRELIMINARY INFORMATION

Mr B T, 34yrs, Married, Hindu Bengali Brahmin, Non-Vegetarian, studied till HSC, now working.
Spouse: Age: 27yrs. Occupation: House wife.

Father: 62 yrs, Retd General Manager. Mother: 57yrs. House wife.
Brother: 27 yrs, Working as a Senior Engineer.
Son: 4yrs

CHIEF COMPLAINTS

L	S	M	C
Musculo Skeletal System Hip to Shoulder to Chest to Back Since 4-5 years, Daily	Ankylosng Spondylosis Pain ² Restricted Movements Cannot Sleep Straight	A.F. Business Tensions < STANDING < Lying On Left side > Belt > Lying on Right side > lying on back, with pillow below legs. Not > Homoeopathic Rx Not > Hot Fomentation	Fatigue
Cardio Vascular System	Giddiness Head Heaviness BP - 140/90 mmHg		

ASSOCIATED COMPLAINTS

L	S	M	C
GIT Freq- 3-4 per day	Loose Motions Stools - Sticky, Semi solid	< Oily < Spicy < Coconut Water < vadapav < bhajia < lemon water < potatoes chips	

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PATIENT AS A PERSON

PERSPIRATION: General ++, odors ++
CRAVING: Oily, Pungent, Non-veg, Palak
C3H2

LIFE SPACE

Mr B T lives with his parents, brother, wife and his child. His Father was a General Manager in a reputed textile company. Pt studied upto SSC, then gave up as

MIASMATIC CLASSIFICATION

1) Ankylosing spondylitis - Classified under SYCOSIS

STRUCTURE

- Vertebrae
- Hip joint
- Shoulder joint
- Costovertebral joint
- Costosternal joint
- Para-articular tissue
- Ligaments

Time - 3 to 4yrs

FUNCTION

- Increased bone formation
- Destruction of cartilage
- Restricted movements
- Fibrosis and Bony bridging
- Degeneration of Para articular tissue

FORM

- A/F Tension
- <STANDING
- <Lying on left side
- >Lying on right side
- >Belt
- >Lying on back with pillow

2) Hypertension - SYCOSIS

3) Mucous colitis - PSORA

PSYCHOLOGICAL CORRELATION

F = Successful executive
Source for business
Unattainable Model

M = Indulgent
Affectionate

Patient
Initial Success
Hard Worker
Irritable, Excitable
High Self Image

Poor Internal and External Communication

1st Divorce

Judgement Poor
Issue of Prestige

Loss in business

Failures / Shocks
Low Self Image

Unconscious Egotism and Inflexibility

Denial, Suppression, Repression

Ankylosing Spondylitis



TOTALITY

A.F. Tensions	< Excitement
< Contradiction	Excitable
Irritable	Reserved
MWD ++	
Dream Falling From Height, Train, Death of Mother	
Chilly	Perspiration: Odor
Cardiovascular	Gastrointestinal
	< Foods
Musculoskeletal	< Fat

CORRESPONDENCE

Irritability and Excitability with food aggravations pointed to *Ferrum-met*. Musculo-skeletal System, CVS and GIT were the 3 locations consistent with *Ferrum* affinities. The reserved behaviour and poor internal and external communication raised the possibility of *Magnesium*. But the core was obviously different.

SUMMARY OF TREATMENT

The experience of case receiving was peculiar. It was almost at the end of interview that the physician realized that the patient may be suffering from Ankylosing Spondylitis. Physical Examination confirmed the suspicion. Patient seemed to be unaware of the diagnosis and its implications. Old medical reports indicated that an Orthopaedic consultant had suspected the condition and had given the patient exercise regimen with diagrams. Yet patient had discontinued Rx and had not done any exercise. Awareness and Acceptance of the disease and appropriate change in life style were a crucial part of the treatment.

Patient was advised X rays and blood tests. He delayed the tests and finally got them done from a wrong radiologist who missed the obvious sacro-ilitis. This was despite specific instructions to the contrary. The opportunity was seized to warn the patient in clear terms against disregarding the advice. He was forced to consult the radiologist suggested earlier. The patient and his wife were explained the course of disease and the importance of physiotherapy along with Homoeopathy.

TREATMENT started in May 2000. Patient received *Fermet* 200 in gradually increasing multiple doses till QDS. *Thuja* 200 was introduced after 1 ½ month of treatment as an intercurrent. It was later given weekly. Patient's response was good. In one month, his Generals were >³. Chest and shoulder pains had disappeared. Chest expansion was 2 ½ cm. Neck movements had improved. Back pain was still bothering him, especially in the evenings. But he was able to work faster. He was doing exercises regularly. At the end of seven months, pains in all joints were better 80%. Lumbar flexion was full. Chest expansion was 3 cm. BP was 120/80. There were no GI complaints. He took up a job in a neighbouring state (Dec 2000). There after he did not continue with medicines despite suggestions.

Nov 2001. Patient reported back for treatment after 11 months. He only complained of mild pain in hip and groin. He was working 12 hours/day. But physical examination showed obvious clinical deterioration. He had developed stooping posture. Lumbar flexion was restricted. Chest expansion had reduced to 2 cm. There were no GI symptoms and BP was 140/86. He as well as his wife were again explained the need for regular treatment and exercise. The treatment was resumed with favourable response till patient discontinued it again.....

We are thankful to **Rob Schoenmakers**, the physiotherapist turned Homoeopath from Melbourne for his write up on physiotherapy for Ankylosing spondylitis. The write up reproduced below should help us understand the basic principles of Physiotherapy.

**ANKYLOSING SPONDYLITIS
PHYSIOTHERAPY MANAGEMENT
ROB SHOENMAKERS**

The management of ankylosing spondylitis (AS) involves three separate problems; control of pain, stiffness and deformity. Pain is due to inflammation and in allopathic management, anti-inflammatory drugs remain the

treatment of choice to maintain maximal mobility and activity. Prevention of stiffness, limited spinal/joint mobility and decreased muscular strength (all ultimately leading to functional impairment) is the main goal of physiotherapy in AS.

Proper patient management includes proper patient education. General measures include use of a firm mattress plus a small pillow. Postural care of the spine, including sitting with the back straight and supported, to avoid long periods of spinal flexion, must be taught. Patients who become stiff easily while sitting for long periods, are advised to get up periodically and walk around. Proper patient education should also include emphasizing that most patients lead an active life. In AS the management involves active participation of the patient and the advantages of remaining as active as possible and the patients' responsibility for self-management must be explained. Inactivity or disuse has consequences for many body systems, organs and tissues and in AS in particular, active involvement preserves mobility and function.

During acute attacks most movements are painful and rest from such painful activities, is then essential. Physiotherapy goals during the acute attacks of the inflammatory arthritides in general, are assisting with alleviation of pain, prevention of deformity and the restoration of function as much as possible. Even in the acute stage, the physiotherapist should aim to involve the patient in minimizing the effects of disuse and inactivity as far as possible. This could mean prescription of a gentle exercise program for unaffected regions or, if appropriate, a cycling, walking or arm-exercise program. Education and support are important components during this stage as well.

Once an acute exacerbation has passed, the patient should be provided with a program that will promote the total health of the patient, to maximize both physical abilities and patient's autonomy and well-being. Exercises are important at this stage for all patients with arthritis and in the management of AS in particular. More than with any other type of arthritis, specific exercises

have been established as an essential component of management, with spinal extension and postural exercises being the key component of any AS exercise program to halt the progression of postural deformity. In addition, "fitness" or aerobic activity exercise such as walking, water exercise, light jogging and cycling can also be encouraged without concern for causing disease exacerbations. It is important to find the right balance between rest and exercise for inflammatory arthritis so that symptoms are not exacerbated. To achieve this balance, the following should be kept in mind:

1. When joints are inflamed, rest is needed, the amount and type is proportionate to the inflammation.
2. If joints ache only on certain movements, rest from those movements is needed.
3. Joints that are stiff, yet have little pain, need more exercise.
4. Joints that feel weak and unstable require more support and exercise.

Hydrotherapy is a commonly used medium for exercise for patients with arthritis in the Western countries with easy access to good pools with specialized hydrotherapy services provided by physiotherapists. The physical properties of warm water provide a number of benefits to enhance exercise.

SOME COMMON GUIDELINES FOR EXERCISE.

1. Begin program slowly and increase amount of exercise gradually.
2. Be aware of pain and swelling and effects of exercise on joints.
3. If pain occurs and lasts more than 2 hours you may need to revise program, by doing less exercise, avoid too many repetitions or perform them with less effort.
4. Muscles and joints are exercised more effectively when they are warmed up. Always start with a warm up period.
5. Do not push through pain.

For AS patients who wish to participate in sports activities, a "soft" type of game is more advisable than "hard contact" or high impact game. There are however no rules as the disease shows a great variation.

OTHER PHYSIOTHERAPY MODALITIES

Certain mobilisation techniques can be used to increase mobility of the spine but traction and manipulation are contraindicated. Heat may be of some advantage before an exercise program is implemented and may also be used to relieve pain. Generally, AS symptoms are worse when patient is inactive and less severe during exercise. Pain however may not only be due to inflammation but may also be due to muscle tension from abnormal postural loading or muscle soreness after strenuous or unfamiliar exercise. Scientific evidence of the efficacy of physical therapy modalities to relieve pain in AS is scarce but common modalities like massage, ice and various electrotherapy modalities such as infrared, microwave (superficial heat), short wave diathermy (deeper penetration), interferential, ultrasound, laser therapy are used.

BIOMECHANICAL AND PATHOPHYSIOLOGICAL ASPECTS IN PHYSIOTHERAPY

Lumbar lordosis in AS patients decreases and the pelvis is posteriorly tilted. Thoracic kyphosis becomes more

pronounced and also leads to shortening of pectoralis muscles and decreased movement in glenohumeral joint. Chest expansion decreases and inflammation of costo-vertebral and sterno-costal joints may cause pain on coughing or even breathing. The neck is often pushed forwards in progressive AS. Some of these postural changes are compensated by flexion of the knees and hips. Hamstrings and hip flexors will develop tightness with weakness in gluteals and hamstrings. The postural changes may cause abnormal loading of structures, which can cause early degenerative processes.

Treatment will therefore be aimed to counteract the above processes. Strengthening of upper back extensor muscles plus flexibility is essential. Pectoral muscles are lengthened. Flexibility and extension exercises are given for lower back including pelvic tilt exercises. Patients are asked to control lumbar curvature in all activities. Patients often suffer from pain and tension in neck and shoulder area and treatment may include stretching, movements and soft tissue techniques. Stretching is useful for hamstrings and hip flexors.

Most scientific physiotherapy studies of AS according to these guidelines give a picture of good treatment outcome. Patients who have to rely on their own exercise regime to maintain mobility may find it harder to prevent deterioration, compared with those entered in a group program supervised by physiotherapists.



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