Syphilinum: An Answer to Osteoporosis

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Abstract: Osteoporosis is gaining increasing importance day by day all over the world among the epidemics of non-communicable diseases. It is multifactorial in origin; but what is the biggest threat is that it is usually asymptomatic until fractures or some serious deformities occur; validating its description as the 'silent disease.' There is an increased resorptive activity of the osteoclasts in comparison to the bone-forming activities of the osteoblasts. The common sites of fracture are distal radius, lumbar vertebrae and the neck of the femur. My experience reveals that Syphilinum, whenever used appropriately, not only lessens the pain, but also reduces the risk of fracture to an immense extent. Other medicines are also required according to the symptom-totality. Also, dietary modifications, exercises and, in some cases, therapeutic supplementation of calcium and vitamin D are mandatory.
Keywords: osteoporosis, Syphilinum, a critical analysis; Syphilinum in osteoporosis

Introduction

Osteoporosis is the most common metabolic bone disorder characterized by reduced bone mass, micro-architectural deterioration of bone tissue and an increased risk of fracture. In osteoporosis, the amount of bone is decreased to a level below which it is incapable of maintaining the structural integrity of the skeleton. The rate of bone formation is often normal, whereas the rate of bone resorption is increased.

Epidemiology

The prevalence of osteoporosis and osteoporosis-related fractures both increase with age in women and men, reflecting an age-related decline in bone-mass. Fractures related to osteoporosis are a major public health concern both in developed and developing countries, and are estimated to affect up to thirty percent of women and twelve percent of men at sometime in their life. The morbidity and indirect mortality rates are very high. Since the disease is clinically evident in middle life and beyond and since women are more frequently affected than men, it is often referred to as 'postmenopausal' osteoporosis. The disease has a progressive degenerative course, leaves residual disability, non-reversible pathological alterations, and requires a long period of supervision, observation, care and special training of the patient for rehabilitation. The impact of osteoporosis on the lives of people is serious when measured in terms of disablement, family hardship, poverty and economic loss. It significantly affects life expectancy and quality of life.

Etiologic & Risk Factors

Female gender and Caucasian/Asian race;
Thin and small bony frame;
Personal/family history of fracture;
Hormonal deficiency (Estrogen/Androgen);
Hormonal excess (Cushing Syndrome, Thyrotoxicosis, Hyperparathyroidism);
Prolonged Glucocorticoid administration (Steroid/Glucocorticoid induced osteoporosis: SIOP/GIOP)
Immobilization & microgravity;
Substance abuse (alcohol, tobacco, caffeinated soda);
Prolonged exposure to heavy metals (e.g., Cd, Pb, etc.);
Malignancy (e.g., Multiple Myeloma);
Medications (excessive vitamin D intake, excessive vitamin A intake, heparin therapy, antiseizure medicines, proton pump inhibitors, antidiabetic Thiazolidinediones, antidepressants, etc.);
Chemotherapy that may cause early menopause;
Genetic disorders (aromatase deficiency, Type I collagen mutations, Osteogenesis Imperfecta, idiopathic juvenile and adult osteoporosis, etc.);
Miscellaneous (gastrectomy, anorexia nervosa, protein-calorie malnutrition, vitamin C deficiency, uncontrolled Diabetes mellitus, rheumatoid arthritis, systemic lupus erythematosis, ciliac sprue, primary biliary cirrhosis, etc.).

Pathophysiology

The pathogenesis includes inadequate peak bone mass, excessive bone resorption, and inadequate for-

mation of new bone during remodeling.

Bone modeling: The skeleton increases in size by linear growth and by apposition of new bone tissue on the outer surfaces of the cortex. This latter process is the phenomenon of modeling, which also allows the long bones to adapt in shape to the stresses placed upon them. Increased sex hormone production at puberty is required for maximum skeletal maturation, which reaches maximum mass and density in early adulthood. Nutrition and lifestyle also play an important role in growth, though genetic factors are the majors determinants of peak skeletal mass and density.

Bone remodeling: The process of bone remodeling is carried out principally by the osteoblasts and the osteoclasts. Exposed collagen attracts preosteoclasts, which after being transformed into osteoclasts, fuse into multinucleated cells that resorb a cavity. Resorption is continued and preosteoblasts are stimulated to proliferate. The osteoblasts start forming osteoid, which gradually gets mineralized. These osteoblasts begin to flatten and finally turn into lining cells. Thus bone remodeling continues.

Factors controlling bone remodeling: Bone remodeling is regulated by several hormones, including estrogen, androgen, calcitriol, parathyroid hormone and various locally produced growth factors, e.g. IGF-I & II (Insulin Growth Factor), TGFβ, PTHrP (Parathyroid Hormone Related Peptide), RANKL (Receptor Activator of Nuclear factor κB Ligand), ILs, prostaglandins, TNF (tumor necrosis factor), OPGL (osteoprotegrin ligand), etc.; additional influences include nutrition (especially calcium intake) and physical activity level.

Imbalanced cellular activity in bone: After age 30 to 45, the resorption and formation processes become imbalanced. This imbalance becomes exaggerated in postmenopausal women. An increase in osteoclastic activity and/or a decrease in osteoblastic activity lead to excessive bone loss. The osteoclasts become very aggressive, leave no template for new bone formation and cause rapid bone loss.

Role of hormones: Estrogen deficiency causes bone loss by two distinct mechanisms. Firstly, the marrow cells and bone cells express estrogen receptors (ERs) α and β. Secondly estrogen may play an important role in determining the life span of bone cells by controlling the rate of apoptosis. Thus, in situations of estrogen deprivation, the life span of osteoblasts may be decreased whereas the longevity of osteoclasts is increased.

Role of calcium and vitamin D: Calcium and vitamin D deficiency leads to compensatory secondary hyperparathyroidism, the long-term effect of which is detrimental to the skeleton, making this deficiency an important risk factor for osteoporosis and fractures.

Clinical Features

Since low bone density alone does not cause symptoms, patients with advanced osteoporosis may be completely asymptomatic until a fracture occurs. However, pain may be felt in various parts of body and tends to be worse from standing, walking, jerking, twisting, flexing the spine, etc., and better from lying down. Virtually any bone can be affected, but there is a greater loss of trabecular bone than compact bone, accounting for the primary feature of the disease. The commonest sites of involvement are the distal radius (Colles fracture), vertebrae, neck and head of femur, pelvic bone, proximal humerus. 'Micro cracks' occur in the weaker spicules of trabecular bones. Vertebral fractures develop after lifting heavy weight, twisting to get out of a car, missteps.etc., and can cause severe band-like shooting pain that radiates around from the back to the sides of the body. Hip fractures are associated with a high incidence of deep vein thrombosis and pulmonary embolism and a mortality rate between 5 and 20% during the few months after surgery. Multiple fractures lead to considerable height loss, kyphosis, a typical hunched-back appearance of the upper back ("dowager hump") and secondary pain of varying severity and discomfort related to altered biomechanics of the back. Even a cough or sneeze can cause a rib fracture or partial collapse of the spine. Thoracic fractures can be associated with restrictive lung disease, whereas lumbar fractures are associated with abdominal symptoms including distension, early satiety and constipation. Although some fractures are clearly the result of major trauma, the threshold for fracture is certainly reduced for an osteoporotic bone.

Laboratory Findings

Serum calcium, phosphate, parathyroid hormone: normal;

Serum alkaline phosphatase: normal (may be slightly elevated following a fracture);

Tests to exclude thyrotoxicosis, hypogonadism and vitamin D deficiency and tests to exclude myeloma (ESR, serum protein electrophoresis);

Bone biopsy (not required for diagnosis; helpful in excluding osteomalacia and unusual causes).

Imaging Study

Vertebral X-ray, Quantitative CT scan or MRI: compression/crush fracture, biconcave 'cod fish'/'fish bone'/'fish head' appearance;

X-ray of the affected parts: osteoporotic changes/ fracture in the bone, loss of bone density, thinning of cortex, reduction of trabeculae of cancellous bone;

CT bone densitometry or Dual Energy X-ray Absorptiometry/DXA/DEXA of lumbar spine or hip bone (Routine bone densitometry during treatment is unlikely to be helpful, because bone density changes so slowly with treatment that they can not be recognized

by repeated DXA scans).

BMD T-score	Interpretation
-1.0 or greater	normal
Between -1.0 and -2.5	'low bone mass' (osteopenia)
-2.5 or below	osteoporosis

For pre-menopausal women, Z-scores (comparison with age group) are preferred instead of T-scores (comparison with peak bone mass).

Therapeutic Measures

Calcium supplements (500-1000 mg daily) and Vitamin D supplements (20μg daily) in conjunction.

General Measures

Diet should be adequate in protein, total calories, calcium (milk and milk products, egg, fish, green leafy vegetables, cereals, millets, sitaphal etc.) and vitamin D (shark/cod/halibut liver oil, butter, egg, milk, fish, fat, etc.); limited intake of caffeinated soda drinks;

Pharmacologic glucocorticoid doses should be reduced or discontinued if possible;

Hot and cold compress;

Acupuncture, acupressure and massage to relieve pain and anxiety;

High-impact physical activity (weight-bearing exercises, walking, jogging, cycling, stair-climbing, etc.) to increase bone density, strength and thereby to reduce the risk of falling, but extreme exercises should be avoided;

Measures to avoid falls at home (adequate lighting, handrails on stairs, handholds in bathrooms, etc.);

Balance exercises to reduce the risk of falls;

Use of a cane or walker in patients having balance problems;

Use of FDA approved hip protector garments for prevention of hip fracture;

Active or passive exercises for bed-ridden patients;

Adequate spinal support; a new spinal device, called Weighted Kypho-orthosis (WKO) has evolved. It is a harness with a light weight attached to it. It is worn daily for 30 minutes in the morning and 30 minutes in the evening, and 10 repetitions of specific back extension exercises are to be done;

Avoidance of rigid or excessive immobilization;

Avoidance of smoking and alcohol.

Syphilinum: A Critical Analysis

Among all the nosodes and sarcodes, *Syphilinum* is one of my commonly used remedies. The prescribing symptoms of *Syphilinum* are listed below:

All symptoms aggravate at night (especially 2-5 a.m.) and are ameliorated by cold application;

Dull, idiotic patients; loss of memory; can not remember names of books, persons or places; arithmetical calculation difficult;

Always washing the hands and feet;

Thoughts of suicide; past attempts of suicide;

Chronic sick headache with falling of hair;

Craving for alcohol; hereditary tendency to alcoholism;

Desire for cold food and drink; aversion to meat;

Obstinate constipation; rectal prolapse, anal fissures;

Infidelity and sexual perversions of all kinds, especially sadism and exhibitionism;

Family history of congenital malformations in any form, suicides or suicidal attempts, destructive or degenerative diseases.

The keyword of the miasm 'syphilis' as well as of the remedy *Syphilinum* is destruction or degeneration. When prescribing *Syphilinum*, this symptom-totality should be kept in mind. It is not necessary to find all the symptoms in a single patient; rather it is the gravity of the symptoms that matters, not the quantity. Thus *Syphilinum* can be prescribed on a single symptom, if that is characteristic enough and reflects the inner dominant miasm quite satisfactorily.

I have a female patient, aged approximately 30, who came to me with diagnosed hypothyroidism (TSH: 63μ/ml), but complained of severe lumbago with right-sided sciatica since the preceding week. Analgesics were giving considerable relief, but she was reluctant to lengthen further her list of medicines. I found not a single symptom of *Syphilinum*; but while enquiring of her family history, I learned that, though she could not confirm what the terminal diseases were, her father, elder two brothers and her elder sister all passed away at the age of 35-40! She believed that her ever-increasing dependency on medicines portended that she had not many days left herself.

Obviously my prescription was *Syphilinum* 200, two doses, with placebo for next twenty days. Her pain began to lessen from the third day of ingesting the medicine and gradually diminished further over the next two months. She was almost free from her distressing backache when the pain again relapsed. I again prescribed *Syphilinum* 200, two doses, and since then about eight months have passed and she has not complained a single time of her lumbago. Now she is taking placebo, but her symptomatology is indicating *Calcarea carbonica* indistinctly. It most likely will take at least 5-6 months for her to develop the *Calcarea carbonica* symptomatology clearly enough to prescribe that medicine. Simultaneous with her remarkable recovery her TSH level has drasticlly fallen to 18μ/ml and her allopathic physician has reduced the levothyroxine sodium dose from 100mcg/day to 50 mcg/day.

Syphilinum In Osteoporosis

In the disease osteoporosis, the osteoclastic activity overrides the osteoblastic activity, thus causing bony destruction to an incredible degee. Destruction is the keyword of osteoporosis, no doubt calling for prompt antisyphilitic medicines. No hormone replacement therapy, bisphosphonates, calcitonin injections or SERMs (Selective Estrogen Receptor Modulator; e.g., Raloxifene) can increase the bioavailability of the bone-forming minerals or their assimilation rates, nor can they re-establish the hormonal imbalance going on in the postmenopausal women sufficiently or permanently. The only permanent solution is to administer an anti-syphilitic (especially *Syphilinum*) to curb the osteoclastic activity and, after that, in most cases, an antipsoric strictly selected upon the presenting totality of symptoms and costitutional background. The medicines correct the disordered vitality, helping to restore the skeletal integrity. At the same time dietary supplements and the general measures (above) are to be maintained strictly. In this way, not only can osteoporosis be treated effectively, but prevented also.

Case Study

The case I am going to discuss is one of my earliest cases. The patient was my own aunt, aged about 65, and had been suffering from chronic low back pain extending to the right heel for ten years. Her pain gradually intensified to an intolerable level and she consulted an orthopedic surgeon. Digital X-ray of the lumbar spine was done and scoliosis was discovered. Routine blood analysis as well as tests of calcium, phosphate, alkaline phosphatase and parathyroid hormone were done which revealed no abnormalities. The BMD (bone mineral density) was -2.1 and was diagnosed as osteopenia. She was prescribed NSAIDs, antacids, calcium, vitamin D supplements and an ointment, and was advised to have physiotherapy at least for six months. But from the very first day of those medicines, she started to have side-effects – nausea, vomiting, giddiness and complete anorexia. Immediately she began an antiemetic. She was taking seven tablets, four teaspoonsful of syrup, and was applying the ointment thrice daily. Simultaneously she continued physiotherapy for two consecutive months. After that the pain again relapsed inspite of continuing medicine, but she was reluctant to consider such massive drugging again. She pleaded with me to give her medicine, but I was scared. After all, she was my own aunt.

Somehow I gathered courage and took the case. Keeping in mind her extreme level of anxiety and fastidiousness, relief of the pain from application of heat, and thirst for small quantities of water at frequent intervals, I prescribed *Arsenicum album* 30C/6 doses, and advised her to continue the calcium-vitamin D supplement and physiotherapy along with my medicine. Two to three days later the pain began to decrease, but again relapsed after two weeks. I knew my medicine was only partialyl similar and could not remove the miasmatic blockage. Being frustrated, I began to prescribe hapazardly – *Colocynthis, Magnesia phosphorica, Rhus toxicodendron, Gnaphalium* - one after another, but to no use. The patient was losing hope gradually. Then I decided to further investigate, restudy and reanalyze the case.

Her mental features were quite striking. She was extremely forgetful; she even could not remember the way to return from the nearby market. She always washed her hands and feet and wanted to wash every washable item. She had been been suffering from constipation which she never mentioned before. She had a past history of a suppressed skin eruption. On the basis of these symptoms and keeping in mind the resorptive pathogenesis going on in her bones, I prescribed *Syphilinum* 200/two doses. Miraculously, the pain vanished within two days and for over a year afterward she never complained to me of her pain, and no further repetitions of *Syphilinum* were necessary. Another radiograph was taken, but no change in the scoliosis was found, a finding I anticipated since the scoliosis was by then an irreversible pathology.

From this very case, I gained confidence in homeopathy as well as in *Syphilinum*. Since this experience I have seen many cases of osteoporosis and have frequently prescribed *Syphilinum*,when indicated, and it has yet to disappoint me.

Management Protocol

The examples of medicines as well as the management protocol is solely based on my clinical experience. It only reveals those medicines which I have used commonly. I remember a few cases which responded surprisingly well to *Sulphur, Lac canium, Thuja, Lycopodium, Medorrhinum* and *Causticum*. Above all, while selecting homeopathic remedies, the symptom-totality should be the sole guide in the selection of the remedy. The miasmatic background, however, often deserves priority over the symptom-totality, particularly in those cases where, after the prescription of the symptomatically indicated remedy, the improvement ceases after a certain interval. Another important point to remember is that it is often quite harmful to prescribe a deep-acting antimiasmatic remedy when the patient's suffering is acute; the remedy might intensify the destructive process causing irreversible damage to the patient, especially when the vitality of the patient is depleted. It is better to resort at first to some superficial/semi-superficial remedies to bolster the patient's vitality and then to consider anti-miasmatics. A correct anti-miasmatic remedy promptly eradicates any miasmatic obstacle, resulting in a clearer expression of symptoms, and thus eventually guiding the physician

to the selection of the exact similimum.

Selection of Potency

Those medicines which are prescribed for acute conditions are best given in 30C, 200C, and, rarely, 1M potencies. I usually prefer 3X, 6X and 12X potencies in cases of *Calcarea fluorica, Calcarea phosphorica* and *Magnesia phosphorica*; however, these medicines, when constitutionally indicated, often yield the best results in higher potencies. The decimal potencies are fruitful particularly when the patient's diet is seriously lacking in calcium, magnesium or fluorides, which is not an uncommon picture in a poor country like India. In a few cases, the 50 millesimal scale also yields a quick and favorable response, particularly when dealing with acute emergencies. In case of *Syphilinum*, I prefer to start with 200C, and, in the more than 300 cases of osteoporosis I have seen, not a single case has required greater than 1M.

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