Homoeopathic Approach To Osteoarthritis

INTRODUCTION:

Osteoarthritis is a fairly common disease prevalent in the community. This article aims to discuss the basic clinico-pathological knowledge relating to OA & its importance for a Homoeopath. The article will try to demonstrate the importance of Susceptibility, Sensitivity and Miasm in Homoeopathic treatment of OA with the help of illustrative cases.

[Editor: The authors had submitted an exhaustive write up for the General aspects, which has not been published as it has covered elsewhere in the issue, in the General section.]

ORIGINS OF JOINT PAIN IN PTS WITH OA

While undertaking study on osteoarthritis two features struck the most

1. A revelation that OA should not be viewed simply as a disease/ failure of single tissue- the cartilage, but of an organ- the diarthrodial joint
2. The pain does not originate from articular cartilage as it is aneural. Hence, it must originate from other structures in the joint.

The tissues involved and the mechanisms of pain are as under ⊥

Tissue	Mechanism of pain
1. Subchondral bone	Medullary hypertension, micro fractures
2. Osteophytes	Stretching of nerve endings in periosteum
3. Ligaments	Stretch
4. Enthesis	Inflammation
5. Joint capsule	Inflammation, distension
6. Periarticular muscle	Spasm
7. Synovium	Inflammation

Finer knowledge of the tissue involved and the mechanisms of pain can improve our therapeutic approach especially in defining the sector remedy for a specific case. Patients describe different types of pains which could be helpful to understand the tissue affected. Prospective studies are required in this area. Such studies can bring about a revolution in our therapeutic management of osteoarthritis.

The joint pain in patients with OA may arise from periarticular as well as articular structures. It is common for the patient with OA to develop soft tissue rheumatism in areas adjacent to the involved joint, for eg: Anserine bursitis in patient with knee OA, trochanteric bursitis in patient with hip OA.

DIAGNOSIS OF OA

The diagnosis of OA is usually based on clinical and radiographic features. In the early stages X-ray may be normal, but as articular cartilage is lost, narrowing of the joint space becomes evident. Other characteristic X-ray findings include subchondral cysts, subchondral sclerosis and marginal osteophytes.

Dr Anand Kapse LCEH
Director, Rural Homoeopathic Hospital,
Palghar, Homoeopathic consultant

Dr Anagha Phanse
Rural Homoeopathic Hospital,
Palghar, Homoeopathic consultant

Dr Sonali Datey Rheumatology OPD
Rural Homoeopathic Hospital,
Palghar, Homoeopathic consultant

A KNEE X-RAY in standing position exhibits joint space narrowing more accurately in the supine position. Therefore the antero-posterior (AP) view is taken in standing position.
Synovial fluid analysis is not usually done in patients with OA.

ANCILLARY MEASURES

Exercise forms an integral part in the management of OA. The goals of an exercise program for the patient with OA should be:

- Reduction of impairment and improvement of function, i.e. reduction of joint pain, increases in Range of Motion (ROM) and strength, normalization of gait and improvement in performance of daily activities.
- Protection of the OA joint from further damage by reducing stress on the joint, attenuating joint forces and improving biomechanics
- Prevention of disability and poor health secondary to inactivity by increasing the daily level of physical activity and improving physical fitness.

For knee OA, a combination of exercises including ROM, strengthening and low-impact aerobic exercises is appropriate. Aerobic exercises that may be recommended include- walking, biking, swimming, aerobic dance, aerobic pool exercises.

Patients generally tolerate walking without an increase in symptoms, if they begin slowly and gradually increase their walking time. Walking regularly with dietary regulation also helps in weight reduction in obese subjects, which in turn may result in a reduction in pain and improvement in function of joints.

Thermal modalities viz. application of heat, cold or both offer short term pain relief. Heat may be applied as superficial & deep heat. Diathermy employed as either shortwave or microwave and ultrasound are the three forms of deep heat. Cold may be delivered by icepacks, ice massage & local sprays.
Proper footwear e.g. wedged insoles may be useful in the conservative treatment of OA in the medial tibiofemoral compartment.
For effective management of many patients with OA encouragement, reassurance, advice about exercise and recommendation of measures to unload the arthritic joint such as a cane and proper footwear are required along with the therapeutic intervention.

CLINICAL EXPERIENCES

Now we will take up study of some representative cases & then try to derive some general conclusions.

CASE 1

Mrs PS, 48, housewife, Education FYBA

CHIEF COMPLAINTS

Location	Sens & Comp	Modality	Accompaniment
KNEE Rt to Lt Ankle Calf Since 5-6 months	PAIN Stiffness Numbness swelling	< Night < Sitting < Crossing Legs < Squatting > Warm Water > Pressure	sleep disturbed

PATIENT AS A PERSON
Cracks < Winter
Heat Palms
Hunger <Nausea, Giddiness
MENSES: Duration - 4days Regular Flow - Moderate
Colour - Brown Stains Fast + Odour ++
Menses Before: Pimples, **Menses During**: Pain In Extremities
Menopause: Since 4 Years
Delivery: FTND
MENTAL STATE:
Grief of mother's death. Weepy when remembers mother, sister, while watching family serials.
Attachment mother, sister, son
Sympathetic, disturbed on seeing others in trouble
Company desires. Fear when alone. Anxious about illness.
Worry about son's marriage (girls refuse proposal as they do not want to stay at Palghar)
Frustrated desire to study due to finances & early marriage (Still has desire to study!)
Confidence – shaky. Anxiety < headache. Isolation < Imaginary fears

REACTIONS PHYSICAL FACTORS
BUS <Vomiting FASTING < nausea, giddiness
C3H2
FAMILY HISTORY; Mother died of IHD
PHYSICAL EXAMINATION
Left knee crepitics, slight tenderness
INVESTIGATIONS
X-ray Lt knee joint - osteophyte formation, degenerative changes. Joint space normal.
X-ray Rt knee joint-(1997) osteophyte formation, degenerative changes. Joint space normal.

PLANNING & PROGRAMMING
Susceptibility–High. Sensitivity–Moderate. Phase–Early structural
Dominant Miasm–Sycosis.
Fundamental Miasm–Syphilis

FOLLOW UP
The patient was given a single dose of *Kali-carb* 200 on 22nd November 2000. There was total relief in all the complaints for 6 months. After 6 months the knee pains reappeared due to a fall. This time (May 01) she needed *Kali-carb* 200 3P weekly for a few weeks along with occasional doses of *Thuja* 200. Patient has not required any medicines since September 01.

CASE 2
Preliminary Information
Mrs MR, 51; Education MA (Eng) BEd
Occupation- Teacher.
Husband- Principal project director in a thermal power station
Daughters: 2, Brothers: 2, Sisters: 2
Father: dead Mother: alive
CHIEF COMPLAINT
Bilateral knee joint pain; piercing type+++ (Right→Left) since 6 yrs with stiffness ++, Swelling ++. Limps while walking. <Anxiety, Worries > Hot Fomentation
Backache On & Off < Exertion
O/E-Bilateral knee tenderness ++. Crepitus++. Swelling.
Weight—83 kg, B.P.- 150/90 mmHg
X-Ray - Osteophytes with joint space reduction.
BMD – Osteopenia spine, femur NAD.

DIAGNOSIS - Osteoarthritis knee.
P/H - Childhood Asthma,
Uterine fibroid-Hysterectomy done.
F/H - Diabetes (Father).
Hypertension, Osteoarthritis (Mother)

REMEDY SELECTION
Patient is the wife of principal project director. Handling of such VIP patient in our Palghar Hospital is a bit difficult. Hence when patient came on the day of appointment, it created kind of a drama. Patient came sharp at the time of appointment with her husband, but the consultant had gone out for some meeting as he

was not aware of the appointment. This was enough for her to get angry & behave harshly. The intervention by another senior physician helped to calm down the situation. It was a very difficult task for the junior Physician to convince & answer patient's questions.

Patient is a fair, obese lady who talked continuously and expressively during interview. She comes from a rich, well-educated and close knit family. Her life since beginning is classy & bossy. Her Father, a dashing & commanding Income Tax commissioner was her role model. It was very clear from her interview, that she has tremendous attachment for her family which leads to anxiety & irritation. She never tolerates anything against her family members. She is very sensitive & weeps immediately for small matters. During interview also she wept when she was narrating about her work. Several times she dominates on others. She has stage fright. As a child & adolescent she had fear [2] of ghost, thieves, and murderers (Had hobby of reading mystery books & watching horror serials). She depends on her husband even for small decisions. She has aspirations to do something different & establish an identity for self. But has no concrete actions in this direction! Anxiety & worries in her mind increase her knee joint pains.

CHARACTERISTIC PHYSICALS:
Thermals - C3H2
Obesity, Flabby
Soles cracks <+ winter
Craving - fried[3], spicy[3],
Aversion - sweets, ice-cream[2],
< B. Menses – breast heaviness ++. Pain ++.
Considering all the above data *Calc-carb* & *Kali-carb* came up for differentiation.

PLANNING & PROGRAMMING

- Susceptibility – Moderate
- Sensitivity - High (mind level)
- Phase - Structural Irreversible
- Fundamental Miasm - Syco-Tubercular. (Considering F/H & P/H & physique of the patient)
- Dominant Miasm – Sycosis (Osteoarthritis of knee with essential Hypertension)

FOLLOW UP

Treatment started in Oct 2002 with *Calc-carb* 200 single dose weekly. It was given for 2 weeks, without any improvement. Patient came with lots of anxiety & irritation. Then again we studied the whole case plus patient's behaviour in the hospital till now & gave *Kali-carb* 200 single dose. Later *Thuja* 200 was introduced as an intercurrent along with main force. Still initially the improvement was slow. After gradually increasing the repetition of constitutional till QDS patient showed 70-80% improvement. In this case obesity is the main barrier in improvement. Patient did not follow proper dietary restrictions or physiotherapy exercises.

CASE NO 3

PRELIMINARY INFORMATION

Mrs S G a short, obese, 59 yrs old married
Mother expired when pt 4 years old. Father expired 1975, Step mother, Brother - 1 Stepsisters - 2
Husband – retired, Sons – 2, Daughter - 1 expired (Rheumatic Heart Disease)

CHIEF COMPLAINT

Pain/ swelling hands & feet since 17 yrs, pain/ swelling IP joints since 2 ½ yrs, pain/ stiffness / tenderness, swelling with inability to form fist. Pain / stiffness knees since 12 years.

PHYSICAL EXAMINATION

Tenderness along the medial aspect of both knees with crepitus ++, halux valgus Lt. > Rt.

INVESTIGATIONS - ESR was 55. RA. Nonreactive, Uric acid – 4.3
Bilateral involvement of small joints and high ESR indicated that the case was not a plain case of OA.
So **Orthopaedic Opinion sought:** His findings were as follows – Polyarticular, distal > proximal joint in-

volvement with pain, stiffness & swelling. Bilateral Lt > Rt halux valgus, PIP & MCP joint synovitis & stiffness. Subtaloid & mid tarsal joints mild swellings. Bilateral knee medial side tenderness, prominence and terminal flexion painful, hand grip weak.

IMPRESSION: OA knee & RA

REMEDY SELECTION:

When patient entered the consulting room she appeared to be a confident lady. During the interview her attachment to her family, anxiety regarding her children's future (Sons not educated, *Rikshaw* drivers) was evident. Old memories tend to bring tears in her eyes. The life was hard due to early demise of mother, illness of step mother, discontinuation of studies due to early responsibility of running the house & poor financial situation with lack of educational facilities. But she adjusted well to all these stresses. She wept for a while when she recounted about discontinuing studies & while narrating about her daughter's death, thus showing her emotional side. But patient described herself spontaneously as a bold & tough person having good sustenance. She had maintained good-inter personal relations even with DIL. There was assertiveness in her statements, which could not be overlooked & though *Kali-carb* was the initial impression of the primary physician, *Calc-flour* was prescribed based on the following totality-

Bold, Tough, Good sustenance.
Adjusting nature.
Degenerative changes.
Modalities- < initial motion > continuous motion.

PLANNING & PROGRAMMING

Susceptibility – Low to Moderate (No characteristic form despite complaints since 17 years)
Sensitivity – Moderate
Phase - Structural irreversible
Dominant Miasm-Sycosis (slow evolution of the complaints)
Fundamental Miasm–Tub–Syph (F/H Diabetes, cancer P/H menorrhagia - Hysterectomy)

FOLLOW UP

Treatment was started in November 2000. *Calc-flour* 30 3P was started with, followed by multiple doses. *Thuja* was released as an intercurrent infrequently. Over a period of time *Calc-flour* was made 200 & later released in multiple doses. Within a period of one year patient was 80% better (Subjectively as well as objectively) in her joint complaints. She was able to walk more freely, could form a fist though not tightly. There was ease in performing her daily activities. With 80% amelioration in her complaints she came infrequently for medicines. (She last reported in July 2003) Overall she was satisfied with her improvement on Homoeopathic medication.

CASE NO. 4

Preliminary Information

Mr RN 58 years, married, retired businessman, Muslim

CHIEF COMPLAINT

Bilateral Knee pain, dull aching, since 1 year. Swelling. Morning stiffness. Cannot stand up for 5 minutes. Limping gait. Has to use cane.

ASSOCIATED COMPLAINTS

Obesity, Hypertension with Dyspnoea on exertion on allopathic Rx, Diabetes on Glycomet 500 BD (Both asymptomatic)

PHYSICAL EXAMINATION

Warmth & swelling both knees
Crepitus Rt > Lt. Varicose veins + .Short & obese, Weight 116 Kg

INVESTIGATIONS

X-Ray knees - Bilateral joint space reduction with osteophytes++, loose bodies seen.
The patient had brought a big files with all blood tests (lipid, renal, liver profiles, thyroid function tests etc),

USG, 2D-ECHO, Venous Doppler study of lower limb etc. All were normal.

DIAGNOSIS – Tri-compartment OA with obesity with hypertension, NIDDM & varicose veins

REMEDY SELECTION

Patient has no child and the couple has led a retired life since many years. Patient was a good student but left his studies early to support father's business of grocery shop as the servants were dishonest. Later he started his separate business with the help of Rs 2200 provided by his father (quickly repaid) and soon prospered. He worked hard from 1963 till 1985. He owned a number of shops. Later he gave the shops on rent & presently earns Rs 25000 per month through rent. Deeply religious, Namazee, Hajee. Chairman of the committee established to build a Masjid which will bear his family's name.

Calm, Timid
Conscientious – about making payments in time
Anticipatory anxiety
Image conscious
Responsible
Obstinate
Dreams–dead, work, meeting relatives
Craving: Fish3
Perspiration stains yellow, offensive++, odour like tea
Chilly

PLANNING & PROGRAMMING

Susceptibility – Low (No characteristic form in any complaint)
Sensitivity – Moderate
Phase – Structural irreversible
Dominant Miasm – Sycotic

FOLLOW UP

Treatment was started on 8th May 2002 with *Silicea* 30 3PHS. The patient showed steady improvement at general as well as sector level. His energy levels improved. Need for purgatives disappeared. Oedema feet improved. Knee pains were relieved to more than 50% & he stopped taking NSAIDs. He could loose 9 Kg. Antidiabetic dose was reduced & Blood sugar remained normal through out the treatment till date. Later *Sil* was hiked to 200→ 3PHS/wk to daily doses till date. So far no intercurrent has been given.

CONCLUSION

The cases presented above demonstrate the role of deep acting constitutional medicines in treatment of osteoarthritis. Majority of the cases fall under Sycotic miasm. Hence role of *Thuja* as an intercurrent is commonly seen. In some patients Osteoarthritic Nosode 30 has been used as an intercurrent. The role of acute/ sector remedies (E.g. *Bryonia, Rhus-tox* etc) appears limited to acute exacerbations with synovitis.

Study of patient as a person is as important in cases of OA as in any other case. We have to appreciate importance of psychosomatic correlations even in cases of advanced irreversible degenerative pathologies.

The four cases presented above indicate variations in posology based on susceptibility, sensitivity & degree of pathology. We could see prolonged remission following single dose of constitutional remedy and other cases demonstrated the need for frequent repetition of constitutional up to QDS with significant palliation. Use of biochemic remedies (eg *Calc-flour, Mag-phos*) in decimal potencies (6X or 12 X) has proved valuable in some cases without clear constitutional indications or in cases of non-registration of constitutional.

Importance of physiotherapy & diet regulation for weight reduction is important. But in the rural set up at Palghar where most of the patients belong to the low socio economic strata and are daily wage earners, to recommend appropriate exercise is difficlt. Swimming facility is not available. Even convincing patients to go for daily walks is a difficult task as most of the patients give reasons of time constraints or uneven roads. Lack

of motivation a major factor.

It is noteworthy that despite lack of physiotherapy we are able to see significant palliation in 60 – 70 % of OA patients with the help of Homoeopathic treatment. Homoeopathic treatment is cost effective & safe as it does not have complications associated with NSAIDs.

Reference Readings:
Diagnosis & nonsurgical management of Osteoarthritis by Kenneth D Brandt
Kelly's Textbook of Rheumatology
Manual of Rheumatology, Editor: Dr Pispatti
Principles & Practice of Homoeopathy by Dr ML Dhawale
ICR Symposium Volume, Editor: Dr M L Dhawale
ICR Operational Manual, Editor: Dr Anand R Kapse

❑

Homoeopathic management of disorders of Lumbar inter-vertebral discs

In aphorism No 3 of 6th edition of Organon of medicine, Dr Hahnemann says that: The homoeopathic physician should have following knowledge in order to achieve IDEAL CURE.

(1) Knowledge of disease, indications.
(2) Knowledge of medicinal powers.
(3) Choice of the remedy, the medicine indicated.
(4) Proper dose. and
(5) Obstacles to recovery.

So, here the first point explained is of very much importance while dealing with Lumbar Intervertrebral Disc Disorders i.e."KNOWLEDGE OF DISEASE , INDICATION"

The sentence is divided into two parts:

1) KNOWLEDGE OF DISEASE: ie understand the pathogenesis and pathology, so we can handle the patient better.

2) And later on how the same disease expresses in an individual ie (KNOWLEDGE OF PATIENT-INDIVIDUALISATION.

So, first let us understand the important DISORDERS OF LUMBAR INTERVERTEBRAL DISCS.

Two important disorders of Lumbar inter-vertebral discs are: 1. Lumbar Disc Prolapse
2. Lumbar Spondylosis

HOMOEOPATHIC MANAGEMENT

Generally in homoeopathic practice, clinical examination, clinical diagnosis, laboratory investigations and special investigations are overlooked by a number of homoeopaths. Only symptomatic approach is used by them and that's why even the best Similimum fails as case is treated without understanding of disease pathogenesis. No proper auxiliary methods are tried. That is why I always use the word **HOMOEOPATHIC MANAGEMENT** than Homoeopathic **Treatment.**

We will discuss the management of above discussed Lumbar Inter-vertebral Disc Disorders.

(A) Acute prolapsed lumbar inter-vertebral disc with lower radiculopathy.

In acute phase:

(1) Immediate Hospitalisation and Continuous Lumbar Traction or Complete bed rest depending upon severity of pains (for 4 days to 10 days)

Dr Prasad Rasal
Sai Swami Homoeo Clinic, Indira Nagar Gali No 1, Sangamner 422 605
Phone: (02425)223913, 226872.
Mobile: 9890168872,
Email: drprasadrasal@rediffmail.com