SLE - Our Lessons learnt

Truth is supreme harmony & supreme delight. All disorder, all suffering is falsehood. Thus it can be said that illnesses are falsehoods of the body and consequently, Doctors are soldiers of the great and noble army, fighting in the world for the conquest of truth-
'The Mother' Sri Aurobindo Ashram, Pondicherry.

SLE or Systemic Lupus Erythromatosis is an autoimmune disease characterized by diverse manifestations involving almost all the systems of the human organism. The tissue damage resulting from the pathogenic subsets of auto-antibodies and immune complexes exhibit the vast destructive potential of this disease. (Femaleness is clearly a susceptibility factor and individuals are genetically predisposed to SLE). Under the influence of active psoro-sycotic and syco-syphilitic miasms, more than often triggered by environmental challenges, the afflicted individual may develop a number of clinical syndromes that fulfill the diagnostic criteria for SLE.

CLINICAL MANIFESTATIONS:

At the onset, the disorder may involve only one organ system or may start with systemic symptoms like fatigue, malaise, low to moderate fever, anorexia and weight loss. As mentioned earlier the disease engulfs all organs but we mainly focus on the musculo-skeletal manifestations. For the disease to start, it often requires a triggering event (an exciting stimuli)-may-be an emotional trauma, vaccination, a physical insult, or a simple viral infection. The severity varies from mild and intermittent to persistent and fulminant stages. Most patients undergo exacerbation's interspersed with periods of relative quiescence. True remission occurs in 20% cases. Almost all patients experience arthralgia's, myalgias and arthritis. The pain may be localized or fleeting and out of proportion to the physical findings. Generally symmetric involvement of small joints of hands and feet, knees, wrists (like Rheumatoid arthritis) are seen but joint deformities like swan neck etc are unusual. Subcutaneous nodules and myopathies are common. A frequent pathology is ischaemic necrosis of bones due to the vasculitis of nutritional vessels of large joints especially when patient is on high doses of steroids.

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DIAGNOSTIC CRITERIA FOR SLE:

1. Eruptions - fixed erythematous, macules or papules on the face (butterfly shaped) - raised red patches with scales any where on the body.
2. Skin - sensitivity to light.
3. Recurrent ulcers in the mouth and pharynx.
4. Recurrent Pain, swelling & effusion of 2 or more peripheral joints (non-erosive arthritis).
5. Serositis - Pleuritis, Pericarditis and / or Effusions, Dropsy.
6. Urine - albumin > 0.5 gms /day, persistent or intermittent.
7. Convulsions.
8. Haematological abnormalities.
9. Positive LE cell phenomenon, Anti DS DNA[1] , Anti SM antibodies, VDRL positive.
10. Anti Nuclear Antibodies-Rising titers

Of the 10, any 4 or more positive criteria in one clinical setting at the same time, may point to the nosological diagnosis of SLE.

INVESTIGATIONS:

Apart from the routine haemogram, ESR and urine examination, the more specific investigations demand mention. A variety of auto antibodies (13 in number)

can be found in SLE. Important ones are
1. Anti Nuclear Antibody (ANA) -98%
2. Anti DS DNA Antibody - 70%
3. Anti-SM Antibody - 70%
4. Anti Lymphocyte Antibody- 70%

GENERAL PRINCIPLES OF MANAGEMENT:

The assessment of such patients always starts with a rational homoeopathic approach directed purposefully towards a better and clearer understanding of the patient, the underlying disorder and the environment surrounding him. It rests on the fundamental bedrock of an incisive clinical history and meticulous physical examination along with holistic investigative means. Elucidation of pathological symptoms from the case history is of supreme importance to arrive at a correct miasmatic remedy or a block remedy in a chronic case. Such an outlook aids the homoeopath in searching for a drug with abundant organotropism for the particular degenerated organ in the patient.

This is directed towards answering the following questions.

1) Do the clinical events reported by the patient truly represent SLE?
2) Is the life- history taken complete in all respects?
3) Is the patient compliant to homoeopathic methods of working?
4) Is the best selected remedy a true similimum or a partial one?
5) Is the constitutional anti-miasmatic medication\remedy given, a correct one?
6) If yes, then are the potency and repetition of doses appropriate, in respect to the patient?
7) Is there a necessity of investigation of a potential surgery?
8) Is the patient on any other treatment (Allopathic anti-convulsants, Ayurvedic, Unani) without the knowledge of the treating homoeopath?

SOLUTIONS

In our clinical set up, we have learnt quite a few lessons in managing patients of SLE.

The 17 point solutions are:

1.The management has to be strictly individualized for every patient. It is preposterous to mention a remedy or treatment for the nosological labeling of SLE in homoeopathy, since our therapy deals with the patient and not with the disease.

2. Disease activity is assessed clinically and by using laboratory parameters. The disease activity refers to reversible manifestations while damage refers to non-reversible changes for more than 6 months.

3. Repeated ANA testing has no clinical utility since these titres point towards the disease but do not correlate with the disease activity.

4. Since SLE is a multi-systemic disorder, it is clinically important and viable to categorize the patients into those with major organ and minor organ involvement as well as those with disease ultimates and their manifestations.

5. Patients have to be prepared for receiving long term homoeopathic care. This is done by educating them regarding the mode of therapeutics, disciplining the lifestyles so as to eliminate the possible exciting and/or maintaining causes.

6. Avoidance of exposure to direct sunlight, advice on contraceptive measures and self medications with analgesics/ steroids should be explicitly outlined to the patient.

7. Associated problems as systemic hypertension, dyslipidemia, electrolyte imbalance, seizures, anaemia etc. need simultaneous attention.

8. No intervention of pregnancy is generally needed.

9. Majority of already diagnosed patients who come to a Homoeopath, are on immuno suppressants like steroids, cyclophosphamide, chloroquine, azathioprine etc. When these patients demand homoeopathic care then gradual tapering of the above drugs with replacement of so called musculo-skeletal specific dynamic remedies (acute palliatives and complimentaries) should be followed.

10. It is wise to know that SLE is not a benign but an aggressive disease. Hence, management too should be

planned, methodical and not empirical. Attention should also be given to active physiotherapy.

11. It is a sweeping statement to say that the indicated remedy works in the patient especially in a progressively advanced pathological condition where the "drug disease" symptoms and disease symptoms are mixed up in the patient.

12. In the treatment of such chronic and recurrent disorders one should keep drug relations in mind. Lack of this knowledge lands the physician in failures or in spoiling the case with frequent antidoting of the inappropriately given drugs.

13. Very frequently homoeopathic treatment has to be started with drugs like *Nux-vomica, Ad-cortex, or X-ray* etc. to remove the bad effects of immuno suppressants.

14.It is worthwhile to consider 'Ailments From' which frequently give a clue to start the line of treatment like A/F Vaccination, mental shock, has never been well since puberty, etc.

15. Daily diary maintenance of routine events is a compass for selection of the second prescription.

16. Deep acting nosodes or constitutional anti-miasmatic therapy should be administered only when the disease is in its remission state.

17. Millesimal potencies work wonders in acute conditions and can be repeated often. But they should be used with care since it is generally seen that shifting back to centisimal or decimal scale of the same medicine in the same patient when called for, fails to give the desired results.

*(**Co-ordinating Editor:** The single criteria for confirming diagnosis of SLE; SLE can not occur with negative / normal ANA)* ❑