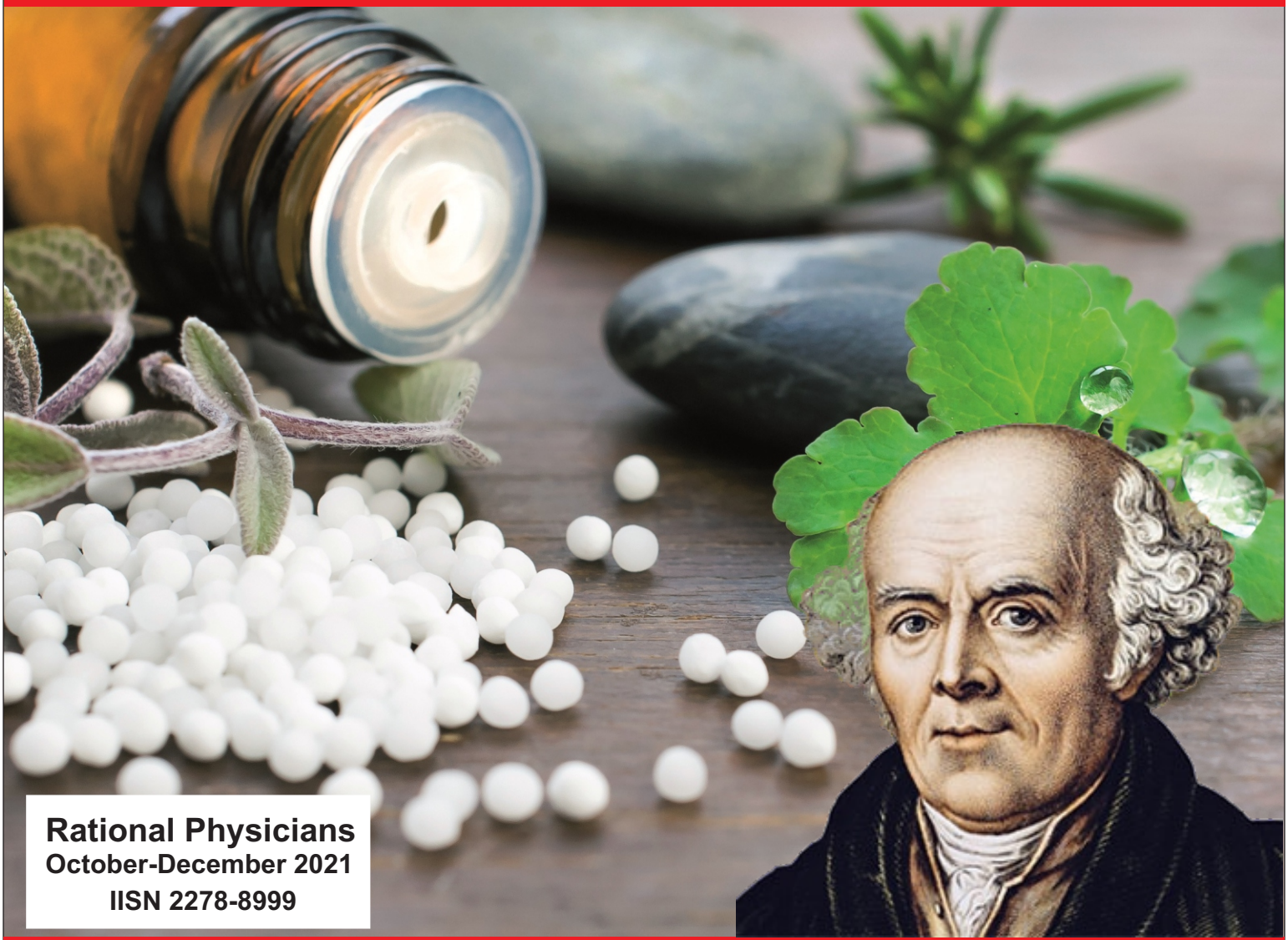
INDIAN INSTITUTE OF HOMOEOPATHIC PHYSICIANS

October - December 2021

RATIONAL PHYSICIANS



Rational Physicians
October-December 2021
IISN 2278-8999

Photo Credit: austin-chan-ukzHIkoz1IE-unsplash.com

JOIN

THE INDIAN INSTITUTE OF HOMOEOPATHIC PHYSICIANS

www.iihp.in

KEY NOTES
The Editorial

Chief Editor: Dr M A Rao
raocghs@gmail.com

First of all wishing you great festive celebrations as the festive season is approaching fast and we hope to reach you just in time. Timely action is very important whether delivery of medicines, dissemination of information or bringing out our journal, as we all know a stitch in time saves nine. This brings us the need to set up deadlines for the publication of Rational Physicians. Although we have been reiterating the need for good articles in the groups, there were delays or last minute requests. In this issue we have brought out deadlines as well as the guidelines for sending the articles. We have been receiving good articles but their presentability was poor. An article needs good storyline to make it interesting to read, with enough facts and records to avoid any criticism. Review it like a critic before sending it for publication, make the necessary tweaks and we hope all of us including you will be satisfied with its quality. It is our endeavour to bring out the best quality in every aspect of homoeopathy and our journal should reflect this philosophy.

It takes a lot of effort to bring out this journal, our effort and that of our contributors should be applauded or criticised or even better there should be suggestions to improve the quality of the journal as well as the IIHP in general. We fail to understand what caused an utter lack of reaction as we did not receive a single letter to the editor since last issue of the journal. Write a letter today only to broaden our understanding of the issues involved.

I am happy our journal has been received well by the student community as we have many articles from student contributors sharing their moments of 'Aha' with homoeopathy, in addition there are many articles by teachers and stalwarts. Feeling happy to cover the breadth of homeopathy.

It is saddening that in the recent times homoeopathy has lost may important persons and the latest is the sad and unexpected demise of Dr Anurudh Verma. A great homoeopath and a greater human being, his contributions to the cause of homeopathy are unforgettable. I hope his life and works shall inspire young homeopaths for long time to come. IIHP family mourns his untimely demise.

We hope you will find this issue of Rational Physicians informative and useful. Waiting for your feedback.

Dr Sudhanshu Arya
Managing Editor
homoeospan@yahoo.com

Dr Sudhanshu Arya
Managing Editor
homoeospan@yahoo.com

Communication
Editor
Rational Physicians
403, C-06 Pioneer Regency
K T Nagar, Nagpur – 440013
Maharashtra, India
raocghs@gmail.com

CONTENTS

October - December 2021

RATIONAL PHYSICIANS

News & Events

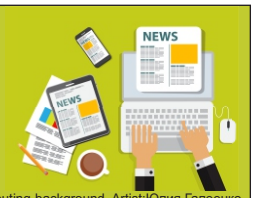


Image Credit: https://www.vecteezy.com/vector-art/2934804-online-news-vector-illustration-flat-computing-background. Artist:Юлия Ганеенко

FREE HOMOEO MEDICAL CAMP

On 31st Oct'21 IIHP-VISAKHA (AP state) doctors have conducted a free Homoeo Medical Camp in Chittivalasa, Visakha district jointly organized with the cooperation of Friends association. Dr.P.Chandra Sekhar Rao, Dr.Raja Srikanth have treated around 200 patients during camp. Nearly six Homoeo medical college students from MIHS college, Nellimarla, well assisted and helped in dispensing medicines for one month. Pioneer company and Friends association's Volunteers took all safety measures and sanitization to the crowd. Over all it was well organized event during this pandemic. Reported by IIHP-VISAKHA PRESIDENT Dr.P.Chandra Sekhar Rao, and General Secretary Dr.Raja Srikanth.

On 31 st October 2021 homoeopathic fraternity lost a real friend with the untimely demise of **Dr Anurudh Verma** of Lucknow. He was former executive member of the Central Council of Homoeopathy. He studied at National Homeopathic Medical College and Hospital, Lucknow and served as a senior medical officer. IIHP expresses condolences on the loss of this veteran homoeopath.

Letters to the Editor

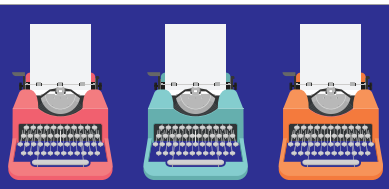


Image Credit: https://www.vecteezy.com/vector-art/1437744-vintage-typewriters-in-different-colors-set. Artist:illustration4stock224427

"Numb"

"Coma"

"Indifferent"

Not a single letter in 3 months!

What Is Your Rubric Dear Reader?

"Absorbed"

"Busy"

Eagle Soars Again on Aconite

Photo Credit: Dmitry Grigoriev@www.unsplash.com

Eagle Soars Again on Aconite

Dr. Tapas K Kundu
[Prof. and Head of the Department of Medicine] and Dr. Anum Kagdi
Motiwala (National) Homoeopathic Medical College and Hospital, Nashik, Maharashtra, India

It was 27th May 2014, around 1.30 pm, there was a heavy storm at Nashik. The climate had suddenly changed from exhaustive May heat in the morning to a threatening storm. Nothing was at its place- living as well as non-living. Trees fell, houses collapsed and roads were cleared off the vehicles. Soon it started raining heavily with hailstones. Amidst enjoying the climate, we noticed a large brown colored bird lying on pavement of society in a state that confused us whether it's alive or dead. We hurried downstairs and to our utter surprise, it was an eagle – live with its beak wide open lying flat on ground, drenched completely in rain and the only sign of its existence was its blinking eyes.

There are about 60 species of eagle which belongs to the family Accipitridae. Eagles are large powerful built birds of prey weighing 500 gm to 6.7 kg with heavy head and beak, extremely powerful eyes having up to 3.6 times human acuity which enables them to spot potential prey from very long distance also. Due to their size and power, eagles are ranked top of food chain as apex predators. In brief, eagles are admired world over as living symbol of power, freedom and transcendence.

Being aware of its power, we dared to hold the eagle, took him to a dry place and first served him water. With its wide open mouth, it started gulping water from the mug in large quantities. Then its wings were opened and head examined to see any visible injury to the bird. To provide some kind of medical help for poor, we got the number of forest resource working in Nashik from Justdial.com. Unfortunately we were not able to connect to the said number. To rescue the eagle, we thought of trying homoeopathic medicines instead of just having pity on the helpless creature.

After quickly analyzing the entire scenario, 2 drops of Aconite 30 were put on his tongue with help of dropper and left him resting in dry place. We also thought of providing external heat but as there was no electricity, could not help him further. We were surprised to observe that within 10 minutes, the eagle was able to stand on its feet with its beak properly closed. In another few minutes it had spread its wings wide and was able to defend itself as now it was not allowing anyone to come near him. Later it started walking along the pavement road for a considerable distance and then flew away.

The totality was taken as: causation from sudden change of temperature and draft of air, sudden appearance of complaints, drinking large quantity of water indicating which pointed Aconite and thus proved to be the exact similimum which rescued the eagle.

Hence this incidence is evidence to the action of homoeopathic medicines on dynamic plane not only on humans but also on animals, and which supports the truth that homoeopathic medicines works and not a placebo effect.

Triumph Of Homeopathy Over 'Mucormycosis'

Photo Credit: Mathew-Schwartz@www.unsplash.com | Image for Artistic Presentation Only

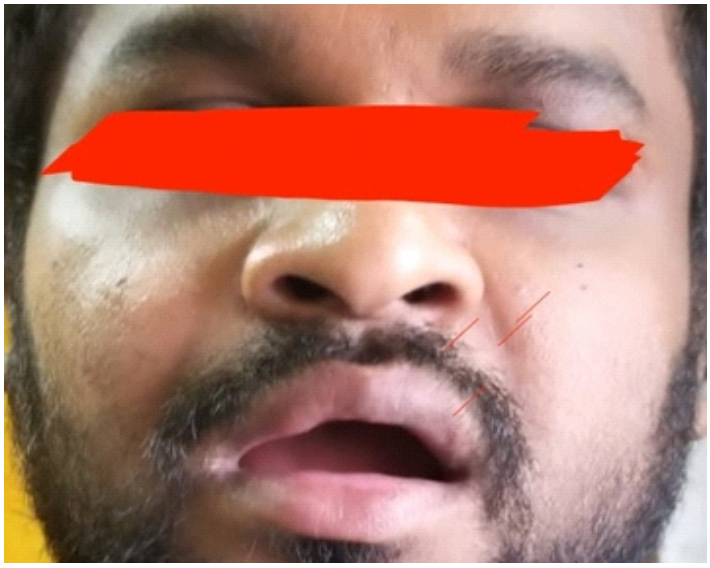
Triumph Of Homeopathy Over 'Mucormycosis'

Dr.Indira Priyadarshini
BHMS,CGO,FIDM,Hon. Doctorate holder –IODP-UN
Mb: 6303856556
dr.priyadarshinipadala@gmail.com.
Dr.Priyadarshini Multi Specialty Homecare

A male patient aged 32 years ,a known case of Rhino-cerebral mucormycosis contacted over phone call on 21/6/2021at 8pm,with a reference from an old patient with faith in homeopathy at a MRI scanning center presenting with symptoms of nausea, headache, vomiting, heaviness and throbbing in eyes and head. After conversation and examining the MRI reports, suggested a single dose of Belladona-200 to be taken and asked him to visit in person.

Symptoms:

- On 22/6/2021, he visited in person, with
- A mild relief in headache,
- Persistent nausea, vomiting, giddiness
- Mild Oedema, excruciating pain in right temple, infra orbital and maxillary region, pain in teeth better by warm application
- Pruritus and eruptions on back
- Blood sugar levels at 200-300 range (was on 24iu insulin morning and 11iu insulin night)
- He was unable to take food sight of food causing nausea
- Feeling restlessness, weak and debilitated, easily exhausted
- Was still, having central venous catheter.
- Mind – Restless, Great fear, fear of death, feeling anxious and worried. Suicidal thoughts
- All symptoms aggravated tonight along with anxiety and thoughts making him sleepless.(Was using sleeping pills and antidepressants)



Case History

Patient was affected with Covid19 50days back and underwent allopathic treatment.

Case History

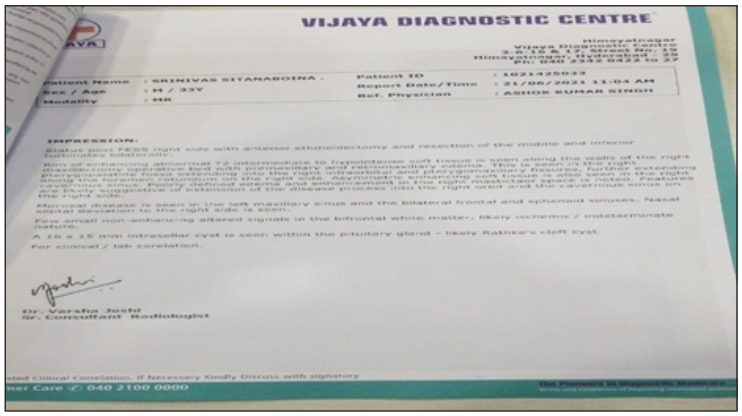
Patient was affected with Covid19 50days back and underwent allopathic treatment.

After 8 to 10 days of treatment he noticed Paraesthesia along right infra orbital and maxillary region. He was suggested to consult a neurologist, who suspected a fungal infection and referred him to a ENT specialist, where in MRI confirmed Mucormycosis on 06/05/2021.Then patient was admitted in a corporate hospital and underwent treatment with surgery, Amphotericin-B and Posoconozole for 40days.

- Within a week of discharge recurrence was suspected and referred for a MRI repeat.
- 21/6/2021 MRI confirmed such recurrence with wider spread and ENT specialist advised for another surgery i.e. Maxillectomy.
- Patient is also a known hypertensive since 2years
- He was always anxious and worried, over thinking prevailed.

INVESTIGATIONS:

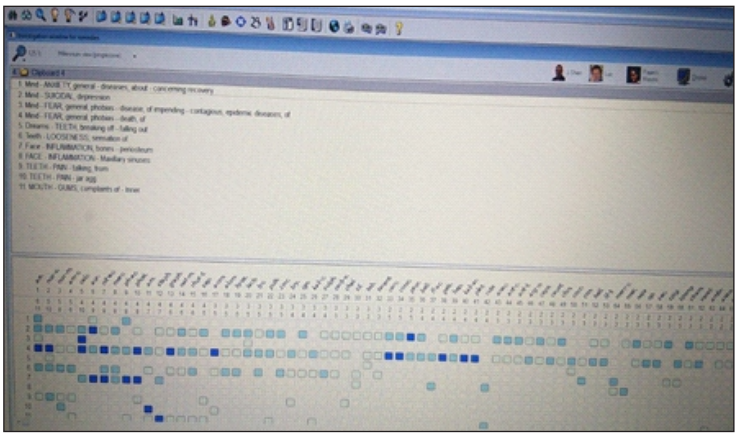
MRI Reports: 21/6/2021



Blood Reports : 23/6/2021

CRP 61.9, LFT – SGPT -49.2, SGOT-67.5, SR.CR 1.7, RBS 272

Repertorial totality :



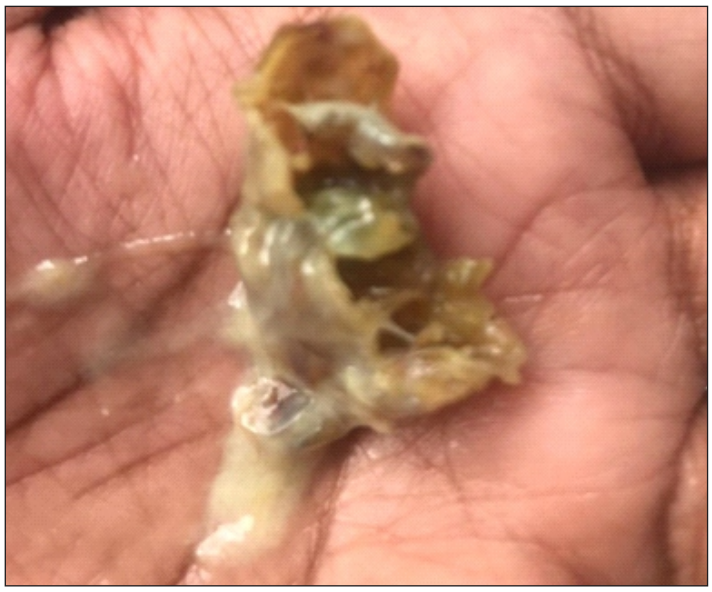
Rx

22/6/2021

Rx Ars.alb200 for 1week

After 5days Pruritus subsided, nausea & vomiting subsided, was able to consume food and patient was feeling energetic and better than before, gained little confidence and went for CVC removal as I Suggested to take only homeopathy medication for mucormycosis. Also sleeping pills and anti-depressants were weaned off with placebo substitution.

- After 2weeks, swelling of eye and cheek subsided, pain in maxillary region and teeth persistent with sensation of looseness in teeth and dreams of tooth falling off.
- Continued with Ars.alb200 for one more week.
- Developed a foetid odour in nose and mouth was unbearable for patient himself with yellowish nasal discharge and discharge of blood with pus discharge in right molar teeth region. I gave Merc.sol-1M, followed by crust like discharge from nostrils and relief of symptoms after 3days.
- Gradually blood sugar levels were coming to control and suggested to reduce 2IU insulin per day by the end of 22days he was free of insulin doses.
- Patient was followed up for 60days and he was doing well.
- Recent biopsy confirms patient is free from any fungal infection.



AIG HOSPITALS

Patient Name : MR. SITANABOINA SREENIVAS
Age / Gender : 33 Yrs 5 Mth / Male
UHID : 2000306811
Patient Type : OP
Ref. Dr. [redacted]

Bill Date : 16-09-2021 17:53
Sample ID : AG2106673184
Sample Collected On : 16-09-2021 18:02
Sample Received On : 16-09-2021 19:03
Reported On : 17-09-2021 11:37

MICROBIOLOGY REPORT

KOH Mount for Fungal Elements

Specimen : Tissue
Site : Right maxillary sinus

KOH mount : Negative for Fungal Elements. [redacted]

End of the Report

Entered By : 10001749

DR. B. SUSHMA
CONSULTANT MICROBIOLOGIST
MD

Blood Reports: 2/9/21

CRP : 1.35

SR.CR : 0.99

HbA1C : 5.8

LIKHITHA'S
Diagnostics - Specialty Lab

TEST REPORT

Reg.No : DIL0076286
Name : MR.SRINIVAS
Age/Sex : 33 Years/Male
Referred By : SELF
Referral Dr : DR.INDRA PRIYADARSHINI

Reg.Date : 02-Sep-2021 /13:43
Collection : 02-Sep-2021 /13:45
Received : 02-Sep-2021 /13:49
Report : 02-Sep-2021 /16:55
Barcode : 2100157082

Clinical Biochemistry

GLYCATED HAEMOGLOBIN (HBA1C)

TEST NAME	OBSERVED VALUE	UNITS	BIOLOGICAL REF. RANGE
GLYCATED HAEMOGLOBIN (HBA1C)	5.8	%	Normal : < 5.7 Diabetes Mellitus : > 6.5 Increased Risk of Diabetes/Pre - Diabetes : 5.7 - 6.4
AVERAGE BLOOD GLUCOSE	119.76	mg/dL	90 - 120 - Excellent control 121 - 150 - Good Control 151 - 180 - Average Control 181 - 210 - Action Suggested > 211 - Panic Value

Comments: HbA1c might be increased in Diabetes .Correlate Clinically

Sample Type : WB EDTA

Please Correlate With Clinical Findings If Necessary Discuss
* This Is an Electronically Authenticated Report *
* Mark Indicated Parameters are Not Under The Scope Of NABL Accreditation*

Dr.Prathibha Rani.A
MD
Consultant Biochemist

**** END OF REPORT ****

Though I dealt with many other cases of black fungus successfully, this was a challenging case, due to fear and anxiety levels of patient and a wider spread of infection. Armed with homeopathy and a little courage coupled with regular intensive counseling of the patient, reassuring cure with strong faith in the system has brought this triumph.

I express my gratitude to Hahnemann and thanks to homeopathy for gentle and permanent cure.

Advertisement Rates

Rational Physicians-The Official Journal of
the Indian Institute of Homoeopathic Physicians
Applicable up to 15.12.2021

	Colour	
1.	Back Cover	Rs.10,000.00
2.	Front Inner Cover	Rs. 8,000.00
3.	Back Inner Cover	Rs. 7,000.00
4.	Full Page	Rs. 6,000.00
	Black and White [Other than covers]	
1.	Full Page	Rs. 4,000.00
2.	Half Page	Rs. 2,000.00

ROAD MAP

January-March 2022 Issue

The editorial team of the Rational Physicians solicits advertisements, articles, news and photos related to homoeopathy to be published in the forthcoming issue to be released in January 2022.

GUIDELINES

Kindly send all the material in soft copy to

The Editor, Rational Physicians

E-mail: raocghs@gmail.com

Please send images/tables/graphs /artwork separately from articles, with due credits & titles.

Please do not compress/resize images so that the resolution and sharpness of the images remains high. If need be use one image per mail or you can share your Google drive so that we may download images in highest resolution.

Please send your articles in Microsoft Word Document format not PDF so that editing is easier.

Only selected /approved material will be published

LAST DATE OF SUBMISSION

15.12.21

For the January-March 2022 Issue

Sterility

Single Rubric : Single Drug : Similimum

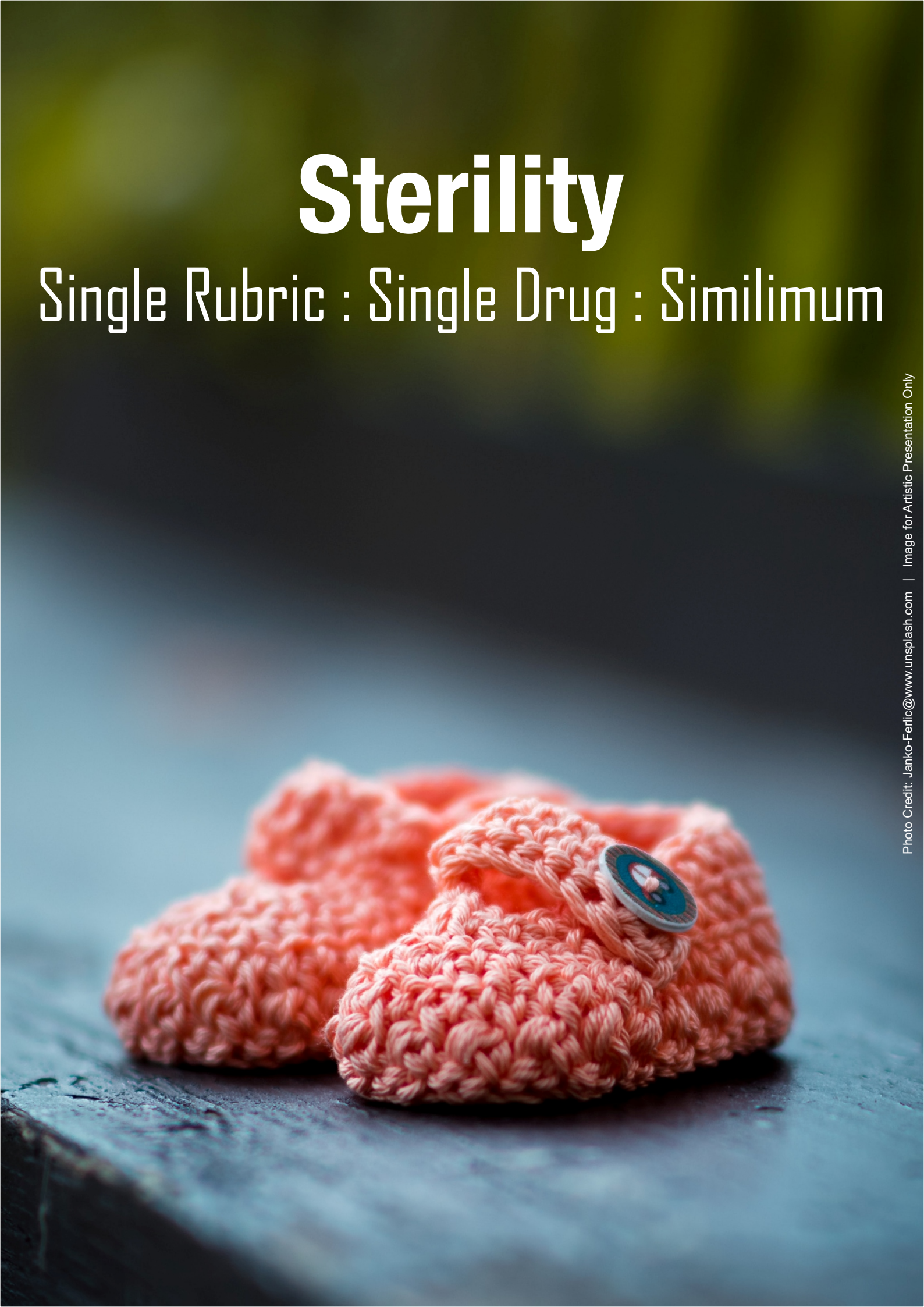


Photo Credit: Janko-Ferlic@www.unsplash.com | Image for Artistic Presentation Only

Sterility : Single Rubric - Single Drug - Similimum

Dr Lakshmi Kanth Ponnuru
Annapurna Homoeo Medicare
No 8, Sravani Apartment, Sivalayam Street, Satyanarayana Puram
Vijayawada, Andhra Pradesh
Mb: 9790733851
E mail: lakshmikanthponnuru@gmail.com

CASE DETAILS:

Female, 30 yrs old, software professional, married since 2014

First conception 2015 July got aborted due to lack of foetal heart beat.

2016 June second conception found as hypothyroid and diabetic, got aborted due to lack of foetal heart beat. D&C done.

2017 May, third conception aborted by tab Misoprost due to absence of foetal heart beat.

TORCH Test -

Toxoplasma G : IGG negative

Rubella : Doubtfully positive IGG

Cytomegalovirus test : Positive+

Anti phospholipid : Negative

Anti cardiolipin : Negative

Infection profile negative for HCV, HIV, S. RPA, HbsAg

Hba1C : 6.0, Homocysteine 12.7. Inj Clexane given to patient

PAST HEALTH:

She was a FT ND girl, Vaccinated, got once Anasa(anal excoriation as a child), Skin hyperpigmentation, Haematuria after puberty, Chicken pox during intermediate study and Chikungunya fever once.

H/O tooth filling for cavities

Tiny warty growths on Cheeks

GENERALS:

Cold weather could cause coryza

Can't tolerate hunger, cause headache often.

Likes Sweets and sour food

Dislikes warm and spices

Thirsty, cold water can cause sinus symptoms

Frightening dreams during pregnancies

WDPV menses before

MIND :

Sensitive moods

Religious

Cautious about money spending

Likes company

OBSERVATIONS:

Hypo pigmentation on right arm, right shoulder, and face since childhood

Dark circles around eyes

Lipoma growths on right forearms, left thigh too patient says

Haemorrhoids now and then

Hair loss on vertex

Dry lips peeling in layers

RUBRIC CONSIDERED:

Phatak repertory:

Females: who deliver, still born children: Cimicifuga

The single drug rubric.

What to give : lot of thought given to Single drug rubric to Constitutional drug.

Finally decided to try Cimicifuga as it's a clinically proven drug and three times of aborted history of absence of foetal heart can lead definitely to above rubric.

TREATMENT GIVEN:

Cimicifuga 30 weekly one dose

Pregnancy Test positive on 4th week

8 th week ultrasound sound scan detected PULSATING foetal cardiac node. Heart beating normally.

Cimicifuga continued weekly one dose till Third trimester.

Fall on abdomen caused ruptured membranes, hospitalized and went for emergency LSCS.

Male baby born and was kept in incubator for a month.

Now that boy is four years old.

Eagerly waiting for his sister to be born in few weeks.

THANKS TO HOMOEOPATHY.

HAIL HAHNEMANN.

NOTE FROM THE AUTHOR:

A very important rubric to consider in cases of Abortion history.

As modern technology advanced, you cant see above situation as mentioned in rubric. But older times, ultrasound sound not there, they couldn't found heart beat status like now a days. Thus the rubric to be applied carefully.

I have verified this rubric in another case also with history of one Abortion case where Gynaecologist could not found heart beat and advised D&C.

Second pregnancy also she said foetal heart beat is missing on 5 th week of pregnancy and given time one more week for observation. D&C again if next scan fails to find pulsations of foetal heart.

They asked my advice upon this. I suggested CIMICIFUGA weekly one dose. Two weeks after Heart beat found and she completed her first trimester and entered into 21st week of pregnancy.

Celebrated Baby shower function last month.

PHATAK REPERTORY:

FEMALES, Women, who deliver, still born children: Cimic.

Not Fit For The Surgery

A Case Of Osteomyelitis/Septic Arthritis/Abscess

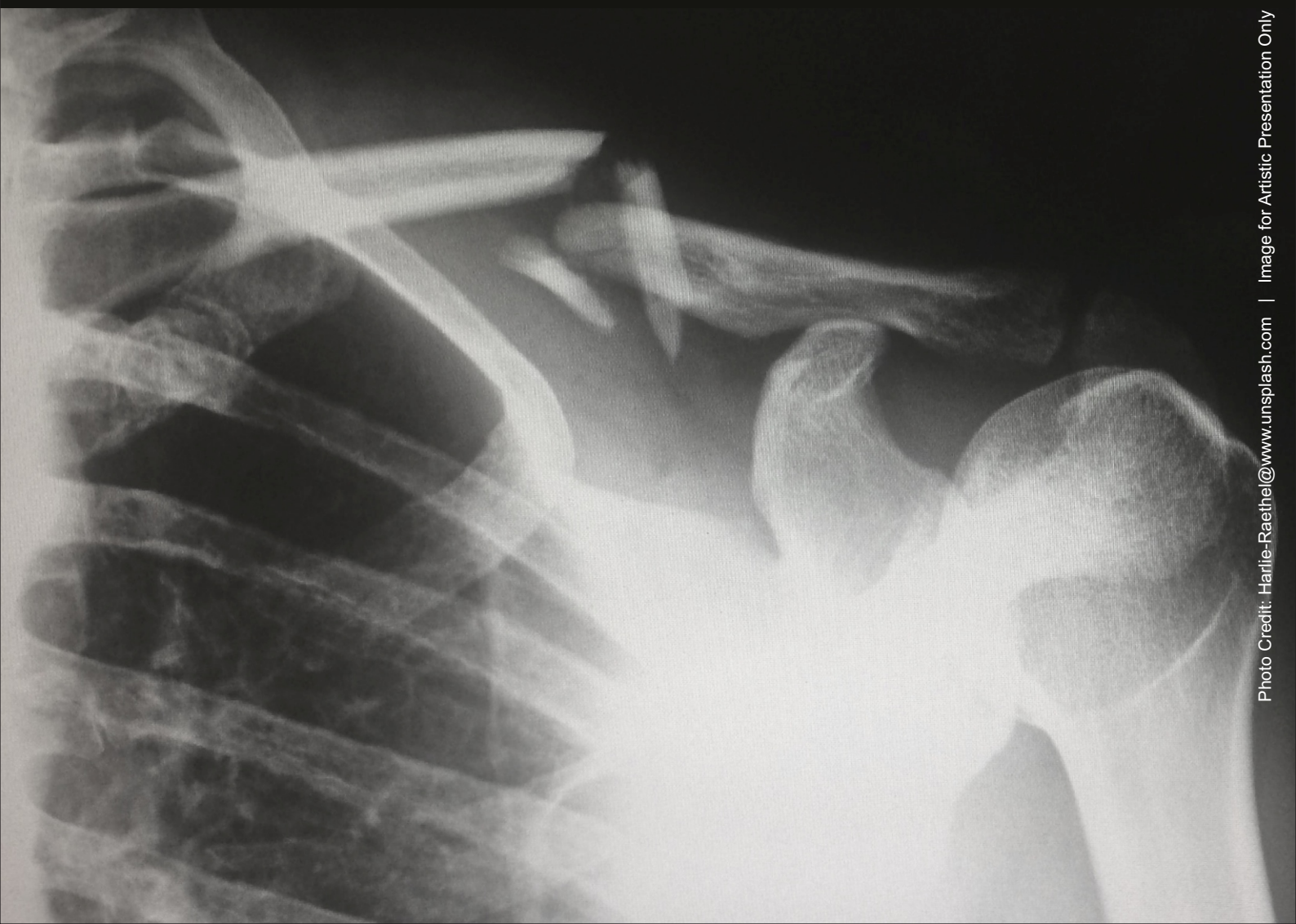


Photo Credit: Harlie-Raethel@www.unsplash.com | Image for Artistic Presentation Only

A Case Of Osteomyelitis/Septic Arthritis/Abscess; Not Fit For The Surgery

Prof. Dr. Mahesh K. Gupta M.D.(Hom.)
Senior Homoeopathic Consultant
Former Principal, Professor Organon of Medicine
V.R.H. Medical College & Hospital Gwalior M.P.
Chief Co -ordinator IIHP For M.P. State
Email-drmkguptagwl@gmail.com

Since the very inception of homoeopathic system of medicine millions & millions of difficult and complicated cases have been cured by many homoeopaths world over.

Homoeopathy has stood the test of time.

Potentiality and efficacy of homoeopathy can be verified in day to day practice.

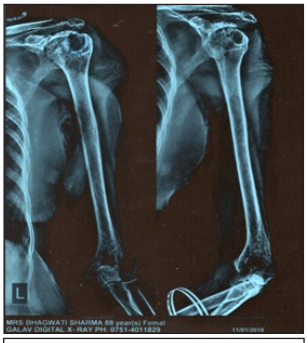
Homoeopathy offers very simple, sweet and safe solution for many difficult and complicated cases which are not amenable with the conventional medicine, provided we choose a logical and suitable approach for the case in hand

A90 years old female brought to us on 30th July 2018, presented with large swelling on left shoulder joint for the last 1 year had been on the antibiotics and painkillers.

- Pain < on movement and night.
- Ghabrahat off & on gases formation.
- Bowels constipated, has to take purgatives. Fever off and on
- Poor appetite, thirst less, liking sweets.
- Sensation of heat and chill both, depressed

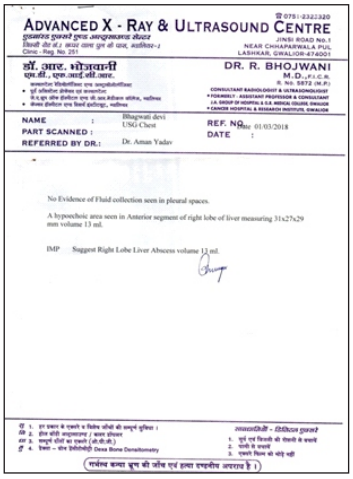
History revealed that patient was admitted in the G.R.M.C. hospital on 14th February 2018 there she was diagnosed as Osteolytic lesions proximal humerus left.

History revealed that patient was admitted in the G.R.M.C. hospital on 14th February 2018 there she was diagnosed as Osteolytic lesions proximal humerus left.



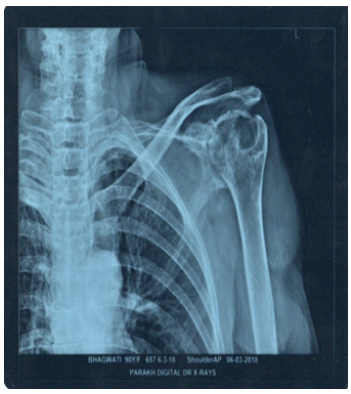
RADIOGRAPH (11TH JAN.18) - A radiolucent area seen in head of humerus bone. Shoulder joint space reduced, Soft tissue swelling seen.

MRI OF LEFT SHOULDER DATED 13/1/2018 REVEALED Severe loss of shoulder joint spaces seen with bony impingement and early sign of fibrosing ankylosis. Multiple lytic lesions seen in humeral head and glenoid cavity with diffuse erosions in the articular surface, diffuse marrow edema, joint effusion and large thick walled extra articular collection along the outer surface of humeral head containing debris like material. Suggestive of possible neuropathic joint disease Vs Septic Arthritis like Tubercular joint disease.

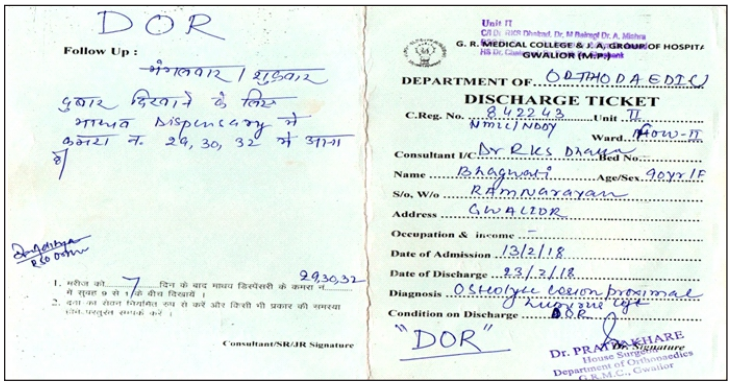


USG ABDOMEN/CHEST (1ST MARCH 2018) - No evidence of fluid collection seen in pleural spaces. A hypoechoic area seen in anterior segment of right lobe of liver measuring 31×27×29 mm, volume 13 ml.

IMP- suggest right lobe liver Abscess, vol. 13 ml.

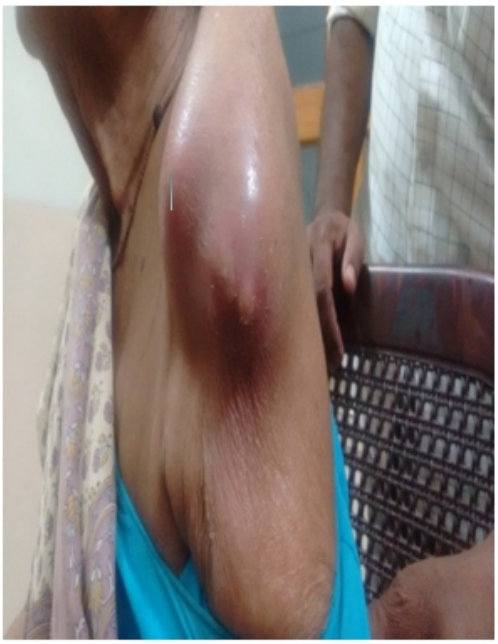
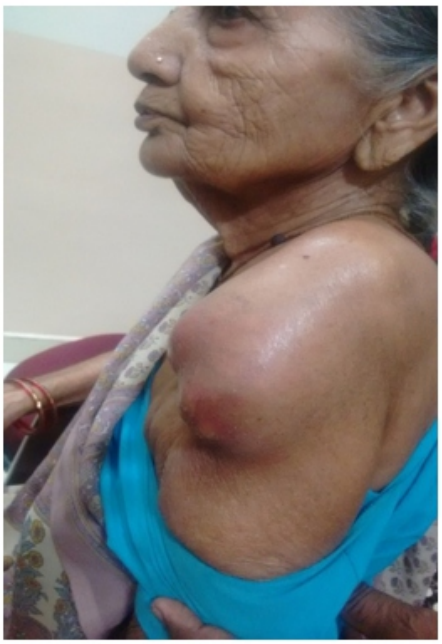
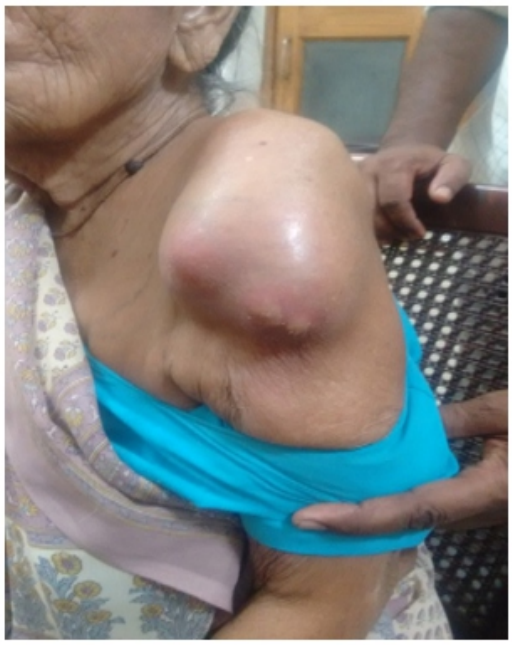


RADIOGRAPH (6TH MARCH 18) – A radiolucent area seen in head of humerus with destruction of articular margin. Articular margin of shoulder joint is irregular, soft tissue swelling seen in upper third of arm



The patient was planned for surgery but could not find fit for surgery hence discharged on 23rd February 2018.

No option left for patient, somebody has referred the case to us

Since the patient was on allopathic drugs, for the last one year and no significant peculiar symptoms were found, we have to depend on few characteristics and pathological findings, indicating for miasmatic base.

- Suppuration, abscess – slow
- Carries of bones, destructive process
- Sensitivity for both heat and chill
- Stinging Pain with sleeplessness
- < on movement, unable to move arm in any direction
- < at night, much depressed

Rx

MERC SOL 200

4 times a day for fifteen days

After 4-5 days, son of patient reported that pus is oozing out, pain is relieved. Advised nothing to do except cleaning and washing wound gently with warm water and cotton. continue the same medicine.

1ST FOLLOW UP – 11 AUGUST 2018

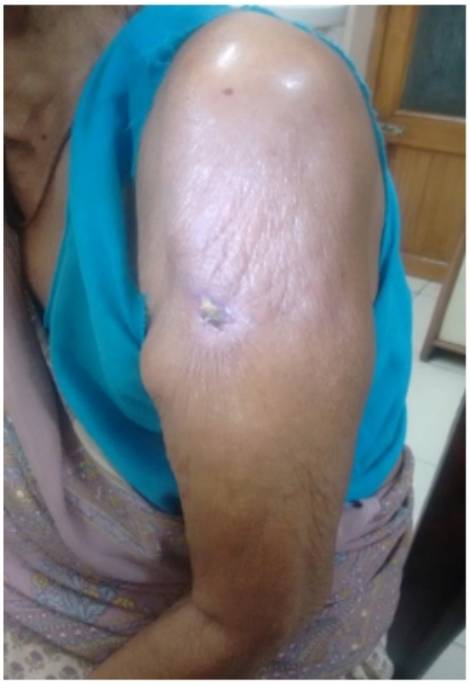
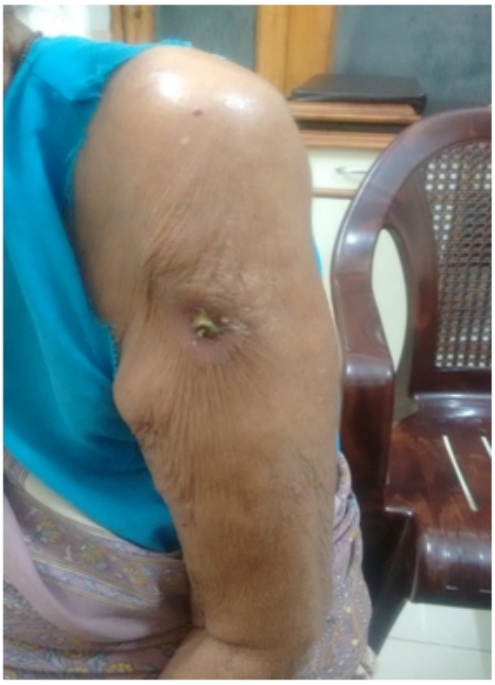
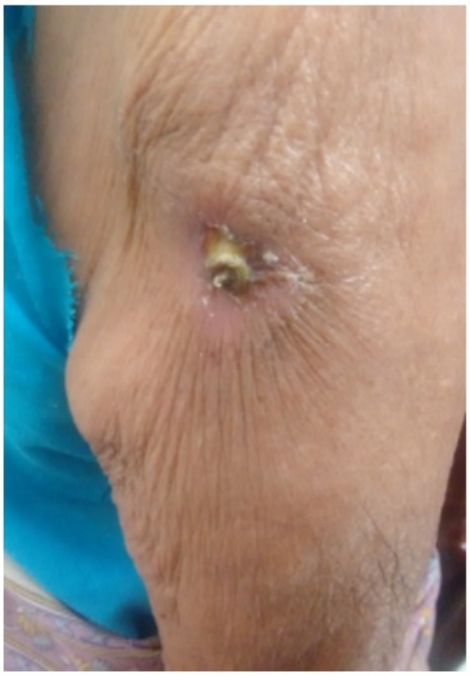
Surgery has been performed by homoeopathic knife, most of the pus has been evacuated swelling and pain reduced. Patient slept well.

Rx

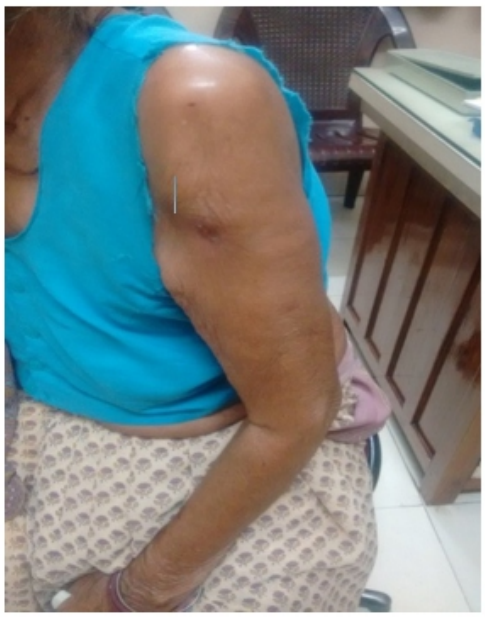
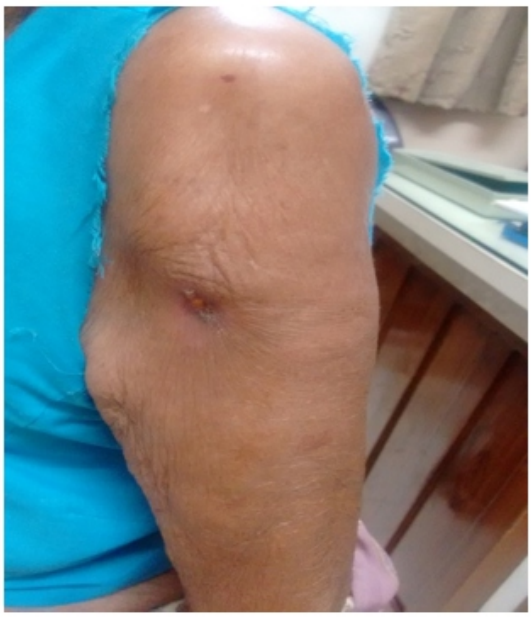
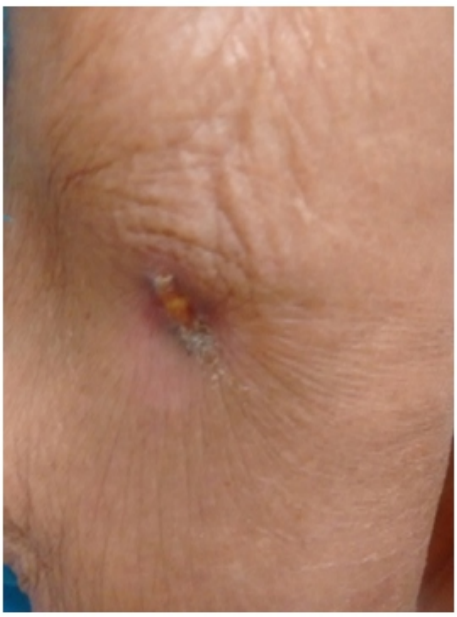
MERC SOL. 200, Four times a day

CAL. HYPOPHOS 3X, wice a day

3rd September 2018

15th September 2018

Patient remain absent for one month without information, appeared on 30th November 18 .

- Developed the pain and some swelling again , sleeplessness
- Sometimes pain become severe
- Wound is still oozing
- Discharge is thin , watery

Changed Medicine

Rx

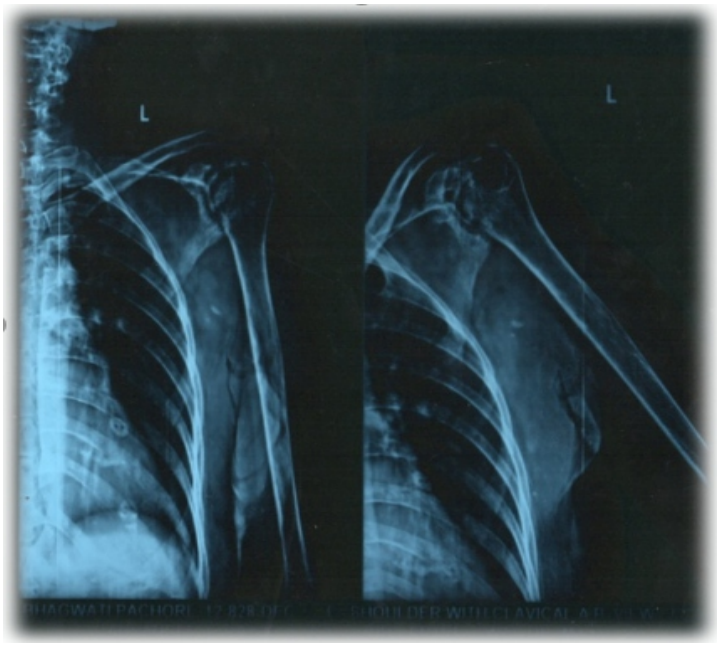
ASAFOETIDA 30

4 times a day X 15 days

CAL HYPO PHOS 3X

Twice a day Continued

Advised X- ray left Shoulder AP view & USG Abd.



USG WHOLE ABDOMEN DATED 17TH DECEMBER 18

Also revealed normal study, liver normal in size, shape and position. Echotexture is homogeneous hepatic and portal veins are normal

Patient's son reported off and on that she has been improving continuously

Discontinued treatment witout information.

14TH DECEMBER18

- Pain stopped
- She slept well
- Appetite improved ,bowels regular ,no flatulence
- Wound is still oozing but discharge is much less
- Now she can move her arm
- Patient is improving in all respect .

RADIOGRAPH DATED 17TH DECEMBER 18

There is radiolucent area seen in head of humerus with sclerosis of margin. Articular margin are regular, No soft tissue swelling seen, Shoulder joint spaces is reduce, Suggestive of LEFT shoulder joint kochs.

ADVANCED X - RAY & ULTRASOUND CENTRE

☎ 0751-2323320

JINSI ROAD NO.1
NEAR CHHAPARWALA PUL
LASHKAR, GWALIOR-474001

Clinic - Reg. No. 251

डॉ. आर. भोजवानी
एम.डी., एफ.आई.सी.आर.

DR. R. BHOJWANI
M.D.,F.I.C.R.
R. No. 5872 (M.P.)

CONSULTANT RADIOLOGIST & ULTRASONOLOGIST
• FORMERLY - ASSISTANT PROFESSOR & CONSULTANT
J.A. GROUP OF HOSPITAL & G.R. MEDICAL COLLEGE, GWALIOR
• CANCER HOSPITAL & RESEARCH INSTITUTE, GWALIOR

NAME : Bhagwati Pachori
PART SCANNED : Whole Abdomen
REFERRED BY DR. : Dr. Dr.M.K.Gupta

REF. NO.
DATE Date: 17/12/2018

Liver normal in size, shape and position. Echotexture is homogeneous Hepatic and Portal veins are normal.

Gall bladder normal in size, shape and position. It has smooth walls and lumen is echo free . CBD normal in caliber.

Pancreas is normal in size, shape and position. Echotexture is homogeneous.

Spleen is normal in size, shape and position. Echotexture is homogeneous.

Right kidney normal in size, shape and position. Parenchymal echoes are normal in thickness. Cortico central pattern is normal.

Left kidney normal in size, shape and position. Parenchymal echoes are normal in thickness. Cortico central pattern is normal.

Retroperitonium is normal.

Urinary bladder normal in size, shape and position. It has smooth walls and lumen is echo free.

Uterus Normal in size , shape and position. Echotexture is homogeneous. Endometrial echoes are normal in thickness.

No adenexal mass lesion seen.

IMP Normal Study.

Dexa Bone Densitometry

Qualms of Being A Homoeopathy Student

Dilemma Of Confusion And Clarity

Photo Credit:www.freepik.com

Dr. Nitya Latchireddy
BHMS 2014 - 2020 (JSPS Government Homoeo Medical College)
Gandhi Nagar, Parvathipuram, AP
drnityalatchireddy@gmail.com
8142955892

Decision making is a skill that some master very late. Blessed are those souls who know exactly what they want to do for the rest of their life - at least professionally. Clarity and confusion are two sides of a very sharp sword.

My first day in college showed me what confusion in life looks like. Out of the 60 in my batch, there were only 3 or 4 of us who chose Homoeopathy knowingly. The rest got in because they didn't get to do MBBS.

Most didn't even know what homeopathy is and how it functions. It was only the 'doctors' tag that attracted them to choose BHMS.

First few questions one gets asked as a fresher in college,
"Will you continue?",
"Will you practice?",
“Do you even know what Materia Medica is?"

I have a strong feeling that these are not the kind of questions posed to a fresh MBBS student. Discouragement, pessimistic remarks and negative connotations - that is how a student life truly begins for a Homoeopath in India.

Read on to find out exactly what happens in the five and half years of BHMS.

FIRST YEAR

- The first year goes by in understanding the names of the subjects - Anatomy, Physiology, Biochemistry, Materia Medica, Organon and Philosophy, Homoeopathic Pharmacy, their relevance in the life of a Homoeopath in the future and also in the fear of being able to dissect a dead body or not.
- Unfortunately I was part of a batch that never saw a dead body, yet I ended up loving anatomy. I still remember the introductory classes - fresh minds eagerly waiting to process new information. And information we did get, along with a lot of comparisons with our MBBS counterparts.
- Even as freshmen we were prepared to understand that the world is not a fair place for Homoeopaths. You have to fight if you want to be recognised. By the time comfort and clarity start to settle, exams are round the corner and we all know what professional level exams look like.

SECOND YEAR

- As we prepare to come back to college for second year after summer break, everyone is settled in. Some are in the mind-set of doing this just for the degree, some are wildly sure of contributing their life to Homoeopathy, while some others leave college to pursue other professions.
- We study Pathology, Forensic Medicine, Organon, Materia Medica and the most exciting part of being a doctor - Patient care. Clinicals are truly a student's best friend in second year - they give an on ground reality of being on the other side of a patient table.
- Second year is when I understood that school and college are very different. They are both institutions of learning, but school has no escape and college is only for those who can brave it. Escaping it is the easy way out.

SUBJECTS	
1st YEAR	2nd YEAR
Anatomy	Forensic medicine
Physiology + Biochemistry	Pathology
Homoeopathic Pharmacy	Organon and Philosophy
Organon and philosophy - Theory part	Materia Medica
Materia Medica	

THIRD YEAR

- Third year is a comfort zone at its best for a medical student. The fear of the unknown is replaced very temporarily by a streak of confidence.
- We study Obstetrics and Gynaecology and Surgery in addition to Homoeopathic subjects. We enter adulthood; start identifying with our profession and start building a network.

FOURTH YEAR

- The fourth year officially marks the end of an era of examinations.
- The subject Medicine covers diseases from point of origin to management. We study Community Medicine as well. Fourth year delves very deep into each Homoeopathy subject and their practical application. It is the best time to summarize all that you have learnt in the past few years.

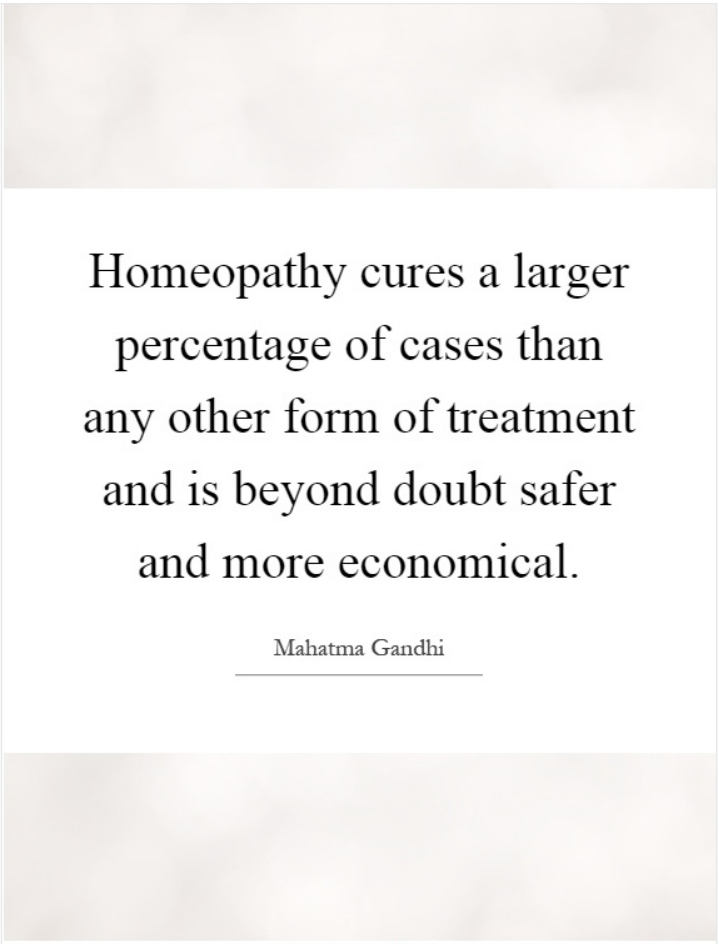
SUBJECTS	
3rd YEAR	4th YEAR
Surgery + ENT, Ophthalmology, Orthopaedics	Medicine + Paediatrics, Psychiatry
Gynaecology and Obstetrics	Social, Preventive and Community Medicine
Organon and Philosophy	Repertory
Materia Medica + Therapeutics	Organon and Philosophy + Chronic Diseases
	Materia Medica + Therapeutics

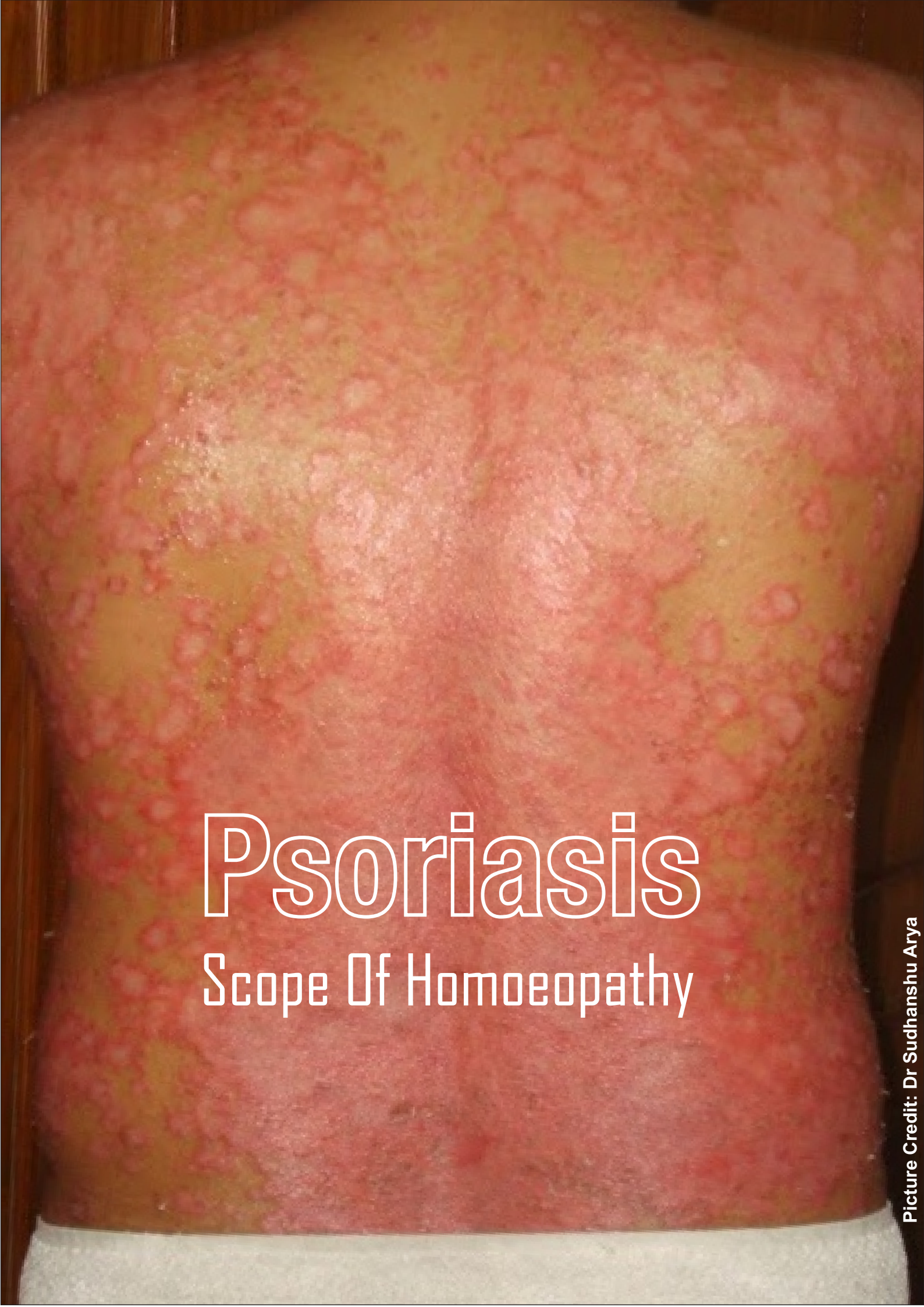
INTERNSHIP

- Just when a sense of clarity hits you, by the end of fourth year, internship flips the boat. Practically applying all the theory to patients and case management proves to be a challenge. For those who take full advantage of the available guidance internship is very fulfilling.
- In my case, COVID happened and almost 6 to 7 months went by in COVID care in the hospital. That time period took away a lot of scope to learn homoeopathy.
- Professors and seniors are your first line of protection and first professional networks. Their guidance, expertise and experience are a great source of learning. It is wise to interact with as many people as you can, explore all your options and keep learning. Only those who are committed to learning attain substantial growth.

By the end of the degree, you look back and realise that the few years went by with both legs in different pools - always straddling the line between confusion and clarity. But this holds true in case of any profession - be it BHMS, MBBS, MBA etc. Those who stick very close to the line end up making mediocre choices. Those who break free and take risks will always find professional satisfaction throughout their journey.

I personally aspire to break free from mediocrity. I choose to





Psoriasis

Scope Of Homoeopathy

Picture Credit: Dr Sudhanshu Arya

Scope Of Homoeopathy In Psoriasis Disease

Prof. Dr. Sunil Raghunath Patil, M. D. (Hom.)
Principal, Dhanvantari Medical College and Hospital, Nashik, (MS) India
09881098971

Abstract

Psoriasis is fundamentally an inflammatory skin condition with reactive aberrant epidermal differentiation and hyper proliferation affecting 2-3 % of world's population. Pathophysiology of the disease includes mainly the activation and migration of T cells to the dermis triggering the relinquishment of cytokines (tumor necrosis factor-alpha TNF-alpha, in particular) which lead to the inflammation and the expeditious engenderment of skin cells. The possible factors and triggers causing psoriasis include emotional stress, skin injury, systemic infections, certain medications and intestinal upsets. Sundry types of psoriasis have been reported such as plaque psoriasis, psoriatic arthritis, scalp psoriasis, flexural psoriasis, guttate psoriasis, pustular psoriasis, nail psoriasis, erythrodermic psoriasis which can be diagnosed by clinical findings such as skin biopsies etc. Therapeutic agents that either modulate the immune system or normalize the differentiation program of psoriatic keratinocytes are suggested for treating psoriasis. Based on the type of psoriasis, its location, extent and severity there are various treatment regimens available for psoriasis such as topical agents, phototherapy, systemic agents and homeopathic approach. This review aims to cover each and every aspect of the disorder Psoriasis and details of concretely plaque psoriasis as about 80% of people who develop psoriasis have plaque psoriasis.

Introduction

Psoriasis is regarded as an autoimmune disease in which genetic and environmental factors have a paramount role. The denomination of the disease is derived from Greek word “psora” which betokens “itch”. Psoriasis is a non-contagious, dry, inflammatory and uncomely skin disorder, which can involve entire system of person. It is mostly inherited and mainly characterized by sharply marginated scaly, erythematous plaques that develop in a relatively symmetrical distribution. The most commonly affected sites are the scalp, tips of fingers and toes, palms, soles, umbilicus, gluteus, under the breasts and genitals, elbows, knees, shins and sacrum. This disease is chronic in nature with a proclivity to relapse. In this disease, the skin keeps scaling as flakes called psoriatic plaques due to expeditious and exorbitant multiplication of epidermis cells which look akin to fishy skin & determinately peels off as exfoliation.

The silvery-white plaques are caused by expedited regeneration and accumulation of skin on sites of predilection due to expeditious ravagement process. Plaques may range in size from a few millimeters to an immensely colossal part of the trunk or limb. Plaques frequently appear on skin of the elbows and knees, but can affect any area including the scalp and genitals. Fingernails and toenails are frequently affected (psoriatic nail dystrophy) and can be seen as an isolated finding. Psoriasis can also cause inflammation of the joints, which is known as psoriatic arthritis. Psoriasis is linked to dandruff and lamentably to some forms of arthritis. It is additionally believed that there is additionally a link between psoriasis and the HIV virus. Psoriasis is one of the most maltreated diseases from olden days, which perpetuates now with the search of a good remedy. This review is a compilation of all the aspects regarding psoriasis.

Psoriasis is a prevalent skin condition that transmutes the life cycle of skin cells. Psoriasis causes cells to build up expeditiously on the surface of the skin. The extra skin cells form thick, silvery scales and itchy, dry, red patches that are sometimes painful. Psoriasis is a sedulous, perennial (chronic) disease. There may be times when your psoriasis symptoms get better alternating with times your psoriasis worsens.

Epidemiology

Psoriasis affects both sexes equally and can occur at any age, although it most commonly appears for the first time between the ages of 15 and 25 years. The study found that 25% of people with psoriasis could be classified as having moderate to severe psoriasis. Around one-third of people with psoriasis report a family history of the disease, and researchers have identified genetic loci associated with the condition. Studies of monozygotic twins suggest a 70% chance of a twin developing psoriasis if the other twin has psoriasis. The concordance is around 20% for dizygotic twins. These findings suggest both a genetic predisposition and an environmental response in developing psoriasis. Onset before age 4 usually indicates a greater genetic susceptibility and a more severe or recurrent course of psoriasis. Psoriasis does not spread from one person to another by contact but can be transmitted genetically [25%]. Psoriasis occurs most commonly in the third decade of life. It has higher incidence in females than males. Children are rarely affected. Whites suffer more than blacks. Nearly 30% of psoriasis patients have arthritis problems. The onset of the disease occurs most commonly at about the age of 20 years. 10 to 15 % of people have psoriatic arthritis. In the United States, about 7 million people (2%-3% of people) have psoriasis. About 150,000- 260,000 new cases are diagnosed each year. Most people who have psoriasis of the nails also have skin psoriasis

(cutaneous psoriasis). Only 5% of people with psoriasis of the nails do not have skin psoriasis. In people who have skin psoriasis, 10%-55% have psoriasis of the nails (also called psoriatic nail disease). About 10%-20% of people who have skin psoriasis also have psoriatic arthritis, a specific condition in which people have symptoms of both arthritis and psoriasis. Of people with psoriatic arthritis, 53%-86% have affected nails, often with pitting. Psoriasis tends to run in families. If you have a parent or a sibling who has psoriasis, you have a 16%-25% chance of having psoriasis, too. If both of your parents have psoriasis, your risk is 75%. Males and females are equally likely to have psoriasis. Psoriasis can occur in people of all races.

Causes

The cause of psoriasis is not plenarily understood, but it is generally believed to have a genetic component. Additionally in psoriasis, factors in the immune systems and other biochemical substances that customarily regulate orderly proliferation and maturation of epidermal cells are impaired. These cause inflammation and increased proliferation of skin cells leading to the characteristic clinical features of scaling and redness. Several factors are thought to aggravate psoriasis. These include stress, excessive alcohol consumption, and smoking. Individuals with psoriasis may suffer from depression and loss self-esteem. As such, quality of life is a consequential factor in evaluating the rigor of the disease. Certain medicines, including lithium salt and beta blockers, have been reported to trigger or aggravate the disease. Excessive alcohol consumption, smoking and obesity may exacerbate psoriasis or make the management of the condition difficult. Individuals suffering from the advanced effects of the human immunodeficiency virus, or HIV, often exhibit psoriasis. Psoriasis is a fairly idiosyncratic disease. The majority of people's experience of psoriasis is one in which it may worsen or improve for no apparent reason. Studies of the factors associated with psoriasis tend to be based on small (usually hospital based) samples of individuals. These studies tend to suffer from representative issues, and an inability to tease out causal associations in the face of other (possibly unknown) intervening factors. Conflicting findings are often reported. Nevertheless, the first outbreak is sometimes reported following stress (physical and mental), skin injury, and streptococcal infection. Conditions that have been reported as accompanying a worsening of the disease include infections, stress, and changes in season and climate. Researches show that whether a person develops psoriasis or not may depend on a “trigger”. Possible psoriasis triggers include emotional stress, skin injury, systemic infections, certain medications and intestinal upsets. Studies have also indicated that a person is born genetically predisposed to psoriasis and multiple genes have been discovered. According to Ayurveda when all these factors combine with change in life style, constipation, indigestion, stress that leads to psoriasis. Stress, skin injuries, a streptococcal infection, certain medications and sunburn are some of the known potential triggers. Medications that can trigger psoriasis are anti-malarial drugs, beta-blockers and lithium. Dermatologists have visually perceived psoriasis suddenly appear after a person takes one of these medications, gets a streptococcal infection, or experiences another triggers. Sometimes pabulum can additionally trigger the disease process. For e.g. citrus fruits, sour foods, sauces, coffee, tea, alcohol and soft drinks.

The cause of psoriasis isn't plenarily kenned, but it's thought to be cognate to an immune system quandary with cells in your body. More concretely, one key cell is a type of white blood cell called a T lymphocyte or T cell. Customarily, T cells peregrinate throughout the body to detect and fight off peregrine substances, such as viruses or bacteria. If you have psoriasis, however, the T cells attack salubrious skin cells by mistake, as if to rejuvenate a wound or to fight an infection.

Over active T cells trigger other immune replications. The effects include dilation of blood vessels in the skin around the plaques and an incrementation in other white blood cells that can enter the outer layer of skin. These changes result in an increased production of both healthy skin cells and more T cells and other white blood cells. This causes an ongoing cycle in which new skin cells move to the outermost layer of skin too quickly—in days rather than weeks. Dead skin and white blood cells can't slough off expeditiously enough and build up in thick, scaly patches on the skin's surface. This customarily doesn't stop unless treatment interrupts the cycle.

Just what causes T cells to malfunction in people with psoriasis isn't entirely clear. Researchers have found genes that are linked to the development of psoriasis, but environmental factors additionally play a role.

Symptoms—Psoriasis signs and symptoms can vary from person to person but may include one or more of the following:

- Red patches of skin covered with silvery scales
- Small scaling pots (commonly seen in children) Dry, cracked skin that may bleed
- Itching, burning or soreness
- Thickened, pitted or ridged nails Swollen and stiff joints

Psoriasis patches can range from a few spots of dandruff-like scaling to major eruptions that cover large areas.

Most types of psoriasis go through cycles, flaring for a few weeks or months, then subsiding for a time or even going into complete remission

3. Erythrodermic psoriasis

It is a categorically inflammatory form of psoriasis that involves widespread inflammation and exfoliation of the skin over most of the body surface. It may be accompanied by astringent itching swelling and pain. It is often the result of an exacerbation of unstable plaque psoriasis, concretely following the abrupt withdrawal of systemic treatment.

Clinical features

This form of psoriasis can be fatal, as the extreme inflammation and exfoliation disrupt the body's faculty to regulate temperature and for the skin to perform barrier functions. Chronic psoriasis may gradually evolve to spread over the whole skin surface to produce a generalized, diffuse redness with profuse scaling. This may rarely be the initial presentation of disease. This syndrome of “erythroderma” also called exfoliative dermatitis is often associated with the disordered temperature regulation, hypoalbuminemia, anemia, and hyperuricemia. This is severe form of psoriasis with terrible itching and redness i.e. widespread redness, severe itching and pain. It may occur in association with von Zumbusch pustular psoriasis. It is the least common type of psoriasis and may occur once or more during a lifetime in 1 to 2 percent of people who develop psoriasis. It generally appears on people who have unstable plaque psoriasis. This means the lesions are not clearly defined. Widespread, fiery redness and exfoliation of the skin characterize this form. Severe itching and pain often accompanies it. The symptoms include severe redness and shedding of skin over a large area of the body. Exfoliation often occurs in large "sheets" instead of smaller scales with severe itching and pain and skin looks as if it has been burned. Heart rate increases and body temperature varies especially on very hot or cold days. Erythrodermic psoriasis is related to unstable plaque psoriasis, a type characterized by lesions which are not clearly defined. In most cases, it will occur in people with unstable plaque psoriasis. In recherché cases, erythrodermic psoriasis can be the first instance of psoriasis for a patient.

Causes

Concrete medications including lithium, antimalarials and interleukin II are shown to be triggers of erythrodermic psoriasis. More causes include infections, calcium deficiency, sudden withdrawal of oral corticosteroids (prednisone), withdrawal of extravagant utilization of vigorous topical corticosteroids, and vigorous coal tar preparations.

4. Arthropathic psoriasis (psoriatic arthritis)

It involves joint and connective tissue inflammation. Psoriatic arthritis can affect any joint but is most prevalent in the joints of fingers and toes. This can result in a sausage-shaped swelling of the fingers and toes kenned as dactylitis. Psoriatic arthritis can also affect the hips, knees and spine (spondylitis). About 10-15% of people who have psoriasis also have psoriatic arthritis. Around 10% - 30% of people who develop psoriasis get a related form of arthritis called “psoriatic arthritis” which cause inflammation of the joints. Patients may develop joint symptoms due to seronegative arthritis. The same immune and inflammatory factors that cause the skin lesions are thought to be responsible for the joint inflammation. A majority of patients with joint will have involvement of one or few peripheral joints asymmetrically. Some may develop a symmetrical peripheral arthropathy resembly rheumatoid arthritis.

5. Nail psoriasis

It engenders a variety of vicissitudes in the appearance of finger and toe nails. These transmutations include discolouring under the nail plate, pitting of the nails, lines going across the nails, thickening of the skin under the nail, and the loosening (onychlysis) and crumbling of the nail. Psoriatic nail disease has many clinical signs. Most psoriatic nail disease occurs in patients with clinically evident psoriasis; it only occurs in less than 5% of patients with no other cutaneous findings of psoriasis. An estimated 10-55% of all patients with psoriasis have psoriatic nail disease. How psoriasis of the nails develops is not completely known. It appears to result from a combination of genetic (inherited), immunologic, and environmental factors.

6. Pustular psoriasis

Generalized pustular psoriasis is a recherché form of psoriasis, which presents as widespread pustules on a background of red and tender skin. Widespread patches may occur arbitrarily on any component of the body. It is also known as acute generalised pustular psoriasis of von Zumbusch. Another form of pustular psoriasis is localised pustular psoriasis, which appears on the hands or feet (palm plantar pustulosis). This needs to be distinguished from a localised form of generalised pustular psoriasis. It appears as raised bumps that are filled with non-infectious pus (pustules). The skin under and circumventing pustules is red and tender. Pustular psoriasis can be localised, commonly to the hands and feet (palm plantar pustulosis), or generalised with widespread patches occuring desultorily on any component of the body.

Clinical features

Initially the skin desiccates fiery red and tender. The patient may withal have a pyrexia, chills, headache, expeditious pulse rate, and loss of appetite, nausea and muscle impotency. Within hours 2-3 mm pustules filled with non-infected pus appear on parts of the body especially the flexures and genital areas. After a day they coalesce to form lakes of pus, which then dry and peel to

Types & Clinical Features

1. Psoriasis of the palms and soles

This type of psoriasis may predominantly affect the palms and soles in sundry ways such as typical scaly, red patches homogeneous to psoriasis elsewhere, generalized thickening and scaling of the palms and soles (keratoderma) with sheets of minuscule yellow- brown pustules (palm plantar pustulosis).

Clinical features

The palms and soles can become very dry and thickened, often with deep painful cracks (fissures), which can significantly interfere with activities. Psoriasis can be quite hard to differentiate from other forms of keratoderma, but signs of psoriasis elsewhere may help make a diagnosis. Palm plantar psoriasis tends to be a chronic recurrent condition. The pustular form is reported to be much more mundane in tobacco smokers, but lamentably giving up smoking doesn't always result in clearance of the psoriasis.

2. Scalp psoriasis (Pityriasis amiantacea)

Pityriasis amiantacea is a condition of the scalp characterized by thick, yellow-white scales densely coating the scalp skin and adhering to the scalp hairs as they exit the scalp. They are arranged in an overlapping manner like tiles on a roof or flakes of asbestos, hence the designation. The underlying scalp skin may appear mundane, aside from the scale, or may be reddened or scaly.

Clinical features

Pityriasis amiantacea is often present without any conspicuous underlying cause, but may be associated with psoriasis, lichen simplex or seborrhoeic dermatitis. Pityriasis amiantacea customarily affects only part of the scalp but may infrequently involve the whole scalp. Young girls may have localised pityriasis amiantacea extending into the scalp from areas of chronic fissures in the skin behind the ears. It may extend from an area of lichen simplex of the scalp. Some hair loss is common is areas of pityriasis amiantacea but hair regrows normally if the condition is effectively treated. This hair loss is sometimes aggravated by the difficulty in combing the hair due to the very adherent, thick scale at the base of the hair shafts. If additional complications such as infection occur then hair loss may be associated with scarring and be permanent. The term tinea amiantacea is incorrect, because fungal infection, tinea capitis, is a very rare reason for this type of scaling. Scalp psoriasis may occur in isolation or with any other form of psoriasis. The back of the head is a mundane site but multiple discrete areas of the scalp or the whole scalp may be affected. Scalp psoriasis is characterized by thick silvery white patches of very red skin. Scalp psoriasis can be very mild, with marginal, fine scaling. It can supplementally be very astringent with thick, crusted plaques covering the entire scalp, which commonly can cause hair loss.

Signs and symptoms of scalp psoriasis

Scalp psoriasis can appear anywhere on the scalp. Sometimes one minuscule patch develops, which can be facile to obnubilate with hair. Scalp psoriasis withal can cover the entire scalp. It can even creep beyond the scalp, appearing on the forehead, back of the neck, or abaft the auditory perceivers. The reddish plaques can creep beyond the hairline and appear abaft the auditory perceivers. The silvery-white scale can cover the entire scalp. When scalp psoriasis develops, people have one or more of these designations and symptoms:

- Reddish plaque on the scalp: Plaques range from barely noticeable to thick and inflamed.
- Silvery-white scale: This often develops on the scalp and can be mistaken for dandruff.
- Dandruff-like flaking: This is common due to the continual shedding of the new skin cells. Unlike dandruff, scalp psoriasis causes a silvery sheen and dry scale on the scalp.
- Dry scalp: The scalp may be so dry that the skin cracks and bleeds.
- Itching: This is one of the most common symptoms. For some the itch is mild; others have intense itching that can interfere with everyday life and cause them to lose sleep.
- Bleeding: Because scalp psoriasis can be very itchy, almost everyone scratches. This can cause the scalp to bleed. Scratching also injures the skin, which tends to worsen the psoriasis. This is why dermatologists tell their patients “Try not to scratch your scalp.”
- Burning sensation or soreness: The scalp can burn. It can feel extremely sore.
- Temporary hair loss: Scratching the scalp a lot or forcefully removing scale can cause hair loss. Once the scalp psoriasis clears, hair usually re-grows.

These designations and symptoms can come and go. Some people have only one mild flare. Others experience flare-ups that range in intensity, with some flare-ups being milder than other flare-ups. Many things can trigger a flare-up, including stress, algid, and a dry environment.

leave behind a glazed, smooth surface on which new crops of pustules may appear. Successive crops of pustules may appear and erupt every few days or weeks. The sudden onset of this condition can be quite alarming. If the patient survives the acute phase and its complications, remission occurs within days or weeks and the psoriasis reverts to its previous state or erythroderma may develop. Relapses are common. Inflammatory mediators attract neutrophils to the site of lesions in all psoriasitic lesions producing “micro abscesses” visible on microscopy. Profound neutrophil accumulation may engender visible sterile pustules on psoriatic lesions or there may be a recalcitrant palm plantar pustular eruption.

7. Guttate psoriasis

Clinical features

“Gutta” is Latin for tear drop; guttate psoriasis looks homogeneous to shower of red, scaly tear drops that have fallen down on the body. Guttate psoriasis is characterized by numerous small round spots (differential diagnosispityriasis rosea- oval shape lesion that tend to affect most of the body. Lesions are usually concentrated around the trunk and upper arms and thighs. Face, auditory perceivers and scalp are withal commonly affected but the lesions may be very faint and expeditiously vanish in these areas. Infrequently there may be only few scattered lesions in total.

Diagnosis

The diagnosis of guttate psoriasis is made by the cumulation of history, clinical appearance of the rash, and evidence for preceding infection. The rash comes on very quickly, usually within a couple of days, and may follow a streptococcal infection of the throat. It tends to affect children and young adults and has a good chance of spontaneously clearing completely. Guttate psoriasis is associated with streptococcal throat infection. In some patients, particularly in children and young adults and after acute streptococcal infections, an acute or sub-acute eruption of small raindrop shaped lesions may develop. The eruption mainly affects the trunk and proximal extremities and the scaling may be less prominent. These are multiple dotted occurrence of psoriasis. In short they are small, red spots on the s kin. Blood test reports generally show a low level of calcium in the blood (hypocalcaemia). Other changes on blood testing include low plasma albumin and zinc, high ESR (eroyhrocyte sedimentation rate), raised neutrophil count, reduced lymphocyte count and raised lactate levels.

8. Flexural psoriasis (inverse psoriasis)

It appears as smooth inflamed patches of skin. It occurs in skin folds, concretely around the genitals (between the thigh and groin), the armpits, under an extravagantly corpulent stomach (pannus), and under the breasts (inframammary fold). It is aggravated by friction and sweat, and is vulnerable to fungal infections. In some patients, psoriasis localises to the skin folds and genitals. Armpits Groin Under the breasts Umbilicus (navel) Penis Vulva Natal cleft (between the buttocks) around the anus.

Clinical features

Due to the moist nature of the skin folds the appearance of the psoriasis is remotely different. It inclines not to have silvery scale, but is shiny and smooth. There may be a crack (fissure) in the depth of the skin crease. The deep red colour and well-defined borders characteristic of psoriasis may still be obvious. Over these sites, the lesions tend to be flatter with a glazed reddish surface without the typical scales. These are smooth inflamed psoriasis in folds of skin without scaling. Scaly plaques may sometimes occur however, concretely on the circumcised penis.

Clinical features

The plaque psoriasis is the most prevalent form, albeit several other distinctive clinical variants of psoriasis are apperceived. It affects 80 to 90% of people with psoriasis. Plaque psoriasis typically appears as raised areas of inflamed skin covered with silvery white scaly skin. These areas are called plaques. The extent and duration of the disease is highly variable from patient to patient, and up to 10-20% of the patients with plaque psoriasis also experience psoriatic arthritis. Acute flares or relapses of plaque psoriasis may also evolve into more severe disease, such as pustular or erythrodermic psoriasis. Plaque psoriasis is universal in its occurrence and varies with race, geography, and environmental factors (eg. Sun exposure). Pustular flares of disease may be provoked by systemic corticosteroid therapy. Such flares can be fatal. Other than this, disease-related mortality is exceedingly rare in psoriasis, and even then, the primary cause of mortality is related to its therapy. Adverse effects of systemic treatments (eg. Hepatic fibrosis from methotrexate) and phototherapy (eg psoralen plus UVA [PUVA] - induced skin cancers with metastases) are the primary disease-related causes of death. Morbidity is much greater problem in patients with psoriasis and is often related to pruritis, dry and peeling skin, fissuring, and the adverse effects of therapy. By far, the patient's quality of life is most affected in plaque psoriasis, and studies have demonstrated patients with psoriasis have deficiencies in quality of life similar to those for persons with congestive heart failure. Self-consciousness and embarrassment about appearance, inconvenience, and the high cost of antipsoriatic treatment regimens all add to the morbidity of this chronic and relapsing disease. Patients report prominent itchy, red areas with increased skin scaling, mild to severe itching, pitting and separation of the plate from the nail beds of nails, lesions and peeling on the scalp and extensor surfaces and new lesions appear at sites of injury or trauma to the skin. (Bulletin) This isomorphic phenomenon (Koebner reaction) typically occurs 7-14

days after the skin has been injured and has been found in 38-76% of patients with plaque psoriasis. In some patients, so called reverseKoebner reactions have also been noted in which preexisting psoriatic plaques actually clear after injury or trauma to the skin. This disease conventionally worsens in the winter and amends in the summer. Consequential joint pain, stiffness, and deformity are reported in the 10- 20% of patients with psoriasis who develop psoriatic arthritis.

Prevalence

Plaque psoriasis can affect persons of any race; however, epidemologic studies have shown a higher prevalence in western European and Scandinavian populations. In these groups, 1.5-3% of the population is affected by the disease. The highest documented disease prevalence is in Artic Kasach"ye with 12% of the population affected, followed by Norway, where 4.8% of the population has psoriasis. Lower prevalence rates for psoriasis have been reported among Japanese and Inuit populations. Psoriasis is thought to be rare in West Africans and African Americans and is nearly absent in North American Indians. Psoriasis was undetected in the Samoan population and in the study that examined 26,000 South American Indians. Psoriasis affects adult males and females equally. Among children and adolescents, plaque psoriasis has been found to affect females more than males, but this observation may be due to earlier age of onset in females. Plaque psoriasis first appears during 2 peak age ranges. The first peak occurs in persons aged 16-22 years, and the second occurs in persons aged 57-60 years. Females develop plaque psoriasis earlier than males, and patients with positive family history for psoriasis also tend to have an earlier age of onset. For siblings of patients whose psoriasis appeared afore age 15 years, a 3-fold higher risk subsists of developing disease compared with siblings of patients who presented after age 30 years.

Causes

Exacerbating causes of plaque psoriases can be divided into local and systemic factors. Local factors are as follows:

- Trauma: All types of trauma have been associated with the development of plaque psoriasis (eg. Physical, chemical, electrical, surgical, infective, and inflammatory types of injury). Even excessive scratching can aggravate or precipitate localized psoriasis. The development of psoriatic plaques at a site of injury is known as the Koebner reaction. See history for more details on the Koebner reaction.
- Sunlight: Most patients generally consider sunlight to be beneficial for their psoriasis. Most report a decrease in illness severity during the summer months or periods of increased sun exposure; however, a small minority find that their symptoms are aggravated by strong sunlight, and these individuals actually experience a worsening of their disease in the summer. Severe sunburn can lead to an exacerbation of plaque psoriasis via the Koebner reaction.

Systemic factors are as follows:

- Infection: pharyngeal streptococcal infections have been shown to produce a clinically distinctive disease flare known as guttate psoriasis. Some evidence suggests that subclinical streptococcal colonization or overgrowth could be responsible for refractory plaque psoriasis. Telfer NR, Chalmers.
- HIV: An increase in psoriasis activity has been observed in patients who are or become infected with HIV. The extent and severity of skin disease initially appears to parallel the disease stage. Psoriasis often becomes less active in advanced HIV infection.
- Drugs: a number of medications have been shown to cause an exacerbation of psoriasis. Lithium and withdrawl from systemic corticosteroids are well-known to cause flares of disease. Beta blockers, antimalarials, and nonsteroidal anti-inflammatory drugs (NSAID"s) have also been implicated.
- Smoking: An increased risk of chronic plaque psoriasis exists in persons who smoke cigarettes.
- Alcohol: Alcohol is considered a risk factor for psoriasis, particularly in young to middle - aged males.
- Endocrine: Psoriasis severity has been noted to fluctuate with harmonal changes. Disease incidence peaks at puberty and during menopause. Pregnant patient's symptoms are more likely to improve than worsen, if any changes occur at all. In contrast, the disease is more likely to flare in the postpartum period, again if any changes occur at all.

Diagnosis of Plaque psoriasis

The diagnosis of psoriasis is usually made on the basis of clinical findings, and ancillary laboratory tests are very rarely re

- Plaques: Psoriasis manifests as elevated lesions that vary in size from one to several centimeters. The thickened epidermis, expanded dermal vascular compartment, and infiltrate of neutrophils and lymphocytes account for the psoriatic lesions being raised and easily palpable. The number of lesions may range from few to many at any given time. The plaques are irregular to oval and are more often located on the scalp, trunk, and limbs, with a predilection for extensor surfaces such as the elbows and knees. Smaller plaques may coalesce into larger lesions, especially on the legs and sacral regions. Fissuring within plaques can occur when lesions are present over joint lines or on the palms and soles.quired. Several cardinal features of plaque psoriasis can be readily observed during the physical examination such as:

- Well-circumscribed margins: psoriatic plaques are well defined and have sharply demarcated boundaries. Psoriatic plaques occasionally appear to be immediately encircled by a paler peripheral zone referred to as the halo or ring of Woronoff.
- Red color: the color of psoriatic lesions is a very distinctive rich, full, red color. When present on the legs, lesions sometimes carry a blue or violaceous tint.
- Scale: Psoriatic plaques typically have a dry, thin, silvery-white or micaceous scale; however, the amount and thickness of this scale is quite variable. Removing the scale reveals a smooth, red, glossy membrane with tiny punctuate bleeding points. These points represent bleeding from enlarged dermal capillaries after removal of the overlying suprapapillary epithelium. This phenomenon is known as Auspitz sign.
- Symmetry: Psoriatic plaques tend to be symmetrically distributed over the body. Lesions typically have a high degree of uniformity with few morphologic differences between the 2 sides.

The following are psoriatic variations and associations that can be observed in persons with plaque psoriasis:

- Nail psoriasis: Cindy Li, DO, Richard K Scher, MD Nail changes are commonly observed in patients with plaque psoriasis. Nails may exhibit pitting, onycholysis, subungual hyperkeratosis, or oil-drop sign. A proper assessment of any patient suspected of having psoriasis should include careful examination of the nails.
- Psoriasis in children: plaque psoriasis manifests slightly differently in children. Plaques are not as thick, and the lesions are less scaly. Psoriasis may often appear in the diaper region in infancy and in flexural areas in children. The disease more commonly affects the face in children compared with adults.
- Inverse psoriasis: This is a variant of psoriasis that spares the typical extensor surfaces and affects intertriginous (i.e. axillae, inguinal folds, inframammary creases) areas with minimal scale.

Prognosis

Psoriasis is a perennial condition. There is currently no remedy but sundry treatments can avail to control the symptoms. Many of the most efficacious agents used to treat astringent psoriasis carry an incremented risk of consequential morbidity including skin cancers, lymphoma and liver disease. However, the majority of people's experience of psoriasis is that of minor localized patches, particularly on the elbows and knees, which can be treated with topical medication. Psoriasis does get worse over time but it is not possible to predict who will go on to develop extensive psoriasis or those in whom the disease may appear to vanish. Individuals will often experience flares and remissions throughout their lives. Controlling the signs and symptoms typically requires lifelong therapy. According to one study, psoriasis is linked to 2.5 fold incremented risk for non-melanoma skin cancer in men and women, with no preponderence of any concrete histologic subtype of cancer. This however could be linked to antisporiatic treatment.

The course of plaque psoriasis is capricious. Presaging the duration of active disease, the time or the frequency of relapses, or the duration of remission is infeasible. The disease rarely is life threatening but often is intractable to treatment, with relapses occurring in most patients. Both early onset and a family history of disease are considered poor prognostic indicators. Some suggest that stress is also associated with an unfavorable prognosis. Environmental factors (particularly sunlight and warm weather) help alleviate the disease and are considered advantageous.

Diet

The first step is reducing the severity of your psoriasis is “Drink lots of water.” Drink at least 5 liters a day. The second step is to “Improve your diet” and eat lots of green leafy vegetables. This will not cure your psoriasis, but it may dramatically reduce it. The following foods are popular triggers; Coke-a-cola, red meat, MSG, chili, hot spices, junk foods, oily foods, berries (such as strawberries) tomato, most acidic food and Vita-C so their consumption needs to be controlled. People with poor diets will likely have much worse psoriasis. It has been proved that a good diet (less of food mentioned above) lots of water and lots of vegetables, a good multi vitamin tablet and also zinc tablets daily can help to reduce psoriasis, it is not a recognized treatment, nor a cure. Any results from a diet are probably due to increased general health and the removal of unhealthy foods. Acidic foods in particular have been proven to worsen psoriasis, so simply eliminating these from your existing diet will improve your psoriasis as much as any “wonder diet” could. Ingestion of alcohol has been reported to be a risk factor for psoriasis in men but not in women. It would be prudent for men with psoriasis to restrict their intake of alcohol or avoid it entirely. Suggestion is given that people with psoriasis may improve on a hypoallergenic diet. It have been reported that eliminating gluten (found in wheat, rye and barley) improved psoriasis for some people. So that a doctor can help people with psoriasis determine whether gluten or other foods are contributing to their skin condition. Fumaric acids, fish oil, triglycerides, folic acid, flaxseed oil, Vita-D are found to be efficacious against psoriasis. Thus victualing well will better prepare your body to respond to any recurring medical condition e.g. if you are taking methotrexate, be sure to get enough folate, a consequential Vita-B.

Teartment of Psoriasis

Homoeopathic Remedies

Homoeopathic treatment requires a deep constitutional analysis. The history of the disease, the family medical history, physical and phrenic characteristics of the patient, the relishes and misprizes, medication details are all taken into consideration. This approach stands inconsonance with the homoeopathic convention: Treat the patient, not the disease. Here is the detail of the top grade homeopathic remedies for psoriasis.

ARSENIC ALBUM–30: Arsenic Album tops the list of homeopathic remedies for treating psoriasis. Homeopathic medicine Arsenic Album is indicated in psoriasis where skin peels off in large scales. Skin is dry, scaly and excessively rough. Dryness is accompanied with burning and itching. Cold applications worsen the itching and burning. The use of homeopathic medicine Arsenic album must also be considered for patients who have alternation between their skin symptoms with respiratory troubles like asthma. In homeopathy mental symptoms of a patient are given extreme importance while deciding the constitutional remedy. An Important mental symptom for selecting Arsenic Album in psoriasis includes anxiety and restlessness.

GRAPHITES 30: Graphites is a highly effective homeopathic remedy for psoriasis. It is mainly used when there is excessive dryness and scaling. Graphites is effective in various types of psoriasis–scalp, guttate, inverse and nail psoriasis. In scalp psoriasis, it is mainly used when psoriatic patches over scalp are attended with marked itching and burning. Slight sticky discharges may be present. In guttate forms it is used when skin is dry and rough with fine scales. In inverse psoriasis it is indicated when patches appear in bends of limbs, groins and behind ears. Lastly in nail psoriasis it is the best indicated when nails are brittle, deformed, and crumbles very easily.

CALCAREA CARB. 30, LYCOPODIUM 200, and GRAPHITES 30: These are selected mainly for scalp psoriasis. Calcarea carb shows a tendency toper spire freely mostly on scalp. In tolerance towards cold, increased body weight and craving for eggs are another set of symptoms that carries importance to make Calcarea carb a choice of medicine in scalp psoriasis. Worsening of symptoms in wet weather may also be seen. The next homeopathic medicine Lycopodium is selected when psoriatic patches over head are attended with excessive itching. Evening time between 4:00 pm to 8:00 pm is the worst time for itching aggravation. The psoriatic subjects needing Lycopodium may give some sort of history related to urinary or gastric sphere. Homeopathic medicine Graphites is used when scalp is covered with thick, dry psoriatic patches and itching with burning accompanies. As a result of intense itching and scratching sticky discharges may be seen on scalp.

GRAPHITES 30, MERC SOL 30, NATRUM MUR 30, SEPIA 30: These Remedies are used for inverse psoriasis. Inverse psoriasis is marked by red, inflamed skin areas in folds of skin like armpits, groins, under breast, bend of knees / elbows. Inverse psoriasis is also called as flexural psoriasis. The main homeopathic remedies for psoriasis for the treatment of inverse psoriasis include Graphites, Merc Sol, Graphites, Natrum Mur and Sepia. Graphites is best choice when inverse psoriasis is mainly seen in groins, bends of limbs and behind ears. Merc Sol is to be thought of in inverse psoriasis when excessive sweating accompanies and worsens the symptoms. Natrum Mur and Sepia both works well in inverse psoriasis when bends of limbs are involved.

ANTIMONIUM CRUDUM 200, GRAPHITES 30: These are used for Nail psoriasis. Graphites is indicated when nails are deformed, brittle and crumbling. Nails may also get thickened, and may become sore and painful. Antimonium Crudum works best where nails are split and grow out of shape. The nails are also discolored ranging from yellow to red.

HEPAR SULH 0, SILICEA 30: Homeopathic remedies for psoriasis when it is of the pustular type are Hepar Sulph and Silicea. Both these medicine occupies high rank in homeopathy for eruption with pus discharges. Hepar Sulph is indicated when excessive burning, stinging pains are present and skin is sensitive to touch. Warm coverings are preferred by the person needing Hepar Sulph. Silicea is second most preferred homeopathic medicine whenever skin shows suppurating tendencies. Silicea helps in proper healing of pustular psoriasis by absorbing the pus in the most harmless manner.

SULPHUR 200, RADIUM BROMIDE 30, STAPHYSAGRIA 30, RHUS TOX 30: These are for psoriasis when joints are involved. Sulphur can be used when incremented utilizations of local medication have suppressed the psoriatic skin lesions and joints are affected thereafter. Radium Bromatum is utilizable for where the psoriatic patches have itching and the joint pains are worse at night. Staphysagria can be used when skin symptoms alternate with joint pains. Rhus Tox is serviceable for mitigating acute joint pain attacks in psoriatic arthritis.

CHRSAROBINUM 30: If the nails become dull and develop ridges and pits. Vesicular lesions with fetid discharge and crust formation. Thighs, legs and auditory perceivers are specially affected.

HYDROCOTYLE ASIATICA 20: Psoriasis of soles, palms and extremities with circular patches. Circular spots with scaly edges. The skin is exorbitantly thick and dry.

CARCINOCIN1M: A monthly dose as an inter current remedy ensures, prompt cure.

Conclusion

Psoriasis is a dreadful disease affecting physical, noetic and gregarious status of the victims. An incipient understanding of this involute disease has catalyzed the development of targeted biological treatments. These revolutionary therapies are not without potential peril, however. A review of alternative natural therapies provides some options for incrementing safety and efficacy in the management of psoriasis. This review will surely prove to be an ocular perceiver-opener for patients suffering from psoriasis as well as the medical practitioners, pharmacists, nurses and other persons involved in the treatment of psoriasis and avail them to understand the disease in a much better way to carry out safe and efficacious treatment of the disease.

References

1. Samuel M.L., Donald P.M., Hurley J.H. (1986). In Jr. Dermatology, Vol-I. W. B. Philadelphia : Saunders Company, p. 204.

2. Lo K.K., Ho L.Y. (1997). In Psoriasis: Handbook of Dermatology and Venereology. 2 nd Edn., Hong Kong: Social Hygiene Service, Dept. of Health.

3. Camp M., Barker J.N. (2005). Psoriasis: Burns D.A., Breathnach S.M., Cox N., Griffiths C.E., eds. In Rook's Textbook of Dermatology. 7th ed. Oxford: Blackwell, 35(1):35-69.

4. Walter L.F., Gundula S. (1981). In Histopathology of the skin. 3rd Edn., Boston, Massachusetts: Lippincott,. p.156-64.

5. Nevitt G.J., Hutchinson P.E. (1996). Psoriasis in the community; prevalence, severity and patients belief and attitudes towards the disease. Br J Dermatol, 135:533-537.

6. Adams P.F. and Marano M.A. (1995). Current estimates from the national health interview survey. Vital health stat, 10(193):1-141.

7. Capon F., Munro M., Barker J., Trembath R. (1998). Searching for the major histocompatibility complex psoriasis susceptibility gene. J Invest Dermatol, 118:745-751.

8. Rahman P., Elder J.I. (2005). Genetic epidermiology of psoriasis and psoriasis arthritis. Ann Rheum Dis, 64(2) : 37.

9. Zachariae H. (1996). Prevalence of joint disease in patients with psoriasis: In implications for therapy. Am J Clin Dermatol, 4:441-447.

10. Sachappert S.M. (1998). Ambulatory care visits to physician offices, hospital outpatient departments and emergency departments: United States, 1996, National center for health statistics. Vital health stat, 134(13):1-37.

11. Deodhare S.G., General Pathology & Pathology of System, Popular Prakashan, Mumbai, 2nd edition,1553.

12. Robbins, Cotran. Pocket Companion to Pathologic Basis of Diseases, 7th ed., p.620.

13. Telfer N.R., Chalmers R.J., Whale K., Colman G. (1992). The role of Streptococcal infection in the initiation of guttate psoriasis. Arch Dermatol, 128(1):39-42.

14. Jain S., Gupta O. P. (2005). Dermatitis in Ayurveda with special reference to psoriasis (Kitibha). Aryavaidyan, 28(1): 226-34.

15. Kumar, Abbas, Fausto, Robins, Cotran. Pathological Basis of Disease, Published By Savnders, 7th ed., p.1256

16. Gottlieb S.L., Gilleaudeau P., Johnson R., Estes L., Woodworth T.G., Gottlieb A.B., et al. (1995). Response of psoriasis to a lymphocyte-selective toxin (DAB389IL-2) suggests a primary immune, but not keratinocyte, pathogenic basis. In Nat Med, 1:442–7.

17. Raychaudhuri S.P., Rein G., Farber E.M. (1995) Neuropathogenesis and neuropharmacology of psoriasis. In Int J D**ermato, 34:685-693.**

18. Ortonne J.P. Aetiology and pathogenesis of psoriasis (1996). Br J Dermatol, 135(49):1-5.

19. Robert C., Kupper T.S. (1999). Inflammatory skin diseases, T cells and immune surveillance. N Engl J Med, 341:1817-1828.

20. Simonetti O., Lucarini G., Goteri G., et. al. (2006). VEGF is likely a key factor in the link between inflammation and angiogenesis in psoriasis: results of an immunohistochemical study. In Int J Immunopathol Pharmacol, 19:751-760.

21. Cruickshank R. (1965). Medical microbiology; a guide to diagnosis and control of infection. 11 th ed. Ediburg; London: E and S Livingston Ltd. p 888-889.

22. Zanolli M.D., Camisa C., Feldman S., et. al. (2000). Psoriasis: the high notes on current treatment. Program of the American Academy of Dermatology, Nashville, TN.

23. Brown A.C., Hairfield M., Richards D.G., McMillin D.L., Mein E.A., Nelson C.D. (2004). Medical nutrition therapy as a potential complementary treatment for psoriasis--five case reports. In Altern Med Rev, 9(3):297-307.

24. Gupta A.K., Ellis C.N., Tellner D.C., Anderson T.F., Voorhees J.J. (1989). Doubleblind, placebo-controlled study to evaluate the efficacy of fish oil and low dose UVB in the treatment of psoriasis. In Br J Dermatol, 120:801-807.

25. Mason J., Mason A.R., Cork M.J. (2002). Topical preparations for the treatment of psoriasis: a sys tematic review. In Br J Dermatol, 146:351-64.
26. Asadullah K., Volk H.D., Sterry W., (2002). Novel Immunotherapies for Psoriasis. In Trends Immunol, 23:47-53.
27. Greaves MW, Weinstein GD. (1995). Treatment of psoriasis. In Drug Ther, 332(9):581-7.
28. Kennet G.L., Gerald D., Weinstein. (1999). Psoriasis: Current perspectives with an emphasis on treatment. The American Jr of Medicine, 107: 595-605.
29. Di Fabio, Anthony (1990). .A Surprising Psoriasis Treatment, Townsend Newsletter for Doctors, (June).
30. Lithell H., Bruce A., Gustafsson I.B., et. al. (1983). A fasting and vegetarian diet treatment trial on chronic inflammatory disorders. Acta Derm Venereol, 63:397-403.
31. Naldi L., Parazzini F., Peli L., et. al. (1996). Dietary factors and the risk of psoriasis. Results of an Italian case-control study. Br J Dermatol, 134:101-106.
32. Adam O., Beringer C., Kless T., et al. (2003). Antiinflammatory effects of a low arachidonic acid diet and fish oil in patients with rheumatoid arthritis. Rheumatol Int, 23:27-36.
33. Calder P.C. (2006). n-3 Polyunsaturated fatty acids, inflammation, and inflammatory diseases. Am J Clin Nutr, 83:1505S-1519S.
34. Andrew I.B., Richard A.B., Jeffery W.J., Mark P.L. (2004). Emerging therapeutic targets in psoriasis. Current opinions in pharmacology, 4:306-310.
35. Lebwhol M. (1995). Future psoriasis therapy. Dermatol clin, 13:915-923.
36. Mark L. (2004). Innovation in the treatment of psoriasis. J American Acad Dermatol, 51(1):40-1.
37. Walter J.F., Stoughton R.B., Dequoy P.R. (1978). Suppression of epidermal proliferation by ultra violet light, coal tar and anthralin. Br J Dermatol, 99:89-96.
38. Williums R.E. et. al., (1992). Re-examining crude coal tar treatment for psoriasis. Br J Dermatol, 126:608- 10.
39. Garg M., Garg P., Mishra D., Jain S., Agashe H., Jain A.P., et al. (2005). Psoriasis: Treatment with Calcipotriol. Ind J Pharm Sci, 67(3): 283-91.
40. Grant W.B., Holick M.F. (2005). Benefits and requirements of vitamin D for optimal health: a review. Altern Med Rev, 10:94-111.
41. Weinstein et. al. (1997). Tazarotene jel, a new retinoid for topical therapy of psoriasis. Vehicle controlled study of safety, efficacy and duration of therapeutic effect. J American acad Dermatol, 37:85-92.
42. Swanson D.L., Barnes S.A., Mengden Koon S.J., el-Azhary R.A. (2007). Caffeine consumption and methotrexate dosing requirement in psoriasis and psoriatic arthritis. Int J Dermatol, 46:157-159.
43. Strober B.E., Menon K. (2005). Folate supplementation during methotrexate therapy for patients with psoriasis. JAm Acad Dermatol, 53:652-659.
44. Salim A., Tan E., Ilchyshyn A., Berth-Jones J. (2006). Folic acid supplementation during treatment of psoriasis with methotrexate: a randomized, double-blind, placebo controlled trial. Br J Dermatol, 154:1169-1174.
45. Fiorentino D. (2007). The yin and yang of TNF-(alpha) inhibition. Arch Dermatol, 143:233-236.
46. Bradley P. (1992). British Herbal Compendium Bournemouth, UK. British Herbal Medicines Association.
47. Brown D.J. and Dattner A.M. (1998). Medical journal article on herbs for common skin conditions. Arch dermatol, 134:1401-04.
48. Satyavati G.V. (1990). In: Farnsworth N.R., Wagner H. (Eds). Economic and medicinal plant research, Academic press Limited; London, 163-198.
49. Davis R.H., Parker W.L., Samson R.T., Murdoch D.P. (1991). Isolation of a stimulatory system in an aloe extract. Journal of the American Podiatric Medical Association, 81:473–478.
50. Hodak E., Gottlieb A.B., Segal T. et al. (2003). Climatotherapy at the Dead Sea is a remittive therapy for psoriasis: combined effects on epidermal and immunologic activation. J Am Acad Dermatol, 49:451-457.
51. Farber E.M., Nall M.L. (1974). The natural history of psoriasis in 5600 patients. Dermatologica, 148:1-18.
52. Rao S., Udupa A., Udupa S., Rao P., Rao G., Kulkarni D. (1991). Calendula and hypericum: Two homeopathic drugs promoting wound healing in rats. Fitoterapia, 62:508.
53. Wardrop P., Waller R., Marais J., Kavangh G. (1998). Tonsilitis and chronic plaque psoriasis. In Clin Otolaryngol, 23:67-8.
54. Malerba M., Gisondi P., Radaeli A. et al. (2006). Plasma homocysteine and folate levels in patients with chronic plaque psoriasis. Br J Dermatol, 155:1165-1169.
55. Poulin Y., Pouliot Y., Lamiot E. et al. (2005). Safety and efficacy of a milk-derived extract in the treatment of plaque psoriasis: an openlabel study. J Cutan Med Surg, 9:271-275.

100 Years of Organon

Photo Credit: https://www.vecteezy.com/vector-art/2093936-100-year-anniversary-design-illustration.Artist:maksum iliasin

100 Years of Publication of the Sixth Organon

Dr. Rachna Srivastava
M.D. (Hom.)
Life Member IIHP
The Healthy Way Homeopathic Clinic, Lucknow
drrachna.srivastava@gmail.com
thehealthyway.in
9453135917

By February of 1842, in his eighty-sixth year, Dr. Hahnemann completed the sixth edition of the Organon. He completed the thorough revision of it by carefully going over paragraph by paragraph, making changes, annotations and additions. This sixth edition of the "Organon" ready for publication, was considered as the most nearly perfect of all, by Hahnemann himself. It contained important changes from the 5th edition published in 1833.

Dr Hahnemann shared a lot of facts of this Organon, (esp. regarding the LM potencies) to his fellow practitioners including Dr Boenninghausen, through his letters. Dr Boenninghausen was one of the best friends and followers of Hahnemann. It is also well known through his letters that Dr Hahnemann, made several attempts to publish his Organon in Germany as well as in France but he could not and unfortunately, passed away in Paris, on 2 nd of July of 1843, leaving his second wife Mrs. Melanie Hahnemann as the custodian of his writings.

Just a few years before Hahnemann's death, Melanie adopted a five-year-old girl named Sophie. In June 1856, Madam Melanie went to Munster, to visit Dr. Boenninghausen, where he requested her to publish Hahnemann's invaluable works and not to keep it in dark. He requested her to let the treasure of the sixth Organon be known to the world for the benefit of the mankind.

During that period Melanie was on the target of Homeopaths of Paris and had also undergone a legal trial owing to having a medical practice without any official license. She wanted to have a secure future for herself and her adopted daughter Sophie. So, when Sophie grew up Melanie wanted to marry her off to one of the sons of Boenninghausen – Karl. Karl was a graduate in medicine and thus an authorised practitioner of Homeopathy. Dr. Boenninghausen was a bit reluctant in the beginning but he later agreed.

Dr Boenninghausen was very excited to know that the sixth Organon will soon be published and that he was about to get some of the hand-made medicines of Hahnemann by Melanie. Dr Boenninghausen happened to share the exciting news with his fellows of Rhineland in a yearly meeting in Westphalia. Without any consent of Boenninghausen the sensational news was published in a famous journal named "Allgemeine Hom. Zeitung" on 29th of August 1856.

This led to a misunderstanding between Melanie and Boenninghausen and she rebuked him of making her statement public in this way. Nevertheless, Sophie and Karl tied the knot in 1857 and started to live with Melanie at her home in Paris. Melanie could achieve all that she wanted to but she did not keep her promise. After this nothing was heard about the sixth Organon nor did she give any samples of Hahnemann's medicinesto Boenninghausen, instead she only sent a few unrelated, mismatched pages from the "Sick Registers" of Hahnemann. Boenninghausen was highly ridiculed by hisfellowsfor this and he finally died in 1864 without witnessing the publication of the sixth Organon.

In 1865, Dr Arthur Lutze of Kothen published his Organon (called Lutze's Organon) with disputed paragraphs that Hahnemann had long discarded. His Organon was highly criticized and the whole homoeopathic profession including that of Europe and America refused to have anything to do with Lutze's edition of Hahnemann's Organon, due to various reasons. Around the same time, Amalie's son and grandson of Hahnemann, Dr. Leopold Suss Hahnemann, declared in a famous journal that he was about to publish the sixth Organon. Melanie got enraged and she instantly denied the authenticity of both versions. Also, for the first time,she publicly admitted in written thatshe and only she had the complete manuscript of the sixth Organon and thus only she was legally authorized to publish it and nobody else and also that she is planning to publish it very soon.

In reply to Melanie's threatening remarks, Dr. Leopold wrote in a journal that it was just a matter a misprint. He was actually about to republish the fifth Organon which has gone out of print, but it was mistakenly printed as the sixth and that he was legally authorised to republish the fifth edition as it was the property of his aunt Louise from whom, now he inherited it. However, later on Dr. Leopold revealed in British Journal of Homeopathy (1865, Vol. 23, Page 422) that he had no intention to publish any version of Organon and that he purposely printed it sixth instead of fifth. In fact, all he wanted was to excite Melanie so that at

least she comes up saying that she is willing to publish the sixth Organon because she did nothing regarding it for more than twenty years.

The trick did work to a certain extent because after this episode Melanie started to receive several approaches from various Homeopaths around the world with a view to publish the sixth Organon. The famous names among them were of Dr Hering, Dr Dunhum, Dr Bayes, Dr Wilson, Dr Campbell, etc. She demanded a handsome amount of 50,000 dollars regarding the same. In today's context, in Indian rupees it holds equivalent to 6 crore, 30 lakh rupees! This was a huge amount and obviously nobody could ever pay it for a book.

This is one of the reasons why Dr Richard Haehl one of the finest biographers of Hahnemann writes in his famous book – Samuel Hahnemann, his life and work, that Mrs. Hahnemann behaved strangely after the death of his husband and that she was completely a business woman. Eventually around 1870-71, Karl and Sophie left for Germany due to Franco-Prussian War and they took with them all literary works of Hahnemann along with the original manuscripts of sixth Organon for safekeeping. It is known that Melanie too went with them but later on returned and eventually died a few years later on 27th May 1878.

Now since, Melanie Hahnemann's death, Boenninghausen family had been owners of the treasure. Sophie continued the talks to various Homeopaths around the world like her mother. In around 1880, she demanded 25,000 dollars and all the royalties of the sixth Organon. In today's context, in Indian rupees it holds equivalent to 5 crore, 3 lakh rupees! Thistoo was a huge amount for a book and therefore homeopaths now began to lose interest in the Organon.

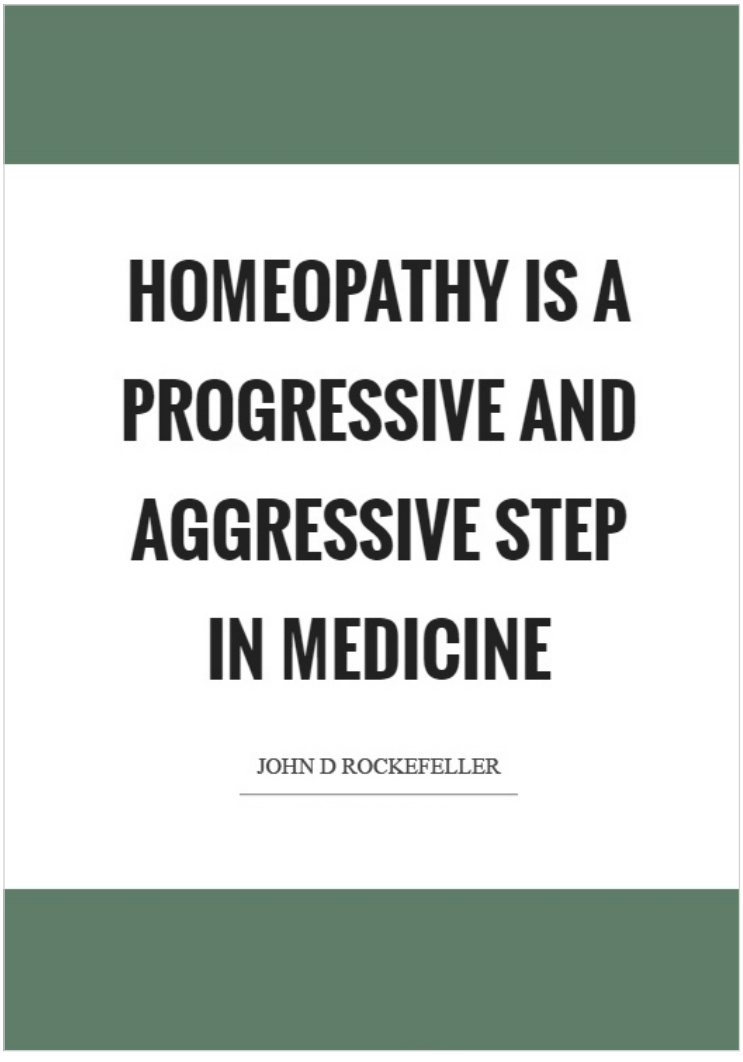
At last, in 1897, Dr Richard Haehl – a student of Dr T.L. Bradford from the Hahnemann College of Philadelphia, took interest and wanted to publish the sixth Organon. He made several efforts to obtain Hahnemann's original manuscripts and records for publication. He was constantly in touch with Sophie through letters and kept negotiating to her regarding the same. In 1900 he could finally visit Darup, a place near border of Netherlands, in Germany, where the Boenninghausen family lived.

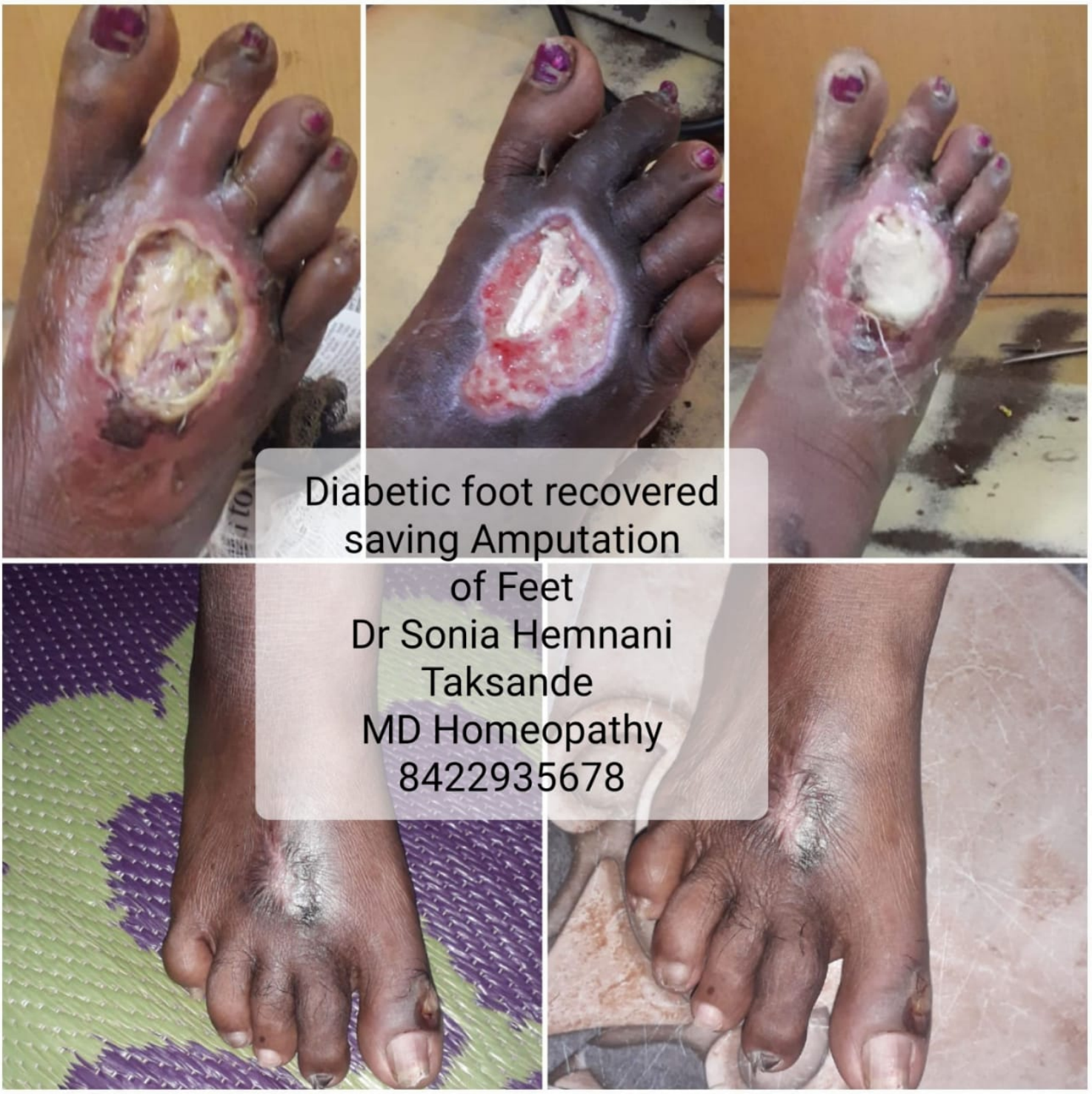
As he reached, it was known that Sophie, had died a year before. So, he tried to negotiate with her husband Karl but all in vain and a couple of years later Karl Boenninghausen too died leaving no direct descendants. In 1906, Dr. Haehl again traveled with his good friend Professor William Boericke, from San Francisco in North America to Darup in Germany, Europe. They both attempted to obtain the release of the literacy legacy, particularly of Hahnemann's case- books, and of the sixth edition of the Organon, but failed.

Hahnemann's literary heritage had changed hands several times. From 1914 to 1918, first world war was started and travelling became almost impossible. In desperation, Dr. Haehl had almost given up hope, when at last he succeeded in obtaining the complete legacy of the master in 1000 dollars. In today's context, in Indian rupees it holds equivalent to 10 lakh 27 thousand rupees!

With the financialsupport of the American homoeopaths, esp. William Boericke, the Stuttgart homoeopath – Richard Haehl managed, to buy Samuel Hahnemann's literary heritage (including the manuscript of the sixth Organon) from the Boenninghausen family in 1921. By Dec. 1921 the English edition translated by William Boericke was published by Boericke and Tafel and came into light by the next year in 1922.

The documents had been held back for almost eighty years, but were at last to become accessible due to the untiring efforts of Dr. Richard Haehl and Dr William Boericke. Twice the manuscripts and casebooks of Hahnemann were in danger of being lost, once during the siege of Paris in the Franco-Prussian War of 1870-71 and a second time during the First World War. It is the reason we are ever grateful to Dr. Richard Haehl and Professor William Boericke. This year as we are celebrating the 100 years of the publication of the lost treasure – the Sixth Organon, we yet again honor them for their great contribution and relentless dedication towards Homeopathy.





Diabetic Foot

Recovered by Homoeopathy

Amputation Averted With Homeopathy: A Case of Gangrene Treated Well With Secale Cor

Dr Sonia Hemnani Taksande.
MD Homoeopathy
Mb: 8422935678

Gangrene is defined as localized death of a body tissue caused due to obstruction of circulation of blood or any bacterial infection. Usually, a chronic case of gangrene terminates into amputation of the part to prevent its spread to the other areas.

But here I would like to present an excellent case of gangrene which has totally healed with therapeutic doses of homeopathy and hence, amputation was avoided.

Mrs. MGS, a 48-year-old female, a known case of diabetes since past 12 years visited me on 30th March, 2021 for gangrene of foot, with great difficulty in moving the leg, pain, bleeding and loss of sensation.

She wanted to keep the wound uncovered and felt better after putting them in water; however, her doctor asked her not to put water on that.

She experienced intense burning on the foot, tingling and numbness around the wound, but it was a dry wound when she came for the first time.

Her physical generals were as follows:

Appetite:	**Cannot tolerate hunger**
Thirst:	**6-7 glasses per day**
Cravings and Aversions:	**Not specific**
Stools:	**Normal**
Urine:	**Normal**
Perspiration:	**On exertion**
Sleep:	**Sleepless**
Thermals:	**Hot**

She belonged to low socio-economic strata, has a turbulent past, a divorcee, while her kids were left to be raised at her sister's place as she couldn't manage the finances.

She was persistently angry on herself and faced tremendous anxiety and apprehension about her future, financial conditions and her current state of living.

Prescription And Follow ups:

30th March 2021: I decided to go with the therapeutic prescription and hence selected Secale Cor 30.

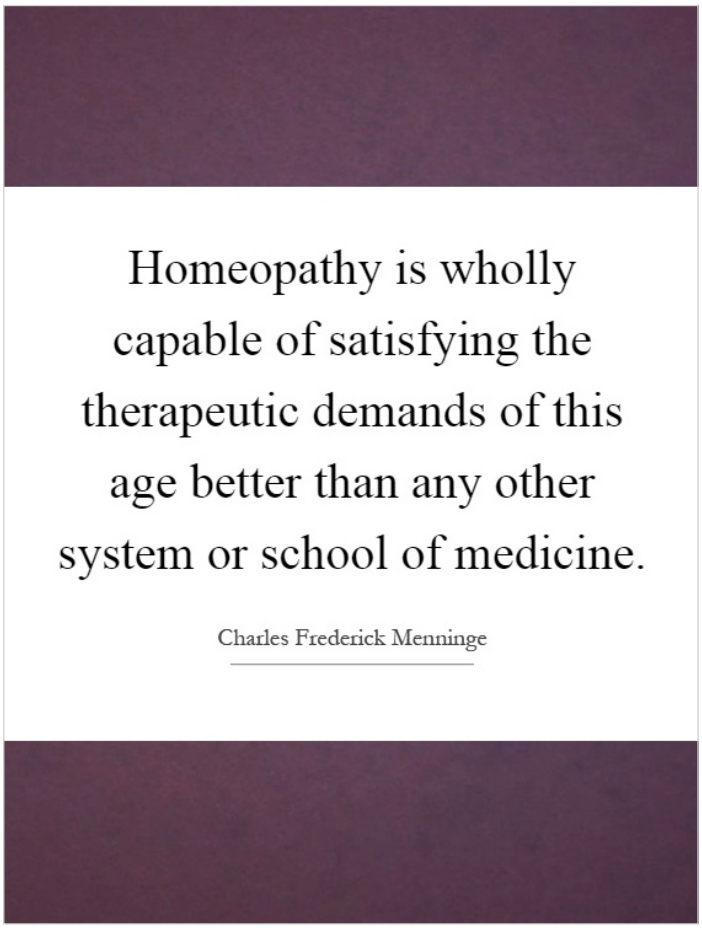
15th April 2021: The wound was healing but still there. There was pain, intense burning, bleeding, and no sensation.

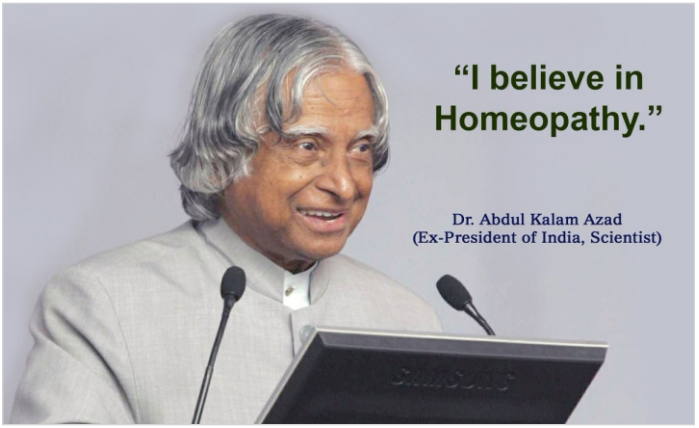
I increased the dose to Secale Cor 200 and repeated for a month.

Her subsequent follow ups have been excellent and she showed great signs of healing.

A detailed progressive report can be seen here in the photographs and one can see how phenomenal the changes have been.

Returning to normalcy, a complete healthy foot and a big smile on the patient's face are the biggest accolades a doctor can ever receive. I am glad I was able to make that difference to the patient's life and it was never possible without the magic and science of Homeopathy.





Puzzle - Authors Of Homoeopathic Literature

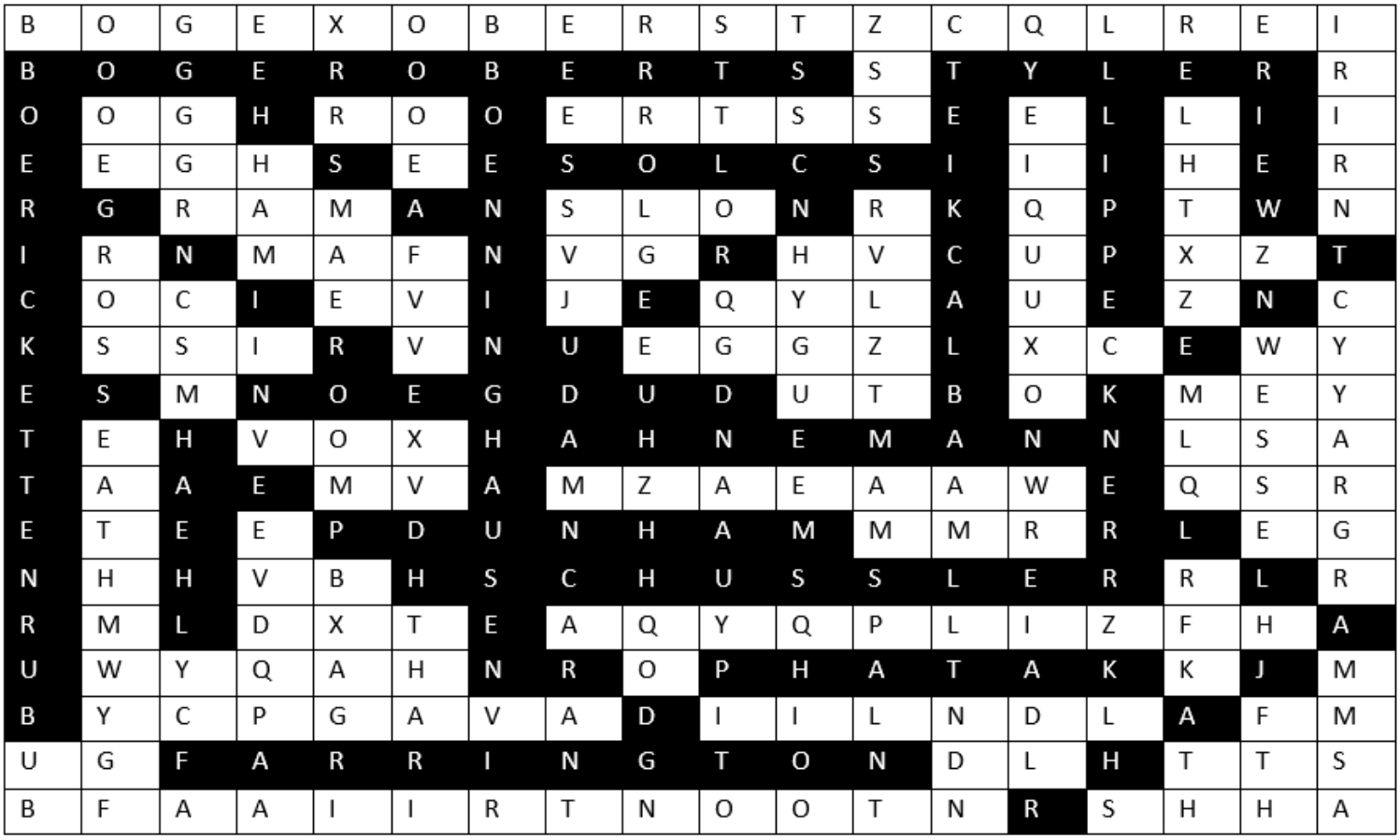
Dr.A.Kaumudi padma mala (M.D)
Sirivennela homoeo clinic Visakhapatnam,A.P
9247177528
Kaumudipadmamala@gmail.com

1) Author of Hahnemann consultation bank
2) Author of Comparitive Materia medica
3) Author OF Repertory Index to Materia Medica
4) Author of Lectures on Homoeopathic Materia Medica
5) Author of Desires & Aversions
6) Author of Thousand Remedies
7) Author of Testimony of the clinic
8) Author of Samuel Hahnemann –His Life & Works
9) Author of Genius of Homoeopathy
10) Author of Studies in the Philosophy of Healing
11) Author of the Science & Art of Homoeopathy
12) Author of How to take the Case
13) Author of Sensations as if
14) Author of Therapeutic Pointers to some common Diseases
15) Author of Homoeopathic Drug Pictures
16) Author of The Patient not the Cure-The Challenge of Homoeopathy
17) Author of Therapeutic Pocket Book
18) Author of More Magic Of Minimum Dose
19) Author of Homoeopathic Therapeutic Hints
20) Author of 50 reasons for being a Homoeopath
21) Author of Repertory to the Guiding Symptoms
22) Author of Model cures
23) Author of concise Repertory of Homoeopathy
24) Author of an Abbreviated therapy –the biochemical treatment of disease
25) Author of the venereal diseases, their pathological nature, diagnosis and homoeopathic treatment

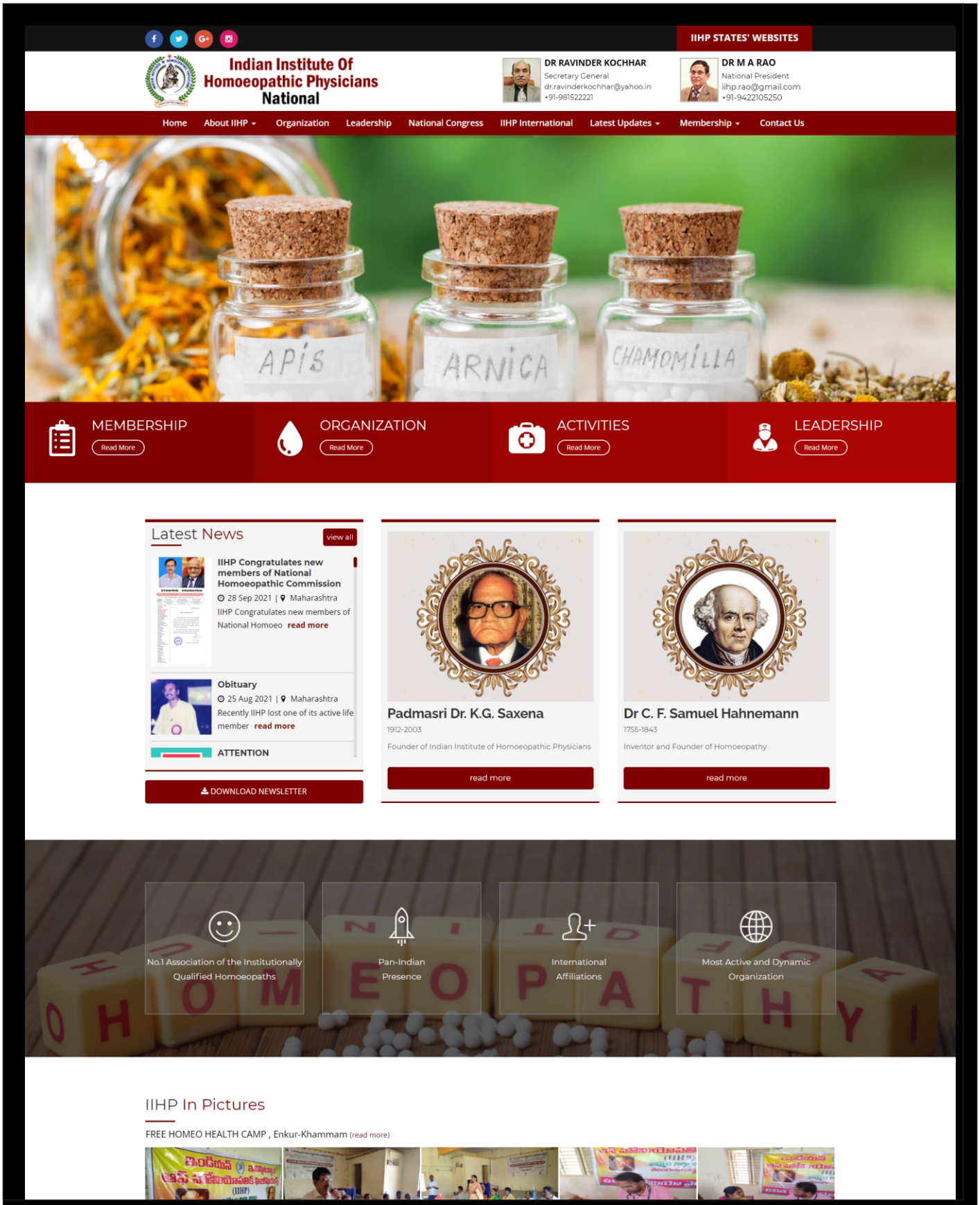
Find the Authors of Homoeopathic Literature in this puzzle- Across, Down, Above downwards,Below upwards,Cross, Reverse etc

B	O	G	E	X	O	B	E	R	S	T	Z	C	Q	L	R	E	I
B	O	G	E	R	O	B	E	R	T	S	S	T	Y	L	E	R	R
O	O	G	H	R	O	O	E	R	T	S	S	E	E	L	L	I	I
E	E	G	H	S	E	E	S	O	L	C	S	I	I	I	H	E	R
R	G	R	A	M	A	N	S	L	O	N	R	K	Q	P	T	W	N
I	R	N	M	A	F	N	V	G	R	H	V	C	U	P	X	Z	T
C	O	C	I	E	V	I	J	E	Q	Y	L	A	U	E	Z	N	C
K	S	S	I	R	V	N	U	E	G	G	Z	L	X	C	E	W	Y
E	S	M	N	O	E	G	D	U	D	U	T	B	O	K	M	E	Y
T	E	H	V	O	X	H	A	H	N	E	M	A	N	N	L	S	A
T	A	A	E	M	V	A	M	Z	A	E	A	A	W	E	Q	S	R
E	T	E	E	P	D	U	N	H	A	M	M	M	R	R	L	E	G
N	H	H	V	B	H	S	C	H	U	S	S	L	E	R	R	L	R
R	M	L	D	X	T	E	A	Q	Y	Q	P	L	I	Z	F	H	A
U	W	Y	Q	A	H	N	R	O	P	H	A	T	A	K	K	J	M
B	Y	C	P	G	A	V	A	D	I	I	L	N	D	L	A	F	M
U	G	F	A	R	R	I	N	G	T	O	N	D	L	H	T	T	S
B	F	A	A	I	I	R	T	N	O	O	T	N	R	S	H	H	A

KEY



1) HAHNEMANN
2) LIPPE
3) ALLEN
4) KENT
5) GUERNSEY
6) BOERICKE
7) NASH
8) HAEHL
9) CLOSE
10) BOGER
11) WEIR
12) DUNHAM
13) ROBERTS
14) FARRINGTON
15) TYLER
16) BLACkIE
17) BOENNINGHAUSEN
18) SHEPHERD
19) DUDGEON
20) BURNETTE
21) KNERR
22) HERING
23) PHATAK
24) SCHUSSLER
25) JAHR



Everything About IIHP – Online

www.iihp.in

Join Indian Institute of Homoeopathic Physicians

APPLICATION FORM FOR LIFE MEMBERSHIP

To

The National Secretary General

Indian Institute of Homoeopathic Physicians

Dear Sir,

I would like to join in IIHP as a Life Member. I am here with furnishing my details for your perusal.

Name of the Doctor : _____

Qualification :_____ Regn. No. _____

Name of the Board / Registering Council_____

Name of the College _____

Mailing Address with PIN Code_____

Contact details : Land Line _____Mobile No. _____Email ID_____

Introduced by : Dr. _____ Place _____

I am here with enclosing the Membership fees of Rs. 3000/- (Rupees Three Thousand only) by Cash / DD/ Cheque / Bank transfer towards Life Membership fees. All the cheques & DD's must be drawn in the name of "Indian Institute of Homoeopathic Physicians", payable at Nagpur

IIHP Account details

Name of the Account : Indian Institute of Homoeopathic Physicians

Account Number : 34824686375 : IFSC Code: SBIN0009060 : Bank : State Bank of India

Branch : Coal Estate, Civil lines, Nagpur, Maharashtra

I here by undertake to abide by the Bye-laws, rules and regulations of IIHP

Signature of the Applicant

Signature of the introducer : _____

Date : _____

READ MORE

How to join IIHP:
http://iihp.in/membership.html

Why Join IIHP
http://iihp.in/why-join-iihp.html

LONELY

In This Networked World

JOIN IIHP

The Network for the Homoeopathic Professionals

www.iihp.in

Photo Credit: brian-asare-b1l8mK24x_k-unsplash.com