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Challenges to homeopathic treatment by previous use of immunosuppressive medicines: observations from clinical practice

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Summary

This article discusses the author's clinical experience with the challenges a homeopath is confronted with in cases where patients have a history of recent or past use of immunosuppressive medicines.

Keywords

Immunosuppressive medicines; Corticosteroids; Methotrexate; Cyclophosphamide; Cyclosporine; Homeopathic treatment

After having treated a few thousand cases of skin diseases such as psoriasis, chronic urticaria, vitiligo, lichen planus, eczema, seborrhic dermatitis, and other immunologically-mediated diseases such as asthma, ulcerative colitis, nephrotic syndrome, psoriatic arthritis, and the like, I would like to share some insights on the challenges placed by the previous use of immunosuppressive medicines to homeopathic treatment.

Immunosuppressive medicines such as corticosteroids, tacrolimus, methotrexate, cyclophosphamide, cyclosporine etc. aim to suppress the immune response of the body, reduce the activation or efficacy of the immune system, and are conventionally used to achieve relief in a range of autoimmune diseases. They are quite effective in bringing about significant improvement in short time. Such medicines often are life saving in critical situations such as acute crisis in nephrotic syndrome, angioneurotic edema (respiratory distress), acute flares of severe forms of atopic dermatitis in infants, severe exacerbation of asthma, etc.

Homeopaths often tend to believe that identifying the constitutional medicine is the only practical challenge in practice, since once it is found all problems automatically end. However, experience in treating difficult diseases suggests that there are greater challenges in homeopathic practice, which have been overlooked and need to be worked over.

Some of such challenges are posed by the use of immunosuppreessive medicines. No matter the route of administration - oral, topical, intramuscular or intravenous injection, mouthwash, etc. - the difficulties to therapeutic management are

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significant. Some of the situations appearing after the used of these medicines, as it can be observed in actual practice, are described below:

1. Disease might initially improve, but *tends to bounce back* once treatment is discontinued. This is a common observation by homeopaths as well as by conventional doctors and patients. The exact mechanism of this bounce back effect is not yet fully understood.

2. When disease bounces back is comparately *more difficult to treat* than originally. This is hinted at by the fact that such situations require higher doses of the same medicine or the use of more powerful ones. This can best be illustrated with the examples of many cases (from my practice) of nephrotic syndrome, rheumatoid arthritis and psoriasis, who are on cortisone for a long time, tend to become resistant and require cyclophosphamide and methotraxate, respectively. Again, the exact immunological dynamics need exploration. The homeopathic angle calls for strategic updates in the form of (deeper acting) remedy selection, (moderate or higher) potency selection, (frequent) repetition and suitable use of nosode administration.

3. The organism develops *dependency* on the medicine. Patients feel relief thus keep on using the medicine, whereas discontinuation is followed by a return of symptoms. A kind of addiction develops in the course of time, and it is a common occurrence also evident to the patients themselves. This variety of immunosuppressive medicine *dependent* (and then *resistant*) cases of chronic diseases is the most challenging observed in my practice. Psoriatic arthritis, Nephrotic Syndrome, severe oral Lichen Planus are some of the examples in this category. It can be emphasized that the professional homeopaths have to deliberate on this challenge; work and research to find practical solution for the treatment of diseases in this category.

4. In situations of bounced back disease, milder medicines *may take longer to work*. For instance, an untreated case of eczema in a young lady who would otherwise respond to *Pulsatilla nigra* 30c, one singlr dose, might not respond to the same when she first consults with post-cortisone *bounced back* eczema. She is likely to need a higher dilution, may be more repetitions, and the subsequent help of some nosode. It can also be said that *immune-compromised* cases call for different therapeutic strategies.

5. Their use is associated with significant adverse effects, which are very well known by medical practitioners.

6. The disease is apparently suppressed, since it actually **expresses itself elsewhere**. This is a common notion in homeopathy and is easily to verify in cases of lichen planus, vitiligo or psoriasis: spots are removed by corticoids only to reappear elsewehere as any homeopath sees in everyday practice. Disease not only changes it localization, but might affect more deeply the organism, as it is illustrated by arthritis followed by suppression of psoriasis with cortisone or methotrexate.

7. It is very easy to start the use of immunosuppressive medicines, but is very *difficult to discontinue it*.

It is widely believed that the adverse effects of immunosuppressive medicines are the only major problem they pose. However, in our experience all the problems listed above are major issues to be dealt with. As a fact, one can dare to assert that adverse effects are not only one among them but even among the lesser ones. For instance, upon reducing or discontinuing the use of immunosppressive drugs, especially after having started homeopathic medication, the resurfaced symptoms might give the impression of having been caused by the latter. Some homeopathic practitioners mistakenly rate them a *homeopathic aggravation* and thus misdirect the line of treatment.

Professional management of such situations includes:

1. Gradual withdrawal of drugs: immunosuppressive medicines cannot be withdrawn abruptly as a rule. I removed the sentence that originally followed, because in Brazil only MDs can be homeopaths and this journal is specifically directed to formally trained health providers.

2. Approach of treatment in stages. Some examples are given below.

- Patients who had recently started immunosuppressive treatment, e.g. methotrexate 10 mg, daily, for psoriasis about a week before.
  In this case it is possible to discontinue treatment quickly, since the patient has not yet developed dependence when it is first-time use and psoriasis is mild to moderate. In more extended or severe affections with joint involvent, strategy is different.

- Patients using topical corticoids twice a day for severe atopic atopic dermatitis for about one month.
  Reduction or discontinuation of treatment will lead to the reappearance of the eruption. Patients must be warned as to this phenomenon. Many homeopathic practitioners use to start treatment and at the same time ask patients to discontinue the use of cortisone and mistake this event as a homeopathic aggravation.

- Patients using high doses of corticoids for nephrotic syndrome every 3 months in decreasing doses for 2 years.
  This instance poses a major challenge to homeopathic practitioners. In my experience, cases of nephrotic syndrome, as well as of psoriasic arthritis or severe oral lichen planus with long-continued use or systemic corticoids are not infrequent.
  This situation actually poses a dual challenge: on the one hand, the treatment of disease and on the other, the treatment of dependence from corticoids. A

prudent use of the constitutional homeopathic medicine together with a local agent and nosodes can help solve the situation.
It is worth to observe that patients are best counseled when one has considerable experience in understanding this situation and compliance increases when the homeopath is confidente. It goes without saying that to ask patients to discontinue corticoids is irrational and medically incorrect.

- Patients have already discontinued immunosuppressant agents.
  When patients consult us for the first time having already discontinued a long-lasting course of corticoids, e.g., for lichen planus, vitiligo or alopecia areata, they presents us a particularly difficult situation, since disease will bounce back by the same homeopathic treatment is started. Practitioners must be sharply aware of this circumstance and warn patients about it and to distinguish explicitly from a potential homeopathic aggravation.

Other aspects also need to be highlighted:

1. Understanding of the disease:
Medical knowledge including that of the immune-pathogenesis of diseases such as lichen planus, chronic urticaria, alopecia areata, etc. that may be pose a challenge due to the use of corticosteroids, helps in determining the course of homeopathic treatment. For example, urticaria tends to be more dynamic and can become eventually life-threatening when angioedema develops. Thus, it requires close watch and patient must be given orientation as to the use of acute medicines during long-term management.

In some situations, e.g. serious flares, (correct) use of immunosuppressive drugs might be indicated. This is not rare in the treatment of immuno-compromised cases of nephrotic syndrome, cortisone-dependent ulcerative colitis, etc., where homeopathic treatment might not induce the desired response (due to various reasons) within the desired time limit. It might be ethically indicated to suggest correct doses of immunosuppressive medicines under close surveillance, rather than acting dogmatically.

2. Detailed knowledge about the nature of immunosuppressive medicines and their effects (including adverse effects):
This knowledge helps in distinguishing the symptoms of the patient from the ones of the medicine. For instance, most immunosuppressive drugs make patients irritable and violent in attitude; thus these features should not base the choice of homeopathic medicines.

3. Patients in remission and relapse:
Patients in remission or relapse after the use of immunosuppressive drugs pose a particular challenge when consulting a homeopath for the first time.
By principle, homeopaths need to know how to act efficiently in both situations and be able to start treatment independly from the stage of disease. In remission or relapse after immunosuppressive treatment, we must be strategically aggressive, since disease is likely to be more hostile in its behavior.

As a fact, we have no choice but to accept patients undergoing relapse of disease after discontinuation of immunosuppressive drugs, even when we know that it is more difficult to handle than the original condition. On the other hand, this is precisely the kind of circumstance that makes patients realize that they need to shift from conventional to homeopathic treatment.

4. Understanding of the patient's susceptibility:
Age, gender, emotions, pathology and genetic tendencies help determining the individual pattern of susceptibility and consequently, doses and repetitions. Heightened susceptibility in an infant with extensive atopic dermatitis may not call for a remedy in very high dilution, especially when there is a history of suppression by cortisone. In spite of this high susceptibility, the baby may need lower dilutions and infrequent repetitions. Also, such a baby may develop a deadly itch upon reducing cortisone, requiring the use of superficial local remedies in low dilutions, such as *Urtica urens*, *Apis mellifica* or *Antipyrine*.

5. Consideration of the immune state of the patient:
Severely immune-compromised states with prolonged use of corticosteroids or cyclosporine in nephrotic syndrome or psoriasic arthritis, may call for frequent repetition of the constitutional medicine, but initially in low dilution to be gradually increased. My experience suggests that shifting from 30c to 200c or from 200c to 1000c may be a too big jump in many cases. Instead, I shift from 30c to 31c or 35c, and from 200c to 205c, from 1000c to 1005c. This strategy has helped me control unwanted aggravations.

6. Experience with the depth of action of homeopathic medicines:
All homeopathic medicines are not alike. It is the depth of action of each medicine that which determines dilution and repetition in deep-seated pathology such as ankylosing spondylitis, cancer or hepatitis C. Thus, remedies such as *Pulsatilla, Calcarea fluorica, Rhus toxicodendron, Gelsemium*, etc. may need more frequent repetitions compared to *Lycopodium clavatum, Sulphur* or *Silicea terra* in cases of rheumatoid arthritis, while withdrawing immunosuppressive drugs. Medicines need to have an action deep enough as to touch and trigger therapeutic changes in deep-seated diseases such as semi-irreversible pathology as e.g. psoriasic arthritis or scarred lichen planus.

7. Proper use of nosodes and correct timing:
Nosodes may operate as a boon when used in a right dilution at the right time. *Carcinosinum* or *Medorrhinum* used in early phases can bring clarity to cases of psoriasis, eczema, genital lichen planus, ankylosing spondylitis, HIV infection, etc. Based on my experience, I can say that there is no need to wait too long to use a nosode in difficult cases. I prefer to be aggressive in the use of nosodes and introduce them early, and even repeate them at suitable intervals, without any fear of aggravation.

8. Posology (dose and repetition), etc.:
Right medicine, near correct dilution and adequate repetitions, use of local medicines (for pain, itch, acute swelling in flares of rheumatoid or psoriasic arthritis), flexibility in choosing the medicines, etc., all these factors are determining for success in handling the challenges placed by the use of immunosuppressive agents.

9. Scientific yet flexible approach:
Homeopathy is an empirical approach to medicine. Difficult diseases complicated by the use of suppressive drugs become all the more difficult to treat. Scientifically grounded yet flexible application of principles, leads to success in practice.
For example, changing the choice of medicine from favorite *Sepia* to *Thuja* (with less mental symptoms) should be carried out with ease, when indicated, without wasting the time of the patient.

Strategically combined knowledge from medical science (including immunology and research parameters) and homeopathy together can help homeopaths to handle such cases successfully over long periods of time. The approach of the totality needs to be applied in such cases, in the real meaning of the term. Experience shows that superficial theorizing based on some mental symptoms or dream interpretation leading to the selection of some fancy remedy rarely helps in difficult disease situations.

Selection of the right remedy alone is not the only challenge in such cases. It is to the long-term management of cases where our attention should be drawn – however, this is not adequately highlighted by traditional homeopathic teachings.

Patients and doctors must be aware of the limitations due to and the challenges posed by the use of immunosuppressive drugs before opting for their long-term use. Homeopaths need to develop a wider perspective on this situation and must be able to explain it accurately to patients in order to achieve long-term compliance and success.

Final remarks

The guidelines merely sketched out here certainly ought to be described in more detail and probably independently one from another, due to their multi-dimensional nature. In this article, I wished to point out some issues to stimulate reflection and discussion on the management of difficult situations faced by present-day homeopathic practices, which did not occur 100 or 200 years ago. Furthermore, no data are available on these matters in our traditional literature. Therefore, I'd like to end this article with an open call to start discussing together the challenges we meet in everyday homeopathic practice.