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Homeopathic Treatment Protocol in the Management of Chronic Kidney Disease- A Case Report

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ABSTRACT:

The prevalence of chronic kidney disease (CKD) has increased in India over the past two decades commensurate with the global trend. The limitation and complications of renal transplant and dialysis procedure can be reduced by Homoeopathic treatment. The case discussed here is a patient having difficult and burning urination since two years, associated with nausea and no appetite, also chronic joint and back pain. Blood report showed high serum urea (82mg/dl) and serum creatinine (5.3mg/dl) with decreased eGFR (24.5 ml/ min). Urine report showed increased pus cells and USG of kidney showed increased cortical echo texture and high PVRU (85cc) suggestive of CKD. The constitutional remedy selected after repertorisation was *Nux vomica* given in LM potency; *Thuja* was given as intercurrent antisycotic for Benign Hypertrophy of Prostate (BHP) and chronic joint pain; *Cantharis* was used to reduce acute symptoms of urinary infection and *Sabal ser*. Q used as organopathic remedy for BHP. The patho-physiologies, diagnosis and management of CKD are discussed. The effects of homeopathic medicines show reduced serum urea (27mg/dl) and creatinine(0.9mg/dl), increased eGFR, along with correction of UTI and normal kidney in USG report with less PVRU (40cc). This case study shows that early diagnosis and appropriate selection of homeopathic remedies are important to cure CKD and possible resulting renal failure can be prevented.

KEY WORDS: Chronic kidney disease; Homeopathic remedies; Haemodialysis.

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Quick Response code

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INTRODOUCTION:

Among the non-communicable diseases, chronic kidney disease (CKD) now affects more than 500 million people worldwide, with 80% of those affected living in low to middle income countries. In India, the prevalence of CKD has increased substantially in the past two decades with significant cause of mortality and morbidity despite several medical advancements. [1] Deaths caused by CKD were estimated at 71,000 in 2000, are expected to increase 352,000 in 2030. [2]

The definition of chronic kidney disease has been simplified over the last 5 years. It is now defined as the presence of kidney damage for a period greater than 3 months.[3] Stages of Chronic kidney disease

are: stage1- normal or increase GFR >/90ml/min/1.73m^2, stage2- GFR 60-89ml/min/1.73 m^2, stage3- moderately decrease GFR 30-59ml/min/1.73 m^2, stage 4 - severely decrease GFR 15-29ml/min/1.73 m^2 and stage5- kidney failure < 15mi/min/ 1.73 m^2 (dialysis or replacement if uraemia present). [4] Stage4 and 5 represent major costs for health care systems and burden for patients. Early detection with primary care intervention reduce risk of progression and sustainability. Risk factors are diabetes, hypertension, acute kidney injury, cardiovascular disease, structural renal tract disease, renal calculi, prostatic hypertrophy, systemic lupus erythematous, hereditary kidney disease, abnormal kidney structure, frequent use of medications etc. [5]

The symptoms of chronic kidney disease typically include tiredness or breathlessness, due to renal anaemia or fluid overload, later pruritus, anorexia, weight loss, nausea, vomiting and hiccups. Then occur swollen feet and ankles, puffiness around eyes, especially in morning, urination often in night, muscular twitching, drowsiness and coma. Decreased immune response, makes the patient more vulnerable to infection, irreversible damage to kidneys (end-stage kidney disease), eventually requiring either dialysis or a kidney transplant. Renal functions should monitor from blood urea and creatinine, urine analysis and quantification of proteinuria, electrolytes, calcium phosphate, 25(OH)D, full blood count, lipids, glucose,HbA1c,ultrasound, kidney biopsy. [6]

Using non-prescription pain relievers for a long time could lead to kidney damage. Cigarette smoking can damage kidneys and make existing kidney damage worse. [7] Management can be done by diet low in protein, sodium, potassium, and phosphate, high in calories and calcium and supplemented with essential amino acids; fluid intake and output monitoring. Long-term emotional support and counselling is needed for adaptation to chronic, potentially fatal disease. [8]

Homoeopathy prevents further progress of disease, like renal failure, minimizes need of dialysis or transplant. A homoeopathic remedy can be selected on the basis of causation, specificity, keynote, miasm, organopathy or totality of symptoms. [9] The totality of the characteristic mental and physical features with particulars are taken into consideration. [10]

When cause lies. in lower urinary tract, repeated urinary infection due to high PVRU for enlarge prostate and neurogenic bladder, repeated antibiotic usage, high recurrence rates and increasing antimicrobial resistance greatly increase the chance of infection. In such case, the scope of a constitutional remedy holds a promising action, especially the LM potencies are often recommended for use in cases with advanced pathology and there is least possibility of aggravations, proved by research studies. [11]

CASE STUDY

The case presented here was treated in OPD of Dr. A.C. Homoeopathic Medical College and Hospital. A male person aged 54years came to my OPD on Dt 04.12.2020 having complain of difficult urination, had to wait for 5 to 10minutes to start urination, increased frequency, unfinished sensation and burning pain before and during urination with pain in lower abdomen; fever with chilliness and headache; nausea and flatulence of whole abdomen, aggravated at night. He had also pain in both knees and back aggravated from motion. He was a chilly patient, used to catch cold easily; had desire for sweets and

warm foods, increased thirst; stool dry, hard and crumbled. Mentally he was irritable, company desired and extrovert. He had no diabetes or hypertension. Once he had accident and injury on back in 2013. Since that day he had bladder emptying problem with high PVRU. Blood pressure 130/80mm of Hg, oedema absent. In family, mother had arthritis and piles. He was taking NSAID for joint pain. Had taken antibiotics several times for urine infection and fever.

Lab investigation reports showed (23.11.2020) Serum Urea 82mg/dl, Serum Creatinine 5.3 mg/dl (Fig1), Hb11.5mg%, TLC 11,000/cu mm, DC –N 73,E 05, L 22, ESR 88 mm/1st hr, eGFR– 24.5ml/min(Fig2). Urine contained pus cell 20-30/HPF, RBC8-10/HPF, Bacteria +, Epithelial cells 2-4 (Fig3). USG report shows Grade 1 bilateral medical renal disease, Grade I prostatomegaly with High PVRU 85cc (Fig4). Here the causes of CKD are repeated use of NSAID for joint pain, neurogenic bladder since injury causing High PVRU and repeated urinary infection with BPH. As the disease progressed, besides taking allopathic medicine several times, he decided to take homoeopathic medicine which is safe and cost effective also. After taking the case, following symptoms were selected as totality of symptoms for repertorisation.

Presenting complaints of the patient taken for repertorisation

- Irritible mind, company desires and extrovert
- Chilly patient and catches cold easily
- Desires for sweet and warm food
- Drinks more
- Stool hard and crumbled
- Urination unsatisfactory, burning pain before and during urination
- Difficult urination with enlarged prostate
- Pain in back with soreness
- Pain in joints, motion aggravation

The case was repertorised with the help of complete repertory of HOMPATH(Classic) software (Fig.5). Basing on the reportorial analysis from total 18symptoms marks obtained by *Nux vom* 31/16, *Phos* 28/13, *Lyco* 27/14, *Bry* 26/13, *Arsenic* 26/10, *Kali carb* 25/11. *Nux vomica* covered maximum mental, physical and particular symptoms with high marks and selected as simmilimum in this case. Other drugs were not covered symptoms as like *Nux vomica* in all grounds. So *Nux vom* was given in LM potency from 0/1- 0/4, 30 ml each, in 8 doses, once daily morning; *Cantharis*30, 6glob once daily evening also was given to reduce the acute complains of cystitis, *Sabal ser*.Q 30 ml, 15 drops twice daily at day and night were also prescribed for BHP along with *Nux vomica* for one month.

FOLLOW UP AND RESULT:

After one month on dt 06.01.2021 the patient came with no pain in abdomen, burning micturition less and nausea absent, but urination not clear. Pain in knees and back was present. On dt.06.01.21 blood report showed TLC 7,200, Hb-10.08, S Urea 28mg/dl, S Creatnine decreased to 1.6mg/dl (Fig 6), eGFR increased to 51.5ml/min (Fig7). *Thuja* 10M one dose was given. Then after 8 days *Nux vom* 0/5 and 0/6, 30ml each, in 8doses was given on alternate days, *Cantharis* 30, 6glob once evening and *Sabal ser* Q 15drops twice daily given for another one month. Patient came after two months having no burning urination, ineffectual urination less, no nausea and no fever, only nocturnal frequency of urination was present. Pain in joints diminished. On dt. 06.03.21, Blood report showed TLC 7000/cmm, Hb 12.4mg%. S Urea 27mg/dl, S Creatinine 0.9mg/dl (Fig8), Urine Pus cells 6-10/HPF, RBC nil (Fig9). USG showed both

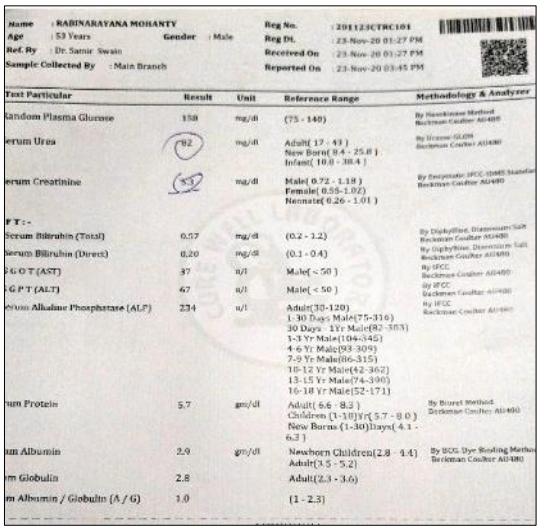
kidneys normal, mildly enlarged prostate with PVRU 40cc. (Fig 10). He had prescribed *Nux vom* 0/7-0/8, 30ml(8doses) alternate days one after another, *Sabal ser* Q 15 drops twice daily, *Calcarea phos* 6X,4tab twice daily. There were no adverse events during the process of treatment; improvement of symptoms was steady. Also, there has been no recurrence of the symptoms till date. The patient is now maintaining normal life

TIMELINE: The detail about the management and results is mentioned in table-2.

Table 2. First prescription and Follow-up

Date	Symptoms	Investigation Reports	Medicine
04.12. 20	Difficult and burning micturition, pain in lower abdomen, fever, nausea, anorexia, constipation, knee and back pain.	TLC-11000, S urea 82mg/dl , S Creatinine 5.3mg/dl, ESR 88mm/1st hr, eGFR – 24.5ml/min. Urine pus cell 20-30, RBC 8-10/HPF. USG -Grade 1 bilateral medical renal disease, Grade I prostatomegaly with High PVRU 85cc.	*Nux vom*0/1- 0/4, 30 ml each in 8 doses, once daily; *Canth*.30, 6glob OD, *Sabal ser* Q 30 ml 15 drops twice daily.
06.01.21	Fever absent, pain in abdomen and burning urination diminished, nausea absent. Pain in knees and back present.	S Urea 28 mg/dl, S Creatnine 1.6 mg/dl, eGFR 51.5 ml/min , USG - Bilateral early medical renal disease with High PVRU 66cc.	*Thuja* 10M one dose, After 8days, *Nux vom* 0/5,0/6,30ml(8doses),alternate morning one after another, *Sabal ser* Q 15 drops BD, *Cantharis* 30 OD, *Ferrum phos* 6X 4tablet twice daily.
10..03.21	Difficult urination very less, nocturnal frequency present. Pain in back and knee less.	TLC 7000/cmm, Hb 12.4, S Urea 27mg/dl, S Creatinine 0.9mg/dl, RBS 98mg/dl, Urine Pus cell 6-10/HPF, RBC nil. USG- Both kidneys are normal, mildly enlarged prostate with PVRU 40cc	*Nux vom* 0/7-0/8, 30ml(8doses) alternate day , *Sabal ser* Q 15 drops twice daily, *Calcarea phos* 6X, 4tab twice daily.

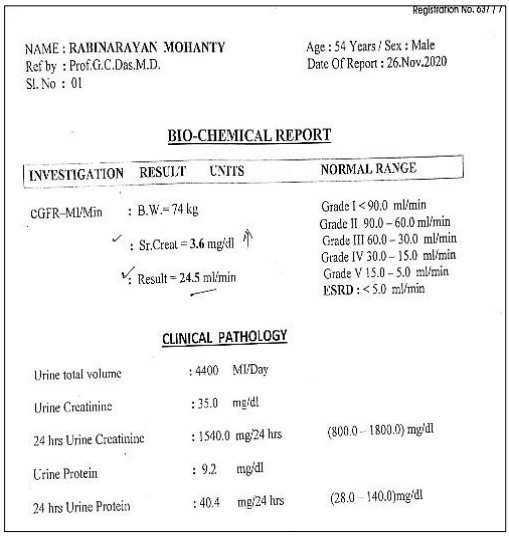
Blood, Urine and USG before treatment



Name	: RABINARAYANA MOHANTY			Reg No.	: 201123CTRC101		
Age	: 53 Years	Gender	: Male	Reg Dt.	: 23-Nov-20 01:27 PM		
Ref. By	: Dr. Samir Swain			Received On	: 23-Nov-20 01:27 PM		
Sample Collected By	: Main Branch			Reported On	: 23-Nov-20 03:45 PM		

Test Particular	Result	Unit	Reference Range	Methodology & Analyzer
Random Plasma Glucose	158	mg/dl	(75 - 140)	
Serum Urea	82	mg/dl	Adult(17 - 43) New Born(8.4 - 25.8) Infant(10.8 - 38.4)	
Serum Creatinine	53	mg/dl	Male(0.72 - 1.18) Female(0.55-1.02) Neonate(0.26 - 1.01)	
LFT :-				
Serum Bilirubin (Total)	0.57	mg/dl	(0.2 - 1.2)	
Serum Bilirubin (Direct)	0.20	mg/dl	(0.1 - 0.4)	
SGOT (AST)	37	u/l	Male(< 50)	
SGPT (ALT)	47	u/l	Male(< 50)	
Serum Alkaline Phosphatase (ALP)	234	u/l	Adult(30-120) 1-30 Days Male(75-316) 30 Days - 1Yr Male(82-383) 1-3 Yr Male(104-345) 4-6 Yr Male(93-309) 7-9 Yr Male(86-315) 10-12 Yr Male(42-362) 13-15 Yr Male(74-390) 16-18 Yr Male(52-171)	
Serum Protein	5.7	gm/dl	Adult(6.6 - 8.3) Children (1-10)Yr(5.7 - 8.0) New Borns (1-30)Days(4.1 - 6.3)	
Serum Albumin	2.9	gm/dl	Newborn Children(2.8 - 4.4) Adult(3.5 - 5.2)	
Serum Globulin	2.8		Adult(2.3 - 3.6)	
Serum Albumin / Globulin (A / G)	1.0		(1 - 2.3)	

Fig 1 -(23.11.20) S Urea and S Creatinine



Registration No. 637 / 7

NAME : RABINARAYAN MOHANTY Age : 54 Years / Sex : Male
Ref by : Prof.G.C.Das.M.D. Date Of Report : 26.Nov.2020
Sl. No : 01

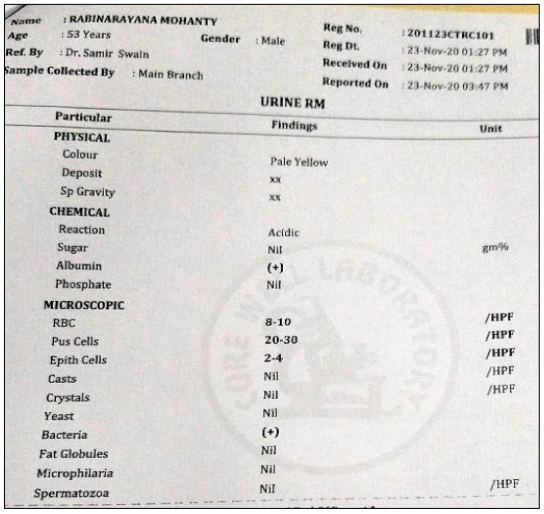
BIO-CHEMICAL REPORT

INVESTIGATION	RESULT	UNITS	NORMAL RANGE
CGFR–Ml/Min	: B.W.= 74 kg		Grade I < 90.0 ml/min Grade II 90.0 – 60.0 ml/min Grade III 60.0 – 30.0 ml/min Grade IV 30.0 – 15.0 ml/min Grade V 15.0 – 5.0 ml/min ESRD : < 5.0 ml/min
	: Sr.Creat = 3.6 mg/dl		
	: Result = 24.5 ml/min		

CLINICAL PATHOLOGY

Urine total volume	: 4400	Ml/Day	
Urine Creatinine	: 35.0	mg/dl	
24 hrs Urine Creatinine	: 1540.0	mg/24 hrs	(800.0 – 1800.0) mg/dl
Urine Protein	: 9.2	mg/dl	
24 hrs Urine Protein	: 40.4	mg/24 hrs	(28.0 – 140.0)mg/dl

Fig 2-(26.11.20) Report for eGFR

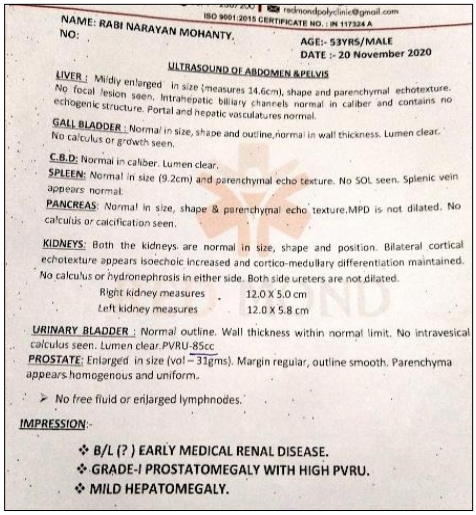


Name	: RABINARAYANA MOHANTY			Reg No.	: 201123CTRC101
Age	: 53 Years	Gender	: Male	Reg Dt.	: 23-Nov-20 01:27 PM
Ref. By	: Dr. Samir Swain			Received On	: 23-Nov-20 01:27 PM
Sample Collected By	: Main Branch			Reported On	: 23-Nov-20 03:47 PM

URINE RM

Particular	Findings	Unit
PHYSICAL		
Colour	Pale Yellow	
Deposit	xx	
Sp Gravity	xx	
CHEMICAL		
Reaction	Acidic	
Sugar	Nil	gm%
Albumin	(+)	
Phosphate	Nil	
MICROSCOPIC		
RBC	8-10	/HPF
Pus Cells	20-30	/HPF
Epith Cells	2-4	/HPF
Casts	Nil	/HPF
Crystals	Nil	
Yeast	Nil	
Bacteria	(+)	
Fat Globules	Nil	
Microphilaria	Nil	
Spermatozoa	Nil	/HPF

Fig 3- Urine Report on Dt. 23.11.20



NAME: RABI NARAYAN MOHANTY, AGE:- 53YRS/MALE
NO: DATE :- 20 November 2020

ULTRASOUND OF ABDOMEN &PELVIS

LIVER : Mildly enlarged in size (measures 14.6cm), shape and parenchymal echotexture. No focal lesion seen. Intrahepatic billiary channels normal in caliber and contains no echogenic structure. Portal and hepatic vasculatures normal.

GALL BLADDER : Normal in size, shape and outline,normal in wall thickness. Lumen clear. No calculus or growth seen.

C.B.D: Normal in caliber. Lumen clear.

SPLEEN: Normal in size (9.2cm) and parenchymal echo texture. No SOL seen. Splenic vein appears normal.

PANCREAS: Normal in size, shape & parenchymal echo texture.MPD is not dilated. No calculus or calcification seen.

KIDNEYS: Both the kidneys are normal in size, shape and position. Bilateral cortical echotexture appears isoechoic increased and cortico-medullary differentiation maintained. No calculus or hydronephrosis in either side. Both side ureters are not dilated.

Right kidney measures 12.0 X 5.0 cm
Left kidney measures 12.0 X 5.8 cm

URINARY BLADDER : Normal outline. Wall thickness within normal limit. No intravesical calculus seen. Lumen clear.PVRU-85cc.

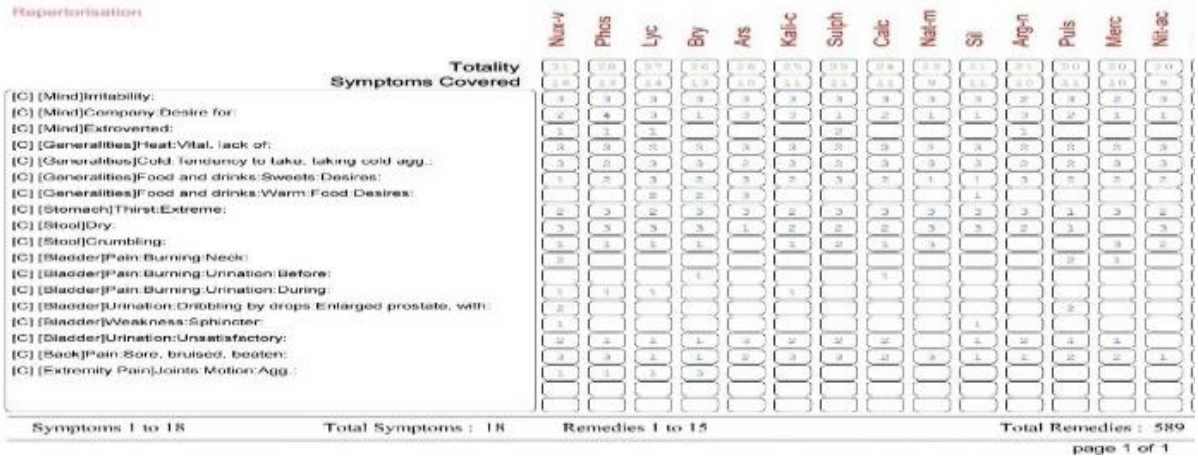
PROSTATE: Enlarged in size (vol – 31gms). Margin regular, outline smooth. Parenchyma appears homogenous and uniform.

- No free fluid or enlarged lymphnodes.

IMPRESSION:-

- B/L (?) EARLY MEDICAL RENAL DISEASE.
- GRADE-I PROSTATOMEGALY WITH HIGH PVRU.
- MILD HEPATOMEGALY.

Fig 4- (20.11.2020)USG of abdomen and pelvis



Repertorisation

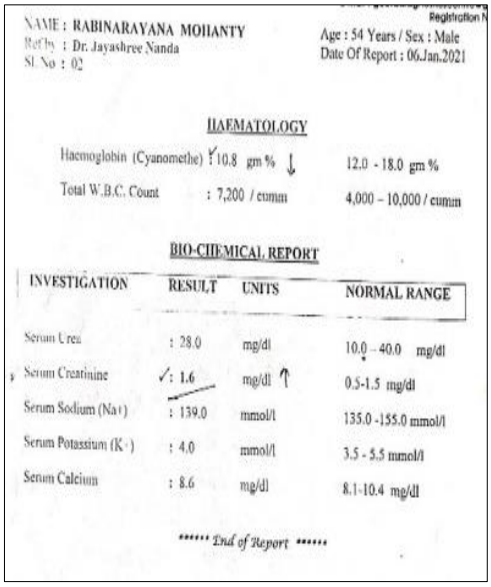
Totality Symptoms Covered	Nux-v	Phos	Lyc	Bry	Ars	Kali-c	Sulph	Calc	Nat-m	Sil	Arg-n	Puls	Merc	Nit-ac
[C] [Mind]Irritability:	3	2	3	2	3	3	2	2	2	2	3	2	2	2
[C] [Mind]Company Desire for:	2	4	3	1	3	3	1	2	1	1	3	2	1	1
[C] [Mind]Extroverted:	3	3	3	3	3	3	3	3	3	3	3	3	3	3
[C] [Generalities]Heat:Vital, lack of:	3	3	3	3	3	3	3	3	3	3	3	3	3	3
[C] [Generalities]Cold: tendency to take, taking cold agg.:	3	0	3	3	3	3	3	3	3	3	3	3	3	3
[C] [Generalities]Food and drinks:Sweets:Desires:	1	2	3	2	3	2	3	3	1	1	2	2	2	2
[C] [Generalities]Food and drinks:Warm Food:Desires:			2	2	3						1			
[C] [Stomach]Thirst:Extreme:	2	3	2	3	3	2	3	3	3	3	3	1	3	2
[C] [Stool]Dry:	3	3	3	3	1	2	2	2	3	3	2	3	3	3
[C] [Stool]Crumbling:	1	1	1	1	1	1	1	1	1	1	1	1	1	2
[C] [Bladder]Pain:Burning:Neck:	2											2	1	
[C] [Bladder]Pain:Burning:Urination:Before:				1										
[C] [Bladder]Pain:Burning:Urination:During:	1	1	1		1									
[C] [Bladder]Urination:Dribbling by drops:Enlarged prostate, with:	2											2		
[C] [Bladder]Weakness:Sphincter:	1													
[C] [Bladder]Urination:Unsatisfactory:	2	1	1	1	2	2	2	2	1	1	2	1	1	
[C] [Back]Pain:Sore, bruised, beaten:	3	3	2	1	3	3	3	3	3	1	1	2	2	1
[C] [Extremity Pain]Joints:Motion:Agg.:	1	1	1	3										

Symptoms 1 to 18 Total Symptoms : 18 Remedies 1 to 15 Total Remedies : 589

page 1 of 1

Fig -5: Repertorisation of the case

Reports of first follow up



NAME : RABINARAYANA MOHANTY
Ref by : Dr. Jayashree Nanda
Sl. No : 02
Age : 54 Years / Sex : Male
Date Of Report : 06.Jan.2021

HAEMATOLOGY

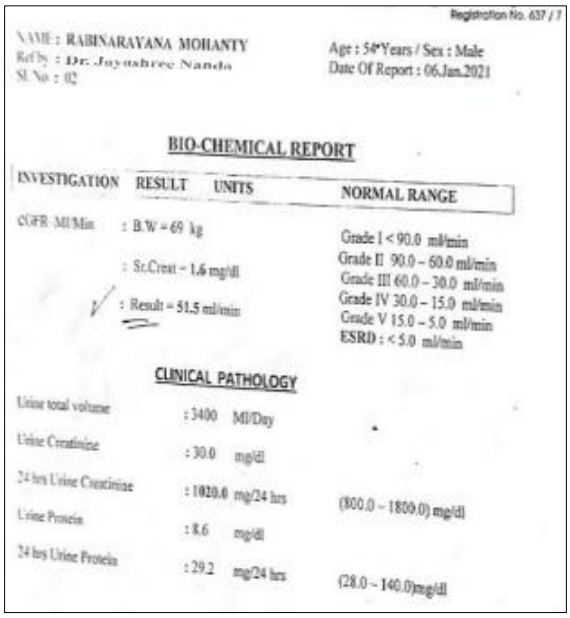
Haemoglobin (Cyanomethe)	: 10.8 gm % ↓	12.0 - 18.0 gm %
Total W.B.C. Count	: 7,200 / cumm	4,000 – 10,000 / cumm

BIO-CHEMICAL REPORT

INVESTIGATION	RESULT	UNITS	NORMAL RANGE
Serum Urea	: 28.0	mg/dl	10.0 – 40.0 mg/dl
Serum Creatinine	: 1.6	mg/dl ↑	0.5-1.5 mg/dl
Serum Sodium (Na+)	: 139.0	mmol/l	135.0 -155.0 mmol/l
Serum Potassium (K+)	: 4.0	mmol/l	3.5 - 5.5 mmol/l
Serum Calcium	: 8.6	mg/dl	8.1-10.4 mg/dl

****** End of Report ******

Fig 6- Fig 6- (06.01.21)Blood Report



Registration No. 637 / 7
NAME : RABINARAYANA MOHANTY
Ref by : Dr. Jayashree Nanda
Sl. No : 02
Age : 54 Years / Sex : Male
Date Of Report : 06.Jan.2021

BIO-CHEMICAL REPORT

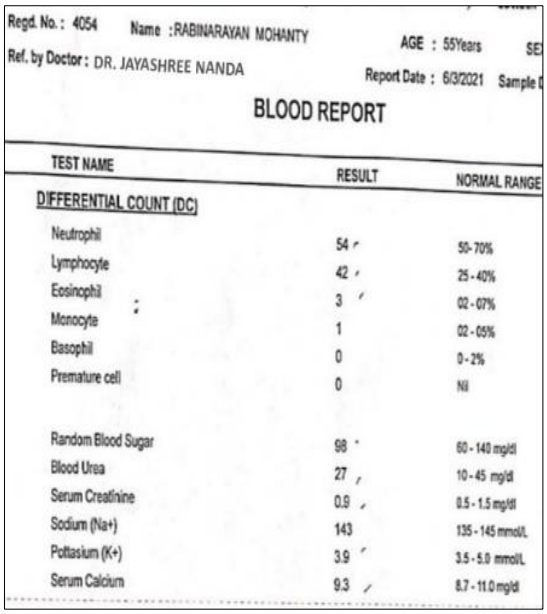
INVESTIGATION	RESULT	UNITS	NORMAL RANGE
eGFR Ml/Min	: B.W = 69 kg		Grade I < 90.0 ml/min
	: Sr.Creat = 1.6 mg/dl		Grade II 90.0 – 60.0 ml/min
	: Result = 51.5 ml/min		Grade III 60.0 – 30.0 ml/min
			Grade IV 30.0 – 15.0 ml/min
			Grade V 15.0 – 5.0 ml/min
			ESRD : < 5.0 ml/min

CLINICAL PATHOLOGY

Urine total volume	: 3400	Ml/Day	
Urine Creatinine	: 30.0	mg/dl	
24 hrs Urine Creatinine	: 1020.0	mg/24 hrs	(800.0 – 1800.0) mg/dl
Urine Protein	: 8.6	mg/dl	
24 hrs Urine Protein	: 29.2	mg/24 hrs	(28.0 – 140.0)mg/dl

Fig 7-(06.01.21) Report for eGFR

Reports on second follow up

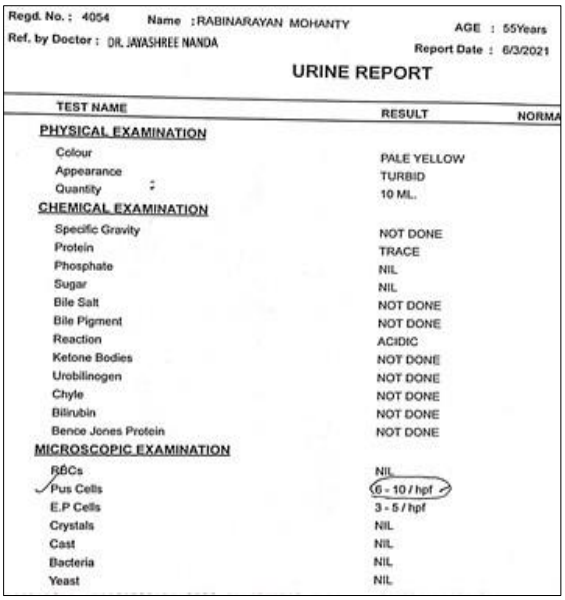


Regd. No. : 4054 Name : RABINARAYAN MOHANTY AGE : 55Years
Ref. by Doctor : DR. JAYASHREE NANDA Report Date : 6/3/2021

BLOOD REPORT

TEST NAME	RESULT	NORMAL RANGE
DIFFERENTIAL COUNT (DC)		
Neutrophil	54	50-70%
Lymphocyte	42	25-40%
Eosinophil	3	02-07%
Monocyte	1	02-05%
Basophil	0	0-2%
Premature cell	0	Nil
Random Blood Sugar	98	60-140 mg/dl
Blood Urea	27	10-45 mg/dl
Serum Creatinine	0.9	0.5-1.5 mg/dl
Sodium (Na+)	143	135-145 mmol/L
Pottasium (K+)	3.9	3.5-5.0 mmol/L
Serum Calcium	9.3	8.7-11.0 mg/dl

Fig 8- Fig 8-(Dt.06.03.21)S Urea and S Creatinine

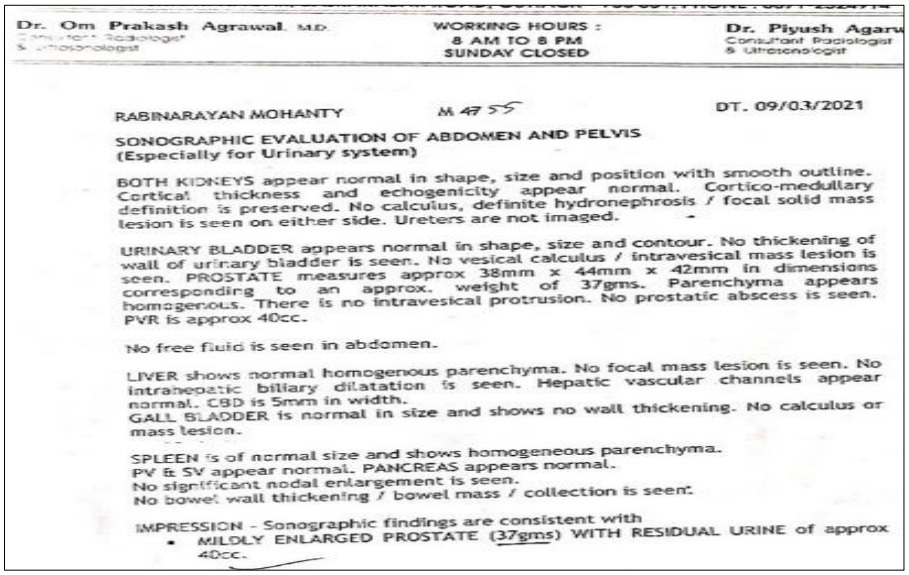


Regd. No. : 4054 Name : RABINARAYAN MOHANTY AGE : 55Years
Ref. by Doctor : DR. JAYASHREE NANDA Report Date : 6/3/2021

URINE REPORT

TEST NAME	RESULT	NORMA
PHYSICAL EXAMINATION		
Colour	PALE YELLOW	
Appearance	TURBID	
Quantity	10 ML.	
CHEMICAL EXAMINATION		
Specific Gravity	NOT DONE	
Protein	TRACE	
Phosphate	NIL	
Sugar	NIL	
Bile Salt	NOT DONE	
Bile Pigment	NOT DONE	
Reaction	ACIDIC	
Ketone Bodies	NOT DONE	
Urobilinogen	NOT DONE	
Chyle	NOT DONE	
Bilirubin	NOT DONE	
Bence Jones Protein	NOT DONE	
MICROSCOPIC EXAMINATION		
RBCs	NIL	
Pus Cells	6 - 10 / hpf	
E.P Cells	3 - 5 / hpf	
Crystals	NIL	
Cast	NIL	
Bacteria	NIL	
Yeast	NIL	

Fig 9-(Dt.06.03.21) Urine report



Dr. Om Prakash Agrawal, M.D. — WORKING HOURS : 8 AM TO 8 PM SUNDAY CLOSED — Dr. Piyush Agarw, Consultant Radiologist & Ultrasonologist

RABINARAYAN MOHANTY M 47 55 DT. 09/03/2021

SONOGRAPHIC EVALUATION OF ABDOMEN AND PELVIS
(Especially for Urinary system)

BOTH KIDNEYS appear normal in shape, size and position with smooth outline. Cortical thickness and echogenicity appear normal. Cortico-medullary definition is preserved. No calculus, definite hydronephrosis / focal solid mass lesion is seen on either side. Ureters are not imaged.

URINARY BLADDER appears normal in shape, size and contour. No thickening of wall of urinary bladder is seen. No vesical calculus / intravesical mass lesion is seen. PROSTATE measures approx 38mm x 44mm x 42mm in dimensions corresponding to an approx. weight of 37gms. Parenchyma appears homogenous. There is no intravesical protrusion. No prostatic abscess is seen. PVR is approx 40cc.

No free fluid is seen in abdomen.

LIVER shows normal homogenous parenchyma. No focal mass lesion is seen. No intrahepatic biliary dilatation is seen. Hepatic vascular channels appear normal. CBD is 5mm in width.
GALL BLADDER is normal in size and shows no wall thickening. No calculus or mass lesion.

SPLEEN is of normal size and shows homogeneous parenchyma.
PV & SV appear normal. PANCREAS appears normal.
No significant nodal enlargement is seen.
No bowel wall thickening / bowel mass / collection is seen.

IMPRESSION - Sonographic findings are consistent with
- MILDLY ENLARGED PROSTATE (37gms) WITH RESIDUAL URINE of approx 40cc.

Fig 10 –(Dt.09.03.21) USG shows normal kidney

DISCUSSION:

The outcomes of this case study clearly show the efficacy of the homeopathic drugs in CKD patient with high serum urea and creatinine, without haemodialysis with cost effective and most harmless way of treatment by symptom similarity, since these readings are a part of the decision making process of whether to start dialysis or not. [13] Several studies have already been established the efficacy of homoeopathy in different kidney disorders.

Quite recently evidence of association between BPH and CKD has arisen in two different studies. A recent study by Yamasaki et al showed that the Post-Void Residual urine (PVRU) of the patients was significantly greater with CKD than that of the patients without CKD and the presence of post-void residual urine was independently associated with CKD, indicating a close association between CKD and residual urine. [14].

In this case, we also see that USG of the kidneys which has bilaterally increased cortical echo texture before treatment (Fig4), a feature of CKD, became normal kidney after treatment (Fig10). PVRU diminished and chronic UTI also became almost normal from urine analysis (Fig9). After repertorisation following the law of symptom similarity, *Nux vom* was given in LM potency in increasing doses. *Nux vomica* is useful in urinary disorders like weakness of bladder function with enlarged prostate, ineffectual urination which is painful during urging to urinate (Neurogenic bladder). [14] *Thuja* used for sycotic pain, tearing in muscles and joints, worse at rest, associated with complains of genito–urinary organs, like BHP and dysuria. [15] Here I had given Thuja in high potency as an intercurrent antisycotic to treat the chronic joint pain which was manifested since childhood and also for enlarged prostate which was another cause of high PVRU and ultimate help in CKD. Then again *Nux vom* was helpful to increase the bladder power after treatment of miasm. *Cantharis* could reduce the acute effect of cystitis which was very essential here to give because the person had suffered cystitis several times and treated allopathically but failed. So to control the symptoms of cystitis it was needed to give Cantharis to relive pain before and during micturition and also to

reduce frequency of urination. *Sabal serrulata* Q used for enlarged prostate as organopathic remedy, biochemic medicines as *Ferrum phos* for anaemia and *Calcarea phos* for bone pain also was given helped to save the life of the patient. As here multiple causes combinely produced CKD, so besides a constitutional remedy some other drugs were also needed to control the acute conditions of the patient and prevent patient to go for dialysis or end stage renal disease. Actually though CKD is due to disorder of a particular organ but the disease and the symptoms were manifested in whole body and made it a generalised disease. So in an artificial chronic disease and also where multi system are affected we can give both chronic and acute remedy which gave beneficial results proved in this case.

CONCLUSION:

In CKD, homeopathic treatment is possible by early diagnosis from appropriate case history, with law of similia after repertorisation, at low cost, no surgical measures or without haemodialysis and preventing renal failure.

LIMITATION OF STUDY:

As this is a single case study it needs to be tried in greater number of cases for its scientific validation.

PATIENT CONSENT:

Author declares that written consent was obtained from the patients to publish the case information

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