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An Evidence Based Approach to Atopic Dermatitis using Homoeopathic Medicine:-A Case Study

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ABSTRACT:

Atopic dermatitis (AD), a distinct type of eczema, is the most prevalent chronic inflammatory skin condition. Its development involves a combination of genetic predispositions and environmental influences, resulting in dysfunctions of both the skin barrier and the immune system. This long-term condition, characterized by persistent itching, typically begins in infancy and is marked by dry skin, eczematous rashes, and thickened, leathery areas known as lichenification. Atopic dermatitis is thought to be linked with other Ig E-mediated conditions such as allergic rhinitis, asthma, and food allergies. It carries a considerable burden on health and quality of life, and its prevalence seems to have been rising in recent decades. Genetic factors involved include loss-of-function mutations in the filaggrin gene a key epidermal protein that degrades into components essential for the skin's natural moisturizing processes.Atopic dermatitis is a chronic relapsing inflammatory skin condition characterized by intense pruritis,erythema,xerosis and lichenification.It commonly begins in childhood but can persist or recur in adulthood,significantly impairing quality of life.Atopic dermatitis is associated with other atopic conditions such as allergic rhinitis and asthma,and its prevalence is rising globally,making it a significant public health concern. This is the case report of an eleven year old girl who had presented with cracks and burning sensation in the sole of foot. Case was taken in detail and Malandrinum 200 was prescribed. There was no recurrence for the next 6 months.The action of malandrinum on reduction in IgE should be studied further.

KEYWORDS: Atopic Dermatitis, Allergic Rhinitis, Asthma, Malandrinum.

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INTRODUCTION:

Atopic dermatitis, or atopic eczema, is a long-lasting inflammatory skin condition marked by red, itchy rashes, dry skin (xerosis), scaling (ichthyosis), and discomfort or pain.[1] Socially, it can lead to challenges in forming and maintaining relationships and may result in feelings of isolation or being stigmatized. The condition is also linked to issues such as disrupted sleep, anxiety, hyperactivity, and depression. While the exact causes are still not completely understood, atopic dermatitis seems to stem from a combination of impaired skin barrier function and abnormalities in the immune system.][2]. Atopic dermatitis (AD), the most prevalent chronic inflammatory skin condition, affects approximately 13% of children and 5% of adults globally. In the United States, the disease results in an estimated yearly economic burden exceeding five billion.[3] Commonly Affected Areas by Age Group[4]

- Infants (0–6 months): Typically affected areas include the face, scalp, trunk, and the outer sides of the arms and legs, while the diaper region is usually not involved. [4]
- Children (6 months–12 years): Eczema tends to appear in skin folds such as the elbows (antecubital fossae), behind the knees (popliteal fossae), wrists, ankles, and the back of the neck. The tops of the hands, feet, and around the eyes may also be involved. [4]
- Adolescents and Adults (12+ years): Commonly affected areas include body folds, the hands, the upper chest and back, and the forehead. [4]
- Adults: The condition may prominently affect the head and neck, as well as the hands and feet, sometimes presenting as dyshidrotic eczema.[4]

Atopic dermatitis is inherited as a polygenic recessive character. The patient inherits an increased tendency for irritable skin and of getting sensitised to various antigens present in the atmosphere. It may be associated with other components of atopy like asthma ,urticaria, hay fever or allergic dermatitis.[5]In developed nations, atopic dermatitis affects up to 20% of children and 10% of adults. It is the most prevalent chronic inflammatory skin condition. Both the person and society as a whole bear a heavy burden from this extremely crippling illness.[6] The majority of innovative therapeutic approaches aim to address particular facets of cutaneous inflammation or the skin barrier. Additionally, a number of trials have demonstrated promise in preventing atopic dermatitis, such as the early application of emollients in newborns at high risk.[6]. Current insights into the disease's cause suggest that damage to the epidermal barrier results in greater skin permeability, triggers abnormal skin inflammation, and facilitates allergen entry through the skin. As a result, many emerging treatments are aimed at restoring the skin barrier or controlling skin inflammation. Additionally, studies have indicated that early application of moisturizers in infants at high risk may help prevent the onset of atopic dermatitis, potentially reducing the likelihood of developing related conditions such as food allergies, allergic rhinitis, and asthma.[6] Acute atopic eczema is characterized by intense itching, redness, and swelling. Small raised bumps (papules) and fluid-filled blisters (vesicles) may appear, along with dry, flaky, and cracked skin. In chronic cases, the skin often becomes

lichenified—thickened, dry, and leathery with more prominent skin lines—due to repeated scratching and rubbing. [7] Atopic dermatitis is usually diagnosed clinically .Patch testing is recommended when allergic contact dermatitis is suspected. If there are signs of secondary infection, bacterial and viral swabs should be obtained. Herpes simplex virus (HSV) can lead to a widespread infection known as eczema herpeticum, often indicated by small, punched-out sores within areas of worsening eczema. Additionally, skin scrapings may be needed to exclude a secondary fungal infection.[7]The general management includes regular use of emollients, such as emulsifying ointments, is fundamental in eczema management. They can be used as bath additives, soap alternatives, or applied directly to the skin. Emollients help minimize moisture loss and reduce the need for topical corticosteroids. Sedating antihistamines may be helpful for improving sleep when itching disrupts rest. Topical corticosteroids come in varying strengths—from very potent (e.g., clobetasol propionate) and potent (e.g., betamethasone valerate) to moderately potent (e.g., clobetasone butyrate) and mild (e.g., hydrocortisone, commonly used on the face). Long-term use of topical steroids can cause side effects such as skin thinning, stretch marks, increased fragility, bruising, and possible systemic effects. However, fear of using steroids ("steroid phobia") often leads to under-treatment, which can be more problematic than the side effects themselves.[7]

CASE REPORT:

Patient Kumari.A, an 11-year-old female patient came to the OPD with cracks on her foot accompanied by pain and a burning sensation. Complaint started 2 years back and she consulted modern medicines initially but she did'nt get a permanent relief.Various treatment options were tried, but none provided relief.

She had no relevant past histories instead of an attack of chicken pox 2 years back .She took Homoeopathic treatment for chicken pox .

Regarding her family history her mother and maternal grandmother had similar skin complaints in childhood.

She was the elder baby of a non consanguineous marriage.Her milstones were proper and not delayed .

During case taking it was found that she had hairfall especially from the occiput. The girl had a habit of biting her own arms while getting angry.Also the patient cannot bear mental exertion.On physical examination she has a flabby tongue.

The patients thermal reaction was towards hot.She had a good appetite and thirst.No special food cravings or aversions. The patient also had profuse perspiration.

A detailed case study was conducted and repertorised. Initially merc sol 200 was given but there was not much relief. Switched treatment: Malandrinum was prescribed after repertorization using the VES method (Figure-2). Also malandrinum covered the rubric EXTREMITIES-CRACKS -toes under. Malandrinum 200 was prescribed and administered monthly. Gradually, the pain, burning sensation, and cracks disappeared.

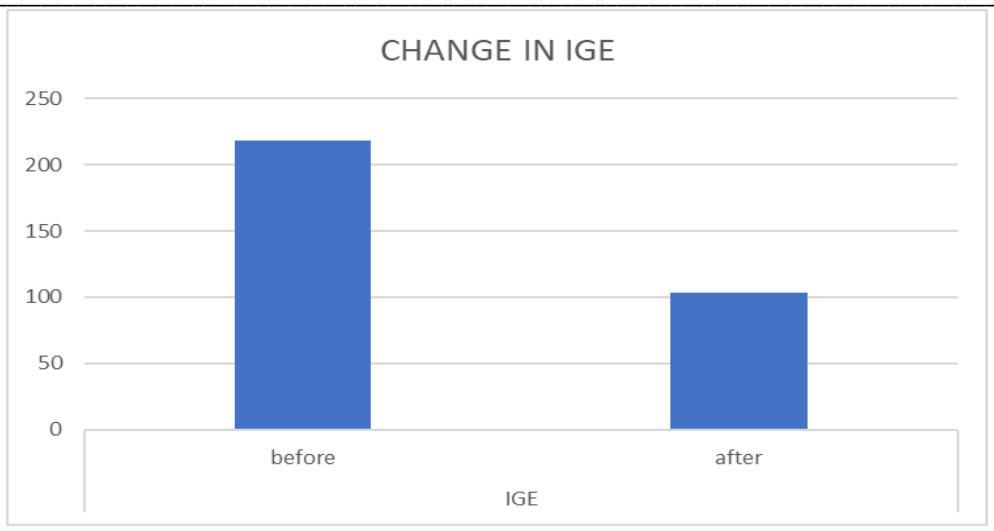

Figure-1: Change in IgE before and after treatment

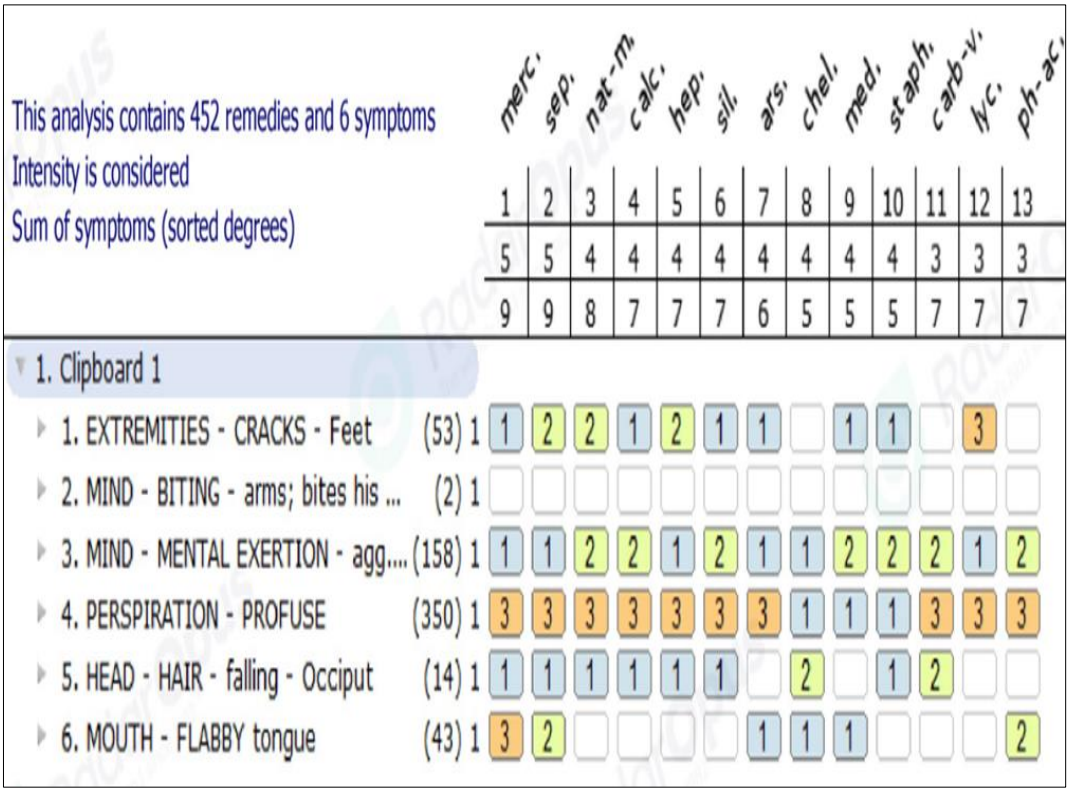

Figure-2: Repertorization Chart

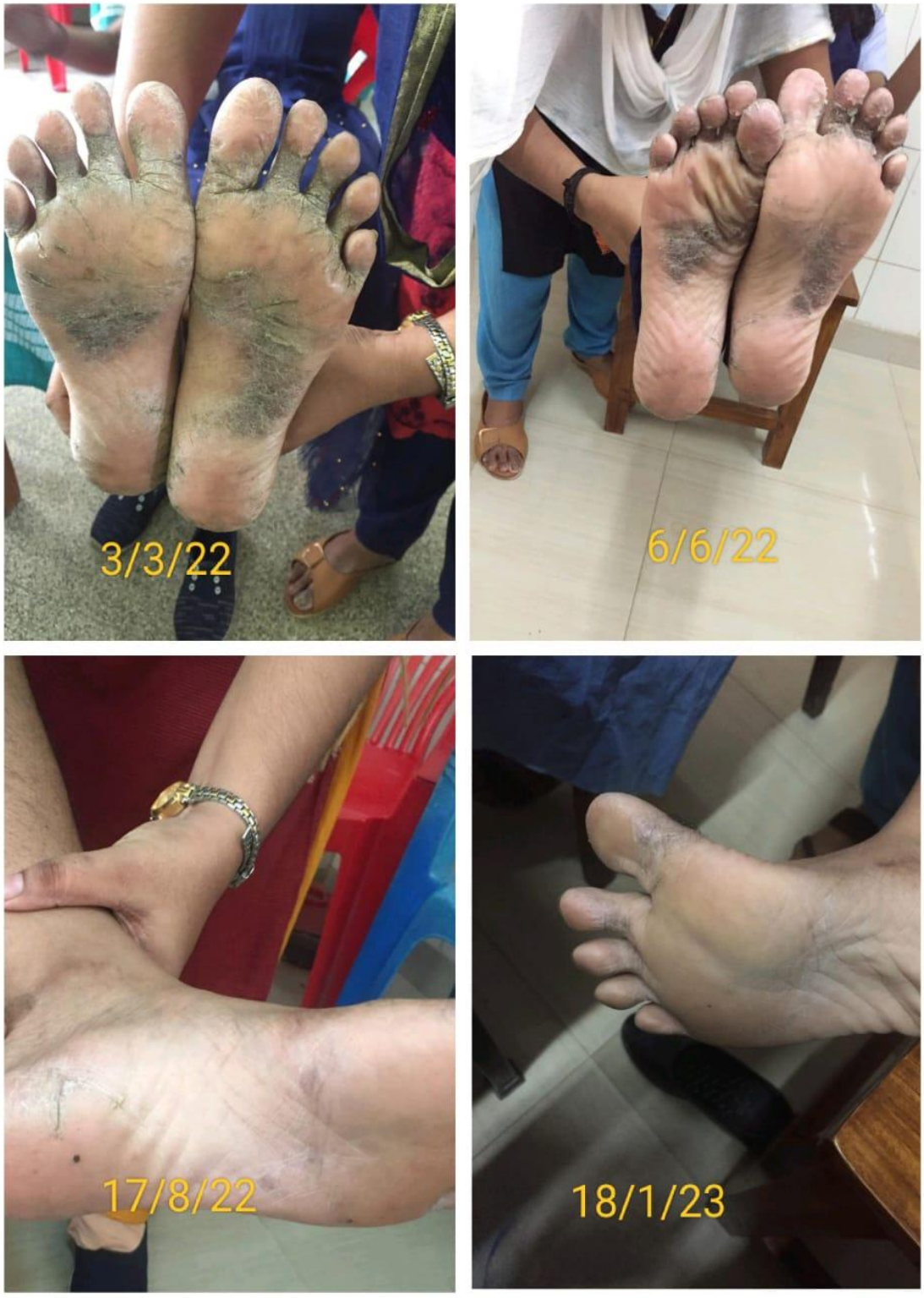

Figure-3: Images of the patient during the course of treatment

RESULTS AND DISCUSSION:

Various forms of stress can act as triggers and worsen atopic dermatitis (AD). In general, different stressors can lead to distinct biological responses. Although "stress" can refer to both physical and psychological types, this discussion centers on psychological stress and its impact on AD. Epidemiological research has explored the link between psychological stress and AD, with findings indicating that stress can intensify the condition[8]. There is a lack of standardization in the assessment methods for atopic dermatitis (AD), making it challenging to interpret treatment studies.[9] Assessing the severity of atopic dermatitis (AD) is essential for monitoring disease progression and evaluating treatment outcomes. In clinical trials, severity scoring is a crucial requirement. To standardize assessment methods and enable comparison across studies, the European Task Force on Atopic Dermatitis (ETFAD) developed the SCORAD (SCORing Atopic Dermatitis) index. However, various modifications to SCORAD have sometimes led to its incorrect application. To assess the extent of AD, the "rule of nines" is used on a body diagram to map inflamed areas, with scores ranging from 0 to 100. The intensity section of the SCORAD index evaluates six features—erythema, swelling/papules, scratch marks, skin thickening, oozing/crusting, and dryness—each rated on a scale from 0 to 3[10].SCORAD score was assesed before and after the study.Changed from 33.8 to 0.IgE before treatment was 218IU/ml and after treatment dropped to 103 IU/ml. After detailed case taking Merc sol was given initially but there was no improvement.Initially patient had a slight improvement but complaints recurred. So considering the rubric extremities cracks toes under , malandrinum was prescribed . IgE was found to be decreased. Modified Naranjo Criteria calculated was +10.

CONCLUSION:

Further research on Malandrinum could benefit many patients, and its impact on IgE could be examined. Whether malandrinum have any role in modifying interleukin -31 expression in atopic dermatitis cases needs to be evaluated through future research studies. Additionally, the effects of Malandrinum at various potencies could be investigated.

Consent of patient: Consent of the patient's parents were taken as the patient is a minor

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