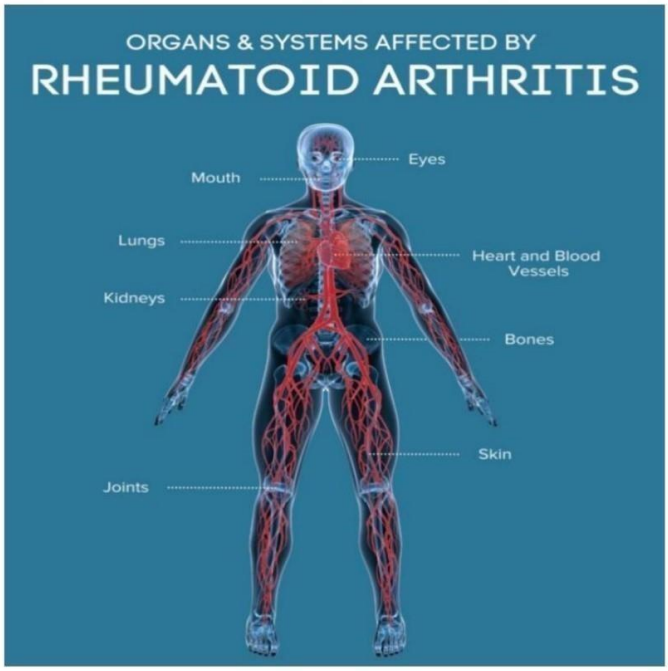
DISSERTATION

RHEUMATOID ARTHRITIS AND ITS HOMOEOPATHIC MANAGEMENT



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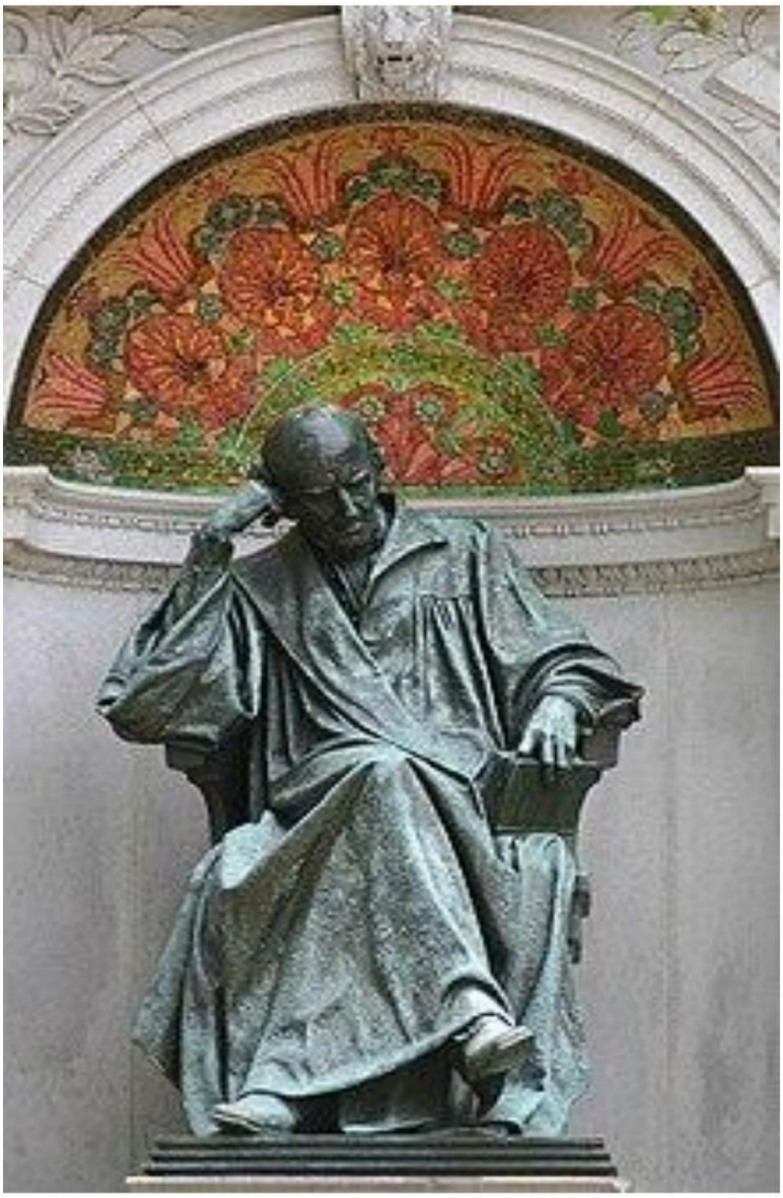

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DR. SMRITI MISHRA
INTERN BATCH 2019

CERTIFICATE BY GUIDE

I hereby certify that, **DR. SMRITI MISHRA** has prepared her dissertation file on the topic allotted to her, **RHEUMATOID ARTHRITIS And Its Homoeopathic Management** under my guidance& up to my satisfaction

During the course of preparation she showed keen interest in her work, I wish her success in life.

DR. RAJ KUMAR KASHYAP

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State National Homoeopathic Medical College And Hospital Lucknow.

CERTIFICATE BY PRINCIPAL

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INTRODUCTION

Arthritis literally means "Inflammation of a joint" since there is many number of factors that can cause inflammation of a joint and different pathological process involved. There are many types of Arthritis.

Some examples of Arthritis include osteoarthritis, psoriatic arthritis, Rheumatoid arthritis and gout. Each of these may affect the patient differently and may have significantly different complications. It is, therefore, very important to know the exact type or form of arthritis that one may be treating.

Rheumatoid arthritis is a chronic, systemic, inflammatory, disease, which chiefly affects the synovial membranes of multiple joint in the body. Because the disease is systemic, there are many extra-articular features of the disease.

For example, neuropathy, scleritis, arthritis, lymphadenopathy, pericarditis and Rheumatoid nodules are frequent component of the disease. In addition the potential for involvement of renal, pulmonary and cardiovascular systems exist.

In most case of rheumatoid arthritis, the patient has remission and exacerbation of the symptoms. This means that there are period of time when the patient "feels good" and times when the patient "feels worse". There will likely be times that a patient with rheumatoid arthritis "feels cured".

It is important to understand that there are very few patients that have complete remission of the disease and it is essential that the rheumatoid arthritis patient does not stop the treatment program established by knowledgeable physicians.

Modern Medicines (Allopathy) accepts their limitation and say that the rheumatoid arthritis is not permanently curable by their medication. The case is not so with Homoeopathy by application of suitable Homoeopathic Medicine not only the pain is removed but the disease is also permanently cured.

Homoeopathic approach to the treatment of rheumatoid arthritis is not different from it approach towards other chronic and constitutional diseases.

It one goes by any standard book of practice of medicine, RA has been branded as "not permanently curable" even from the description of disease. It may seem that only symptomatic relief is possible but it needs to be remembered that these are the limitation of dominant medical system (Allopathy) and not of Homoeopathy. There are numerous cases in various journals where Rheumatoid arthritis is permanently cured any Homoeopathic physician with considerable experience will vouch to have cured a few cases of rheumatoid arthritis.

However, like any other chronic disease, the desired cure of rheumatoid arthritis depends upon the knowledge, skill, patience and observation of the physician. One of the important criteria is to master the art of Homoeopathy. Success depend upon how successful the physician is in getting the complete picture of the

AIMS AND OBJECTIVES

- To see the place of deep acting and short acting medicine in treatment.
- To see Homoeopathic dosage directions.
- To see miasmatic and constitutional Background in the treatment.
- To see the auxiliary management in the treatment.
- To see preventable Ways to prevent rheumatoid arthritis .
- To have a deep knowledge about the disease .

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LITERATURE

STRUCTURE & FUNCTION

JOINT:

The point of juncture between two bones. There are three main subtypes.

TYPES OF JOINT

	Type	Range of Movement	Examples
1	Fibrous	Minimal	Skull Sutures
2	Fibrocartilage	Limited	• Symphysis pubis • Intervertedbral disc
3	Synovial	Large	Most limb joint • Temporomandibular • Costovertebral

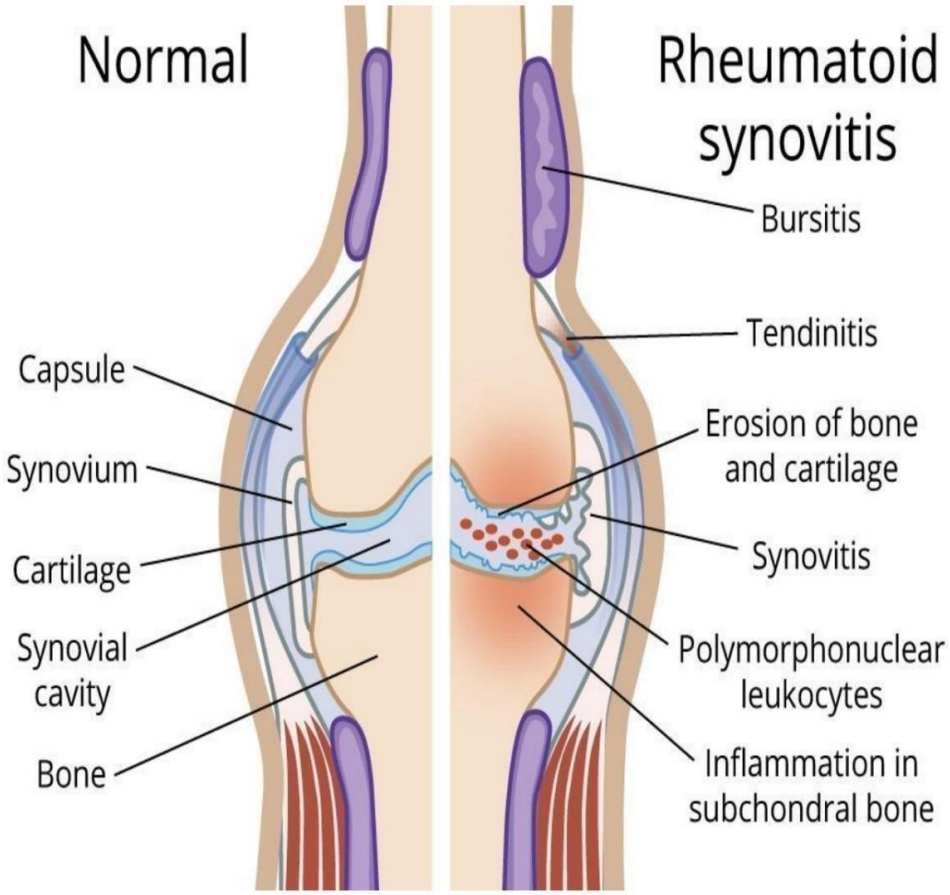
FIBROCARTILAGINOUS JOINT:

Fibrous and fibro cartilaginous joints are composed of a simple bridge of fibrous or fibro cartilaginous tissue joining two bones together.

They occur in the skeleton where there is little requirement for movement of one bone in relation to another. The inter-vertebral disc is a special type of fibro cartilaginous joint in which an amorphous area termed the nucleus pulposus lies in the centre of the fibro cartilaginous bridge. This structure has a high water content and act as a cushion to provide the inter-vertebral disc with improved shock-absorbing properties compared with ordinary fibro cartilaginous joint.

SYNOVIAL JOINT:

Synovial joint are more complex structure containing several cell types. They are found in the region of the skeleton where a wide range of movement is required.



ARTICULAR CARTILAGE:

The ends of the bone in a synovial joint are covered with a layer of articular cartilage. This is an avascular tissue that consists of cartilage cells (chondrocytes) embedded in a thick matrix of proteoglycans, water, type II collagen and smaller amount of other protein. Chondrocytes are metabolically active cells that are responsible for synthesis and turnover of cartilage matrix throughout life.

The matrix consist of a meshwork of type II collagen fibrils that run through a hydrated "gel" of

proteoglycan molecules the most important of which is "Aggrecan".

With the ageing, the amount of chondroitin sulphate in cartilage decreases whereas that of keratan suphate increases. Although the reasons for this are unknown, the end result is a reduction in water content and impairment of cartilage's shock absorbing properties. Cartilage matrix is constantly being turned over, and in health a perfect balance is maintained between synthesis and degradation of matrix components.

SYNOVIAL FLUID:

The surface of the articular cartilage is separated by a space filled with synovial fluid, a viscous liquid that lubricate the joint.

Synovial fluid is basically an ultra-filtrate of plasma into which synovial cell secrete Hyaluronon and proteoglycans.

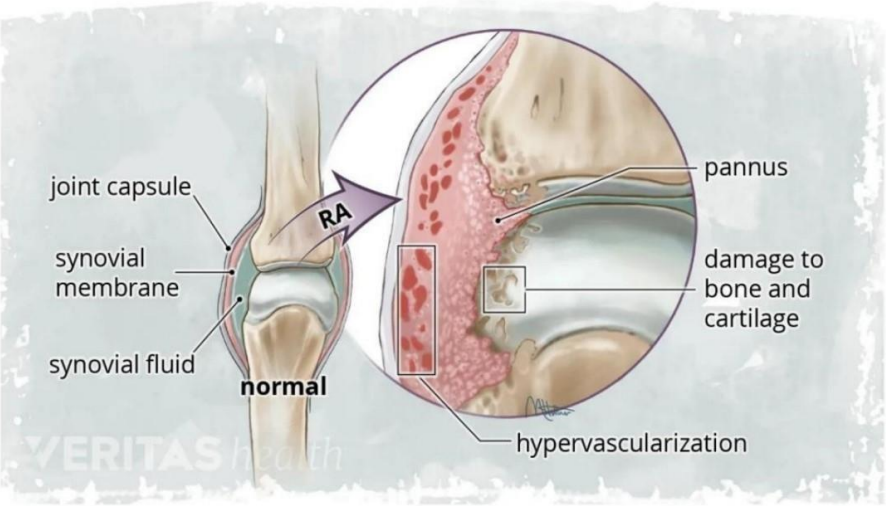
INTRA-ARTICULAR DISC:

Some joints contain fibrocartilagenous disc within the joint space (for example, the menisci of the knee) that act as shock absorbers, like articular cartilage these structures are avascular and remain viable by diffusion of oxygen and nutrient from synovial fluid.

THE JOINT CAPSULE AND SYNOVIAL MEMBRANE:

The bones of the synovial joints are connected together by the joint capsule, a fibrous structure richly supplied with blood vessels, nerves and lymphatics that encompasses the joint cavity ligament are discrete regional thickenings of the joint capsule that act to stabilize joints.

The inner surface of joint capsule is lined by the synovial membrane which comprises an outer layer of blood vessels and loose connective tissue and an inner layer 1-4 cells thick, consisting of two main cell types, termed Type A and Type B synoviocytes, Type A synoviocytes are phagocytic cells derived from monocytes/macrophase lineage and are responsible for removing particulate matter from the joint cavity, Type B cells are fibroblast like cells that are thought to be responsible for the secretion of synovial fluid most inflammatory and degenerative joint disease are associated with thickening of the synovial membrane and infiltration by lymphocytes, polymorphs and macrophages.



RHEUMATOID ARTHRITIS

DEFINITION:

Rheumatoid arthritis (RA) is classified as a connective tissue disease. It is a chronic systemic inflammatory disorder that damages the joints of the body. Classic symptoms of rheumatoid arthritis include joint swelling, deformity, pain, weakness, and stiffness of the smaller joints such as those of the hands, wrists, elbows, knees, ankles and feet. These are referred to as the articular manifestations of the disease. When rheumatoid arthritis affects other organs of the body these are known as extra-articular manifestations.
Skin changes of rheumatoid arthritis are considered extra-articular manifestations and can be divided into

two types: general cutaneous manifestations and specific cutaneous manifestations.

AETIOLOGY:

The etiology of the rheumatoid arthritis is unknown. But a number of risk factors have been suggested as important contributors to the development or progression of RA of these, the best studies have been genetics, infectious agents, smoking and formal education, which are proposed to exacerbate RA.

Evidence for the genetic importance of genetic susceptibility comes from higher concordance rates in monozygotic (12-15%) than in dizygotic twins (3%) and an increased frequency of disease in first degree relatives of patient with RA. Upto 50% of the genetic contribution to susceptibility is due to gene in to Human Leukocyte Antigen (HLA) region. HLA-DR-4 is the major susceptibility haplotype in the most ethnic groups, occurring, for example in 5075% of caucasians patient with RA compaired to 20-25% of the normal population. However DR-1 is more important in Indians and Israelis and DW-15 in Japanese. It is likely that genetic factors influence

inflammation, granuloma formation and joint destruction.

PATHOLOGY:

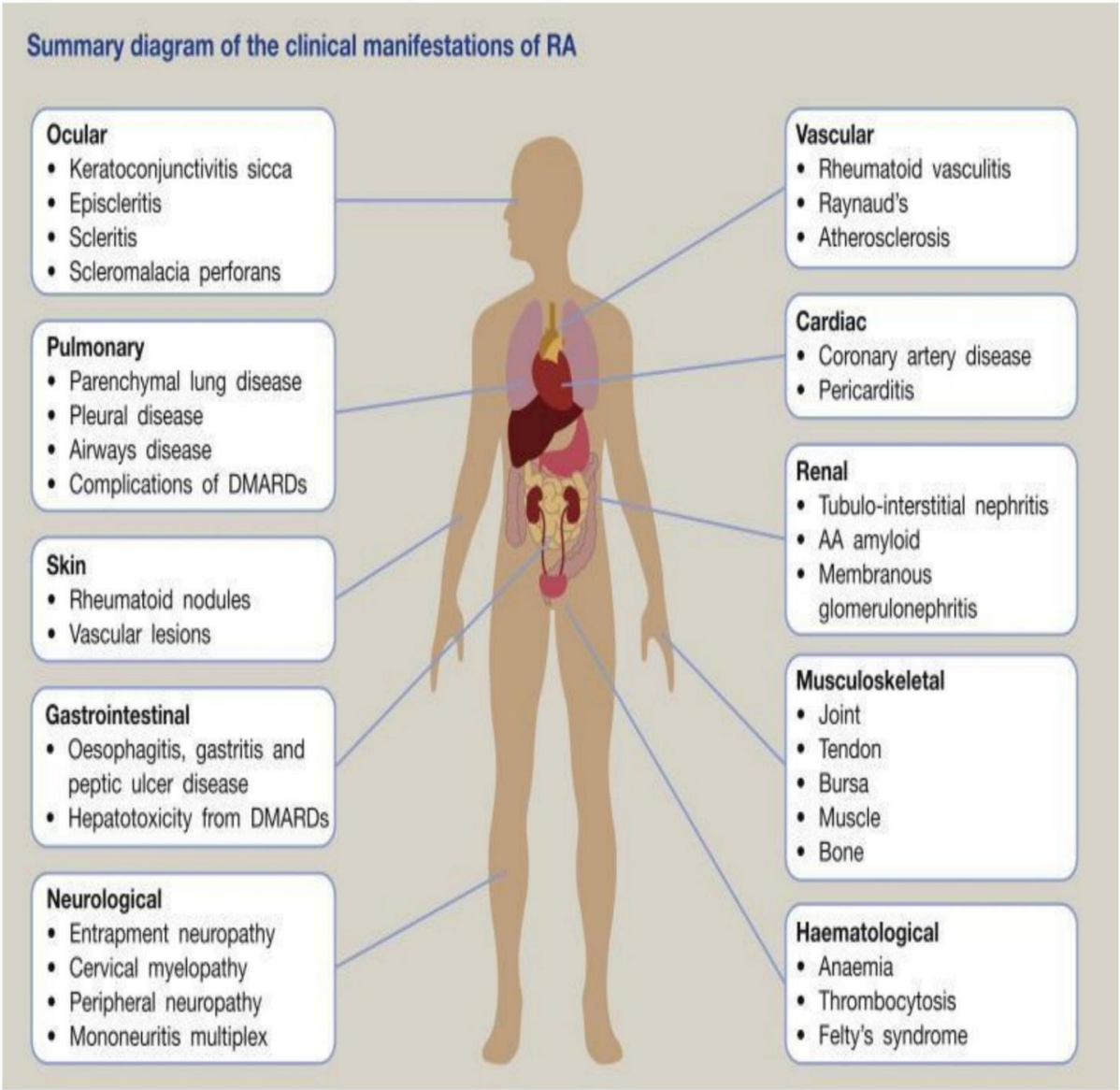
The synovial membrane of the joint is first affected. The earliest change is swelling and congestion of the synovial membrane and the underlying connective tissues, which become infiltrated with lymphocytes (especially CD4 T-cell) plasma cells and macrophages effusion of synovial fluid in to joint space takes place during active phases of disease. Hypertrophy of synovial membrane occurs with the formation of lymphoid follicles resembling an immunologically active lymph node inflammatory granulation tissue (Pannus) spread over and under the articular cartilage, which is progressively eroded and destroyed.

Later, fibrous or bony ankylosis occur Muscle adjacent to inflamed joints atrophy and there may be focal infiltration with lymphocytes.

Subcutaneous nodules consist of a central area of fibrinoid material surrounded by a palisade of proliferating mononuclear cells similar granulomatous lesion may occur in the pleura, lung, pericardium and sclera. Lymph nodes are often hyperplastic, showing

many lymphoid follicles with large germinal centres and numerous plasma cells in the sinuses and medullary cords. Immunoflurescence confirm Rheumatoid factor synthesis by plasma cell in synovium and lymph nodes.

CLINICAL FEATURES:



Rheumatoid arthritis is a systemic disease so the clinical features are consider as.

1. Articular Features
2. Extra Articular Features

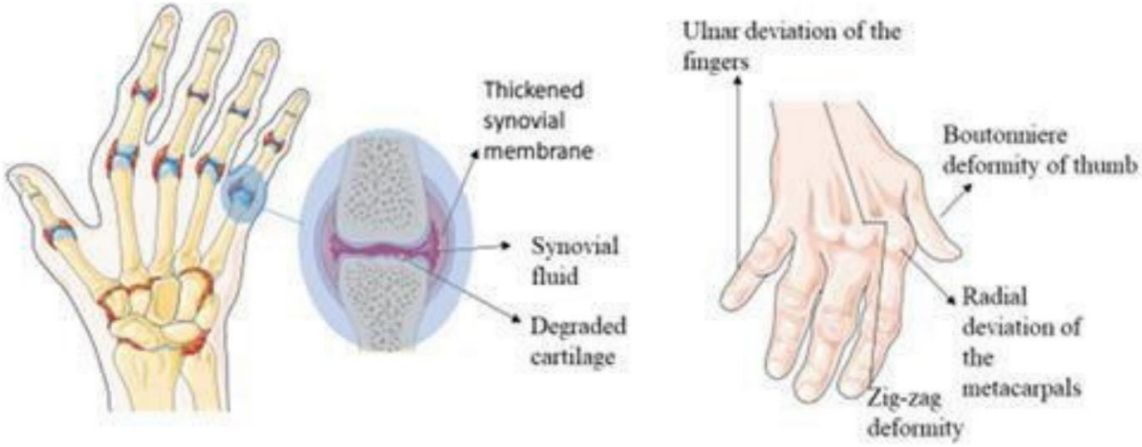
ARTICULAR FEATURES :

The hand is crucial to overall patient function and provides a good reflection of overall disease activity. The typical features are symmetrical swelling of the metacarpalphalangeal (MCP) and Proximal Inter Phalangeal (PIP) joint. These and other joint are considered to be actively inflamed if they are tender on pressure and have stress pain on passive movement or non-bony effusion swelling. Note that erythema is not a feature of rheumatoid arthritis and usually implies coexistent sepsis.

DEFORMITY:

Specific hand abnormalities include –

- Swan Neck Deformity
- The Boutonniere or Button Hole Deformity
- Z- Deformity of Thumb



1. <u>SWAN NECK DEFORMITY :</u>

Hyperextension of the proximal interphalangeal joints with compensatory flexion of distal interphalangeal joints.

2. <u>BOUTONNIERE DEFORMITY:</u>

Flexion at the proximal inter-phalangeal joint and hyperextension at the distal interphalangeal joint. This occurs when the middle slip of the extensor tendon of the finger ruptures due to the rheumatoid process affecting the neighborhood joint.

3. <u>Z – DEFORMITY:</u>

Radial deviation at the wrist with Ulnar deviation of the digits often with palmar subluxation of the proximal phalanges.

rarely symptomatic, but on occasion they break down because

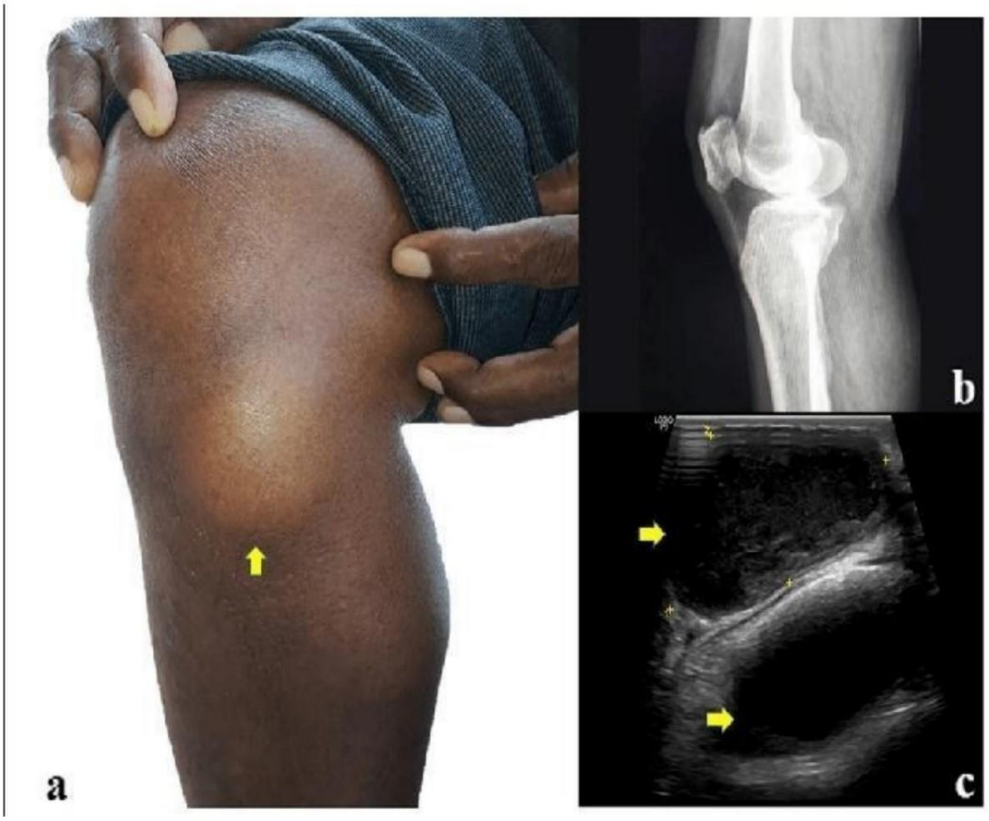
occur at presentation, especially in men most features are due to serositis, granuloma/ nodule formation or vasculitis.

CHANGES IN THE DIFFERENT PARTS

AND SYSTEM OF THE BODY

CUTANEOUS FEATURES

RHEUMATOID NODULE: Such nodule are characterized by the pressure of subluxation of the metatarsophalangeal (MTP) j: Rheumatoid nodules develop in 20 to 30 percent of person with rheumatoid arthritis. They are usually found on



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periarticular structures, extensor surfaces, or other area subjected to mechanical pressure common locations include the olecranon bursa, the proximal ulna, the Achilles tendon Surounded by a palisade of epitheliod cells lymphocytes and plasma cells are prominent in the outer layer.

Nodule may appear at any stage and if present, are very important for diagnosis from other form of inflammatory arthropathy. Bursitis, occasionally with nodular walls to the bursa may develop most frequently in the olecranon bursa. Tendon nodules in the flexors in the palm may cause triggering of the fingers.

MUSCLES:

Clinical weakness and atrophy of skeleton muscles are common. Muscle atrophy may be evident within weeks of the onset of rheumatoid arthritis and usually apparent in musculature approximating affected joints.

Rheumatoid myopathy rarely and can be responsible for muscle weakness and wasting over and above that resulting from the arthropathy.

BLOOD:

Anemia is an almost variable feature. This may be due to iron deficiency or simple the anemia of chronic inflammation. Iron deficiency commonly arises from occult gastro intestinal tract bleeding as a result of

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vessels necrotic changes in the arterial wall resemble those seen in polyarteritis nodosa.

Arteritis is a feature of severe sero-positive disease, usually with nodule, commonly this presents with ischemic skin lesions appearing as dark brown area 1-2mm in diameter in the nail folds. The development of these is often the first sign that the disease is assuming as a more widespread form larger area of necrosis or skin ulceration result from involvement of medium sized arteritis, rarely peripheral gangrene or mesenteric occlusion may develop. Neuropathy in the form of a mononeuritis probably results from such an arteriopathy comparable to that seen in polyarteritis nodosa. It is usually affect the lower limbs.

RESPIRATORY SYSTEM:

Pleura-pulmonary manifestations, which are more commonly observed in men, include pleural disease, interstitial fibrosis pleurapulmonary nodule pneumonitis and arteritis. Pulmonary nodules may appear singly or in clusters when they appear in individuals with pneumoconiosis, a difference nodular Fibrotic process (caplan's syndrome) may develop on occasion. Pulmonary nodules may cavitate and produce a pneumothrorax or bronchio-pleural fistula. In addition to pleura-pulmonary disease, upper

manifestation of systemic rheumatoid disease Felty's Syndrome may develop after joint inflammation has regressed. The leucopenia is a selective Neutropenia with polymorphonuclear leukocyte counts of less than 1500 per cubic millimeter and sometimes less than 1000 per cubic millimeter. Bone marrow examination usually reveals moderate hypercellularity with a paucity of mature neutrophils. Hypersplenism has been proposed as one of the causes of leucopenia, but splenomegaly is not invariably found and splenectomy does not always correct the abnormality. Patients with Felty's syndrome have increase frequency of infections usually associated with neutropenia.

DIAGNOSIS:

The course of RA is quite variable and difficult to predict in individual patient. Most patient experience persistent but fluctuating disease activity accompanied by a variable degree of joint deformity approximately 15 percent have a short lived inflammatory process that remits without major deformity, whereas 10 percent experience relentlessly progressive disease leading to marked deformity and disability.

Remission of disease activity is most likely to occur during the first year person who have a worse prognosis, are individuals with subcutaneous nodules or radiographic evidence of erosions at the time of initial evaluation.

The median life expectancy of persons with rheumatoid arthritis is shortened by 3 to 7 years. The increased morality rate seems to be limited to patients with more severe articular disease and can be attributed largely to infection and gastrointestinal bleeding.

In a majority of patients, the disease assumes its characteristic clinical feature within 1 to 2 years of onset. The typical picture of bilateral symmetric inflammatory polyarthritis involving small and large joints in both the upper and lower extremities with sparing of the axial skeleton except the cervical spine suggests the diagnosis constitutional features inductive of the inflammatory nature of the disease. Such as morning stiffness, support the diagnosis, demonstration of subcutaneous nodules is a helpful diagnostic feature. Additionally, the presence of rheumatoid factor, inflammatory synovial fluid with increased number of polymorphonuclear leukocytes, and radiographic findings of juxtaarticular bone

AMERICAN RHEUMATISM ASSOCIATION CRITERIA FOR THE DIAGNOSIS OF RHEUMATOID ARTHRITIS

1. Morning stiffness.
2. Pain on motion or tenderness at least one joint.
3. Swelling (Soft tissue thickening or fluid) in at least one joint.
4. Swelling of at least one other joint.
5. Symmetric joint swelling.
6. Sub-cutaneous nodules.
7. Radiological changes typical of RA.
8. Demonstration of Rheumatoid factor in serum.
9. Poor mucin precipitates from synovial fluid.
10. Characteristic histological changes in synovium.
11. Characteristic histological changes in nodules.

- Criteria 1 – 5 must be continuous for at least 6 weeks.
- Criteria 2 – 6 must be observed by a physician.

INVESTIGATIONS

RA FACTOR:

No tests are specific for diagnosing RA. However, rheumatoid factor, are found in more than Two-thirds of adults with the disease. Although rheumatoid factors are found in less than 5% of healthy persons, they are not specific for RA The frequency of rheumatoid factor in the general population increases with the age, and 10 to 20 percent of individual over 65 years old have a positive test. In addition, a number of conditions besides rheumatoid arthritis are associated with the presence of rheumatoid factor. These include Systemic Lupus Erythematosus, Sjogren's syndrome, chronic liver disease, sarcoidosis, interstitial pulmonary fibrosis syphilis, subacute bacterial endocarditis, visceral leishmaniasis, schistosomiasis and malaria. The presence of rheumatoid factor does not establish the diagnosis of RA but can be of prognostic significance because patient with high titers tend to have more severe and progressive disease with extra-articular manifestation not everyone who has the proteins develop the disease.

The for rheumatoid serum factor are positive in 80 percent of patients with classical rheumatoid arthritis and in all patient with rheumatoid nodule.

BLOOD:

Normochromic, normocytic anemia is frequently present in active rheumatoid arthritis. The white blood cell count is usually normal, Eosinophilia, when present and usually reflects severe systemic disease. The neutropenia may be profound and secondary infection is a common and critical complication spontaneous remissions occasionally occur.

The Erythrocytes Sedimentation Rate (ESR) is increased in nearly all patients with active RA. The ESR is one of the most reliable indications of inflammatory joint disease but it is of course, quite non-specific.

X-RAY:

Radiography is of prime importance in the diagnosis. Early in the disease, X-ray of the affected joints are usually not helpful in establishing a diagnosis. They reveal only that which is apparent from physical examination, namely evidence of soft tissue swelling and joint effusion, none of the radiographic findings are diagnostic of rheumatoid arthritis whilst soft tissue swelling is visible clinically

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MANAGEMENT & HOMOEOPATHIC TREATMENT

MIASMATIC EVOLUTION

Rheumatoid arthritis has following miasm.

1. Psora
2. Sycosis
3. Syphilis
4. Tubercular

PSORA

PAINS

Neuralgic pains may be psoric or pseudo-psoric.

MODALITIES

Usually better by quite rest and warmth often worse motion better rest and warmth.

CHARACTERISTICS

Hands and feet are dry, hot often with burning sensation in palm and soles. Cramps in lower extremities in calves of legs, in feet, toes, ankles and insteps.

Burning of sole of feet, numbness of extremities with tingling sensation feeling as if parts were going to sleep worse lying down or after sleep or if any

pressure is brought to bear on the part, as lying lightly on the arm or crossing the limbs etc., pricking or tingling in finger or extremities due to poor circulation, coldness of single parts as knees hands, feet, arm, nose etc.

BOILS

They may depend on both psoric and pseudo-psoric influences. Small suppurative and non-suppurative boils.

The psoric patient can walk well but it kills him to stand.

SYCOSIS

PAINS

Pains in the joints or periosteum are due to gouty concretion or chalky deposits in the tissues conveyed from circulation. Shooting or tearing pains in the muscles or joint pains in the fingers or small joints.

MODALITIES

Worse rest, patient is better moving, by rubbing stretching and better in dry, fair weather, worse at approach to storm or a damp, humid atmosphere,

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and a falling barometer or becoming cold, heat does not always ameliorate.

Rheumatoid pain worse during cold damp weather, better in the morning and on stretching.

CHARACTERISTICS

Stiffness and soreness, especially lameness, is very characteristic or sycosis, worse stooping, bending or beginning to move.

In arthritis or rheumatism we have an infiltration of inflammatory deposits but it readily absorbs and in never formative as we find in syphilitic and tubercular changes which are permanent unless dissipate by treatment. Nail may be ridged or ribbed.

SYPHILIS

PAINS

The tubercular and syphilitic bone pains are very similar both as to their character and times of aggravation.

Stitching, shooting or lancinating pains in the periosteum or long bones of the upper and lower extremities.

MODALITIES

Worse at night or approach of night, worse change of weather by cold and damp.

NAILS

In nails we have many inflammatory changes due to syphilis and tuberculosis we have in both, true onychia though not of such specific character in the tubercular process an in the tertiary syphilis.

TUBERCULAR

LOOK

Pale skinned, anemic tubercular subjects, fingers are long and do not taper gradually are blunt or club-shaped at "extremities". This long fingered individual with the lengths so irregularly arranged is characteristic. Hands are often thin, soft and flabby and easily compressed, usually very moist or often cold, damp perspiring profusely.

NAIL

The nails of these patients are brittle, break or split easily, often hang nails. Nails thin as paper, bend easily and are convexly is reversed, spotted nails, show white specks sometimes anterior edges are

HOMOEOPATHIC APPROACH FOR THE TREATMENT

There are two types of Homeopathic approach for the treatment of rheumatoid arthritis which are fallowing

1. Constitutional treatment
2. Therapeutic treatment

1. CONSTITUTIONAL TREATMENT:

In constitutional treatment, the most similimum remedy is selects on the basis of the constitution of patient. According to stuart close "Constitution is that aggregate of hereditary Characters, influenced more or less by environment, which determines the individual's reaction, successful or unsuccessful to the stress of environment" constitution consists the various factors. The chief are **Physical make up of the body, Temperament, Heat and Cold relation, desire an aversion of the food, miasm, diathesis, susceptibility and responses, addictions, habit etc.** on the basis of the constitutional symptoms of the patient, we form constitution diagnosis and select constitutional medicine. Which is prescribing to

the patient constitutional treatment is given in the chronic case of rheumatoid arthritis.

2. THERAPEUTIC TREATMENT:

In therapeutic treatment of rheumatoid arthritis, the medicine prescribed on the basis of the few local symptoms (Location, sensation and character of pain) of the suffering. In acute case of the RA, The whole history or constitution is not taken in the consideration for the selection of similimum.

ARSENIC ALB:

The medicine may be indicated as a constitutional remedy and also in recent very acute case rapid onset, high fever, pain in knee that kept patient turning and twisting, though every movement provoked cries and both elbow were quickly worn through with the effort to tern.

Mouth and tongue were dry on waking and there were night sweat. As a constitutional remedy it is indicated by its intense restlessness mental and physical, its anxiety and prostration.

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AURUM MET:

Rheumatism which jump from joint to joint and finally settles on heart impossible to lie down, must sit bent forward Visible throbbing of carotid, face cyanotic, gasps for breath, can hardly speak above a whisper. Much perspiration along with swelling of feet and leg. Aurum is of all drugs the most depressed and despairing.

BRYONIA ALBA:

It is indicated both in muscular and articular rheumatism both as an acute and constitutional remedy. The muscles are sore to the touch and at times swollen the pain are aggravated from the slightest motion and are relieved by perfectly quite. Where only joint are involved. It is indicated when the local inflammation is violent. The affected parts are very hot and dark red or pale red. The pain are sharp, stitching or cutting in character and the great feature of the drug should always be present namely the aggravation from the slightest motion. Thirst for large and cold drinks, dry coated tongue Bryonia especially affects serous membranes in all part of the body synovial membrane.

CALCAREA CARB:

It is of service in rheumatic affection caused by working in water, rheumatism of back and shoulder, rheumatism of finger joints gouty nodosities about the fingers are also present.

Aggravation, new moon, full moon by prolonged standing, mental or physical exertion, cold, washing, charge of weather, getting wet, ascending.

Amelioration in dry weather lying on painful side, joints are swollen especially knee. Other characteristics of Calc Carb like physical constitution chilliness, costiveness and delayed milestones are important guidelines fro selecting the medicine for rheumatoid arthritis.

CAUSTICUM:

Rheumatic pains worse from cold dry weather. Better wet weather, warm wet burning pain in joints. Rheumatism articulation of jaws, stiffness, hips & back rises with difficulty.

The restlessness of this remedy occurs only at night. Pain compels the patient for constant motion, which does not relieve. Causticum has gouty concretion in joints. The patient of causticum will suffer from oesteo-cartilagenous or osteomuscular rheumatism with muscular paresis and pain radiating to the right

knee. It is one of the most indicated remedy for rheumatoid arthritis.

COLCHICUM AUTUMNALE:

Arthritic pains a jar makes patient scream. Affect periosteum and synovial membranes redness, hard swelling of affected joints. Worse cold, wet weather and checked sweats in autumn better by warmth. Patient is cold, weak sensitive and restless loathes the smell or sight of food. It is indicated proper, when it begin in on joint.

The affected joints are swollen and dark red or pale in colour extremely sensitive to touch and to slightest motion. The pains are acute, tearing or jerking in character and are associated with paralytic weakness of limbs and numbness and coldness of the surface.

KALMIA LATIFOLIA:

Wandering pains, worse motion, go downwards down arms legs shoulder to finger; shoot and tearing along the nerves, pain shift suddenly come and go suddenly. Rheumatism finally attacks heart with thickening of valves. Rheumatism usually travels downwards fallowing the direction of the pain.

ARNICA MONT:

It is useful in local rheumatism mostly for those which occur in the winter : chief characteristics are sore and bruised feeling of the affected part : Aggravation from any motion sharp shooting pain which run down from the elbow to forearm, rheumatic pain after or with history of injury confirm arnica.

AUXILIARY TREATMENT

(AS PRACTICED IN ALLOPATHY)

The most common allopathic drugs used to treat rheumatoid arthritis include.

1. Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)
2. Corticosteroid
3. Disease Modifying Anti-rheumatic Drugs (DMARDs)
4. Immuno Suppressive Drugs

Non-steroid anti-inflammatory drugs and corticosteroid are generally the first drugs prescribed.

1. **Non-steroidal anti-inflammatory Drugs (NSAIDs):** Cox-2 inhibitor like NSAIDs, Cox-2 inhibitor suppress an enzyme called cyclo-oxygenase

(cox) that triggers joint inflammatory and pain

NSAIDs are used to reduced inflammation and pain. They include Aspirin, Indomethacin, naproxen Ibuprofen, tolmetin and etodolac side effect of NSAIDs include Nausea, GIT irritation and bleeding rash Ulcers and impaired renal function.

2.Corticosteroid:

These medications (cortisone, prednisone and others) reduced inflammation and slow joint damage they are most often used for sever flares of rheumatoid arthritis, side effect of corticosteroid include : weight gain, facial puffiness, thinning of the skin and bone, severe mood, swings, insomnia, diabetes, hypertension, cataract.

3.Disease Modifying Anti-rheumatic Drugs(DMARDs) This medication have been shown to slow or halt the progression of RA DMARDs are comparatively slower acting, take week or even month to produced effect. In same cases they may bring about a temporary remission and inhibit joint destruction and deformity. However the side effect of DMARDs can be much more severe. These include: skin, rash, nausea and vomiting, diarrhea, anemia, muscles

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weakness, kidney damage, bone narrow damage bloomy vision, increased susceptibility to infection.

2. **Immuno Suppressive Drugs:**

Immuno suppressive medicines are only used in extreme cases to slow down the effect of rheumatoid arthritis due to very serious side effect of this type of medication side effects of immuno suppressive drugs include:

Depressed bone marrow functioning

Low white blood cell counts

Liver cirrhosis

Allergic reactions in the lungs

SURGERY:

Surgery play a significant role in the management of patient with severely damaged joints especially where irreversible changes have taken place open or arthroscopic synovectomy may be useful in some patient with monoarthritis, especially of knee in addition early tendosynovectomy of wrist may prevent tendon rupture.

Synovectomy is a procedure designed to remove some of the inflamed synovial tissue that line affected joint the entire joint is needed to be replaced with a metal or plastic prosthesis.

Homoeopath would never favor surgery but at the same time one has to be well aware of the progress of disease process. Being conscious of the limitation of Homoeopathy only help to practice a better and more rational Homoeopathy. In such cases where there are severe irreversible pathological changes one has to advice surgery, if it will help in increasing the mobility and reducing the suffering.

MANAGEMENT:

Management of patient with RA involves an interdisciplinary approach which attempts to deal with the various problems that these individuals have with functional as well as psychological interaction.

Rest ameliorates symptoms and can be an important component of the total therapeutic program. In addition splinting to reduced unwanted motion of inflamed joints may be useful.

Exercise directed at maintaining muscles strength and joint mobility without exerbating regimen.

REST:

To control bad days, planning of activities and rest period is advisable. This is necessary because a flare by over working or by increasing physical or

emotional stress. Rest is important for patient with RA and can not be overemphasized.

SPLINTING:

Splinting is another way to minimize joint destruction. A splint can be utilized to support a joint that is inflamed, thereby reducing pain and the inflammatory process.

EXERCISE:

Presentation of muscle strength is also very important for rheumatoid arthritis patients muscles atrophy can quickly occur in these patients because of disease: splinting or the inflammatory process, loss of muscle bulk is correlated with loss of functional ability. Thus an exercise program should be undertaken that will maintain or increase the strength of the patient with rheumatoid arthritis.

CHANGE OF POSITION:

Positioning of the affected joints and part is valuable in preserving motion and increasing its function patient should frequently change body position at work home and even during leisure.

MODIFICATION IN LIFE STYLE:

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PRECAUTIONS:

- To maintain good health a nutritious diet and regular exercise is necessary.
- Avoid stress, learn to cope with it.
- Plenty of salads and lightly cooked vegetables should be eaten.
- Low fat, law protein vegetation diet should be preferred.
- Dairy product, red meat, acid fruit like lemons, orange, tea.

  Coffee and alcohol should be avoided.
- Raw fruit and vegetable juice should be taken regularly.
- Keep active except when pain is very severe.
- Rest is advisable when pain become severe.
- Keep joint mobile as much as possible do gentle joint specific exercise or walk every days for at least 30 minutes.
- Physiotherapy exercises will help in restricting deformity and maintaining mobility.
- The counter morning stiffness day should be started with slow gradual movement of joints.
- Yoga will help to relax as well as have a beneficial effect or arthritis.
- If overweight –weight reduction is necessary and will help especially when lower back and leg or affected.

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- ❖ Do not lift heavy weights instead of lifting one can slide objects (if kept on table).

ANNEXURE :

NATIONAL HOMOEOPATHIC MEDICAL COLLEGE & HOSPITAL, LUCKNOW

CASE PROFORMA

Case No …… **Name Of The Physician**……..
Reg. No. …… **Intern** **Incharge**
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Patient Name……
Age / Sex:
Occupation:
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Religion
:……..
Marital Status:……
……. **Address**:
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Diagnosis: ……..

CLINICAL HISTORY:

Chief Complaints ***D*** ***L*** ***S*** ***<*** ***>***
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History Of Present Illness:

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Past Illness:

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Personal History:

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Family History:

Father :
Mother :
Brother :
Sister :
Wife / Husband :
Social Status :
Dietetic Habits :

PHYSICAL EXAMINATION:

General Examination

Appearance **Build**
Nutritional State **Hydration**

Anaemia ***Obvious Focal Sepsis***
Pulse **Teeth / Gums**
B. P.
Tonsils Respiration
Ear
Temperature **Skin**

Local Examination:
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Systemic Examination:

- **Respiratory System**

- **C. V. S.**

- **C. N. S.**

GENERAL SYMPTOMS

PHYSICAL GENERAL SYMPTOMS

Appetite	**(D /A)**
Thirst	
Reaction to heat/ cold	**Sleep**
Stool	
Urine	**Dream**
Menstruation	

MENTAL GENERAL SYMPTOMS

WILL:

Love
Hate
Fear
Anger
Temper

UNDERSTANDING:

INTELLECT:

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Thought
Illusion
Hallucination

Delusion
Memory

INVESTIGATIONS

ROUTINE INVESTIGATION:

SPECIAL INVESTIGATION:

EVALUATION OF SYMPTOMS & RUBRICS FORMATION

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CONSULTATION OF REPERTORY

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FINAL PRESCRIPTION

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PROGRESS REPORT

DATE	PROGRESS	TREATMENT

SIGNATURE

INTERN / H. P.

MASTER CHART

S.No	Name	Age & Sex	Presenting Complaint	Miasm	Prescription Basis	Prescription	Result
1	Mr. Suraj soni	45/M	Pain in knee joint; < motion; sensitive to touch; soreness.	Psora & Sycosis	Local symptoms	Arnica 30 BD ×7 days	Improved
2	Mr. Hari singh	58/M	Pain in small joints of hands & feet; tenderness; > hot water.	Psora & Sycosis	Local symptoms	Lithium carb 200/ BD ×7 days	Improved
3	Mrs. Vinita gupta	47/F	Right shoulder tearing pain; < cold, night.	Psora & Sycosis	Local symptoms	Sanguinaria 200/BD ×15 days	Improved
4	Mr. Raja sahu	59/M	Right big toe pain; < motion, touch; red & swollen.	Psora & Sycosis	Local symptoms	Colchicum 30 TDS×7 days	Improved
5	Mr. Shankar	60/M	Right knee pain; > motion; < rest; stiff & sore; anxiety.	Psora	Mental & physical generals	Rhus tox 200 ×3 doses	Improved

6	Mr. Jugal Kishore pahariya	88/M	Left ankle pain; swollen; < night, pressure; > cold; extends to knee.	Psora, Sycosis & Syphilitic	Physical generals	Ledum pal 200/BD	Improved
7	Mrs. Meena devi	45/F	Right hip pain extending to knee; tearing; < motion.	Psora, Sycosis & Syphilitic	Local symptoms	Kalmia latifolia 200/BD ×7 days	Improved
8	Mr. Kanhaiya parihar	50/M	Right elbow pain; cutting & throbbing; red & swollen.	Psora & Sycosis	Local symptoms	Belladonna 30/BD ×7 days	Improved
9	Mr. Atul verma	50/M	Knee pain; < cold; > dry climate; burning soles; chilly, anxious.	Psora & Sycosis	Mental & physical generals	Calcarea carb 200 ×3 doses	Improved
10	Mr. Suresh Kumar	77/M	Ankle pain; heel aching; > elevating feet; shooting, shifting pain.	Psora	Local symptoms	Phytolacca 200/ BD ×15 days	Improved
11	Mr. Sonu soni	89/M	Right shoulder pain &	Psora &	Local symptoms	Sanguinaria 200 BD ×7 days	Improved

			stiffness; < night, cold.	Sycosis			
12	Mr. Rama Shankar yadav	77/M	Lumbar pain; < morning, motion; irritable; chilly.	Psora	Mental & physical generals	Nux vomica 200 ×3 doses	Improved
13	Mrs. Seeta dubey	65/F	Pain & swelling of wrist & finger joints; stiffness.	Psora, Sycosis & Syphilis	Local symptoms	Actea spicata 200/BD ×7 days	Improved
14	Mr. Ravindra kushwaha	69/M	Pain & stiffness in both knees; < motion, heat; > rest; irritable.	Psora	Mental & physical generals	Bryonia 200 ×3 doses	Improved
15	Mr. Santosh rajpoot	66/M	Lumbar burning pain; > hot application; restless, weak.	Psora, Sycosis & Syphilis	Mental & physical generals	Arsenicum album 30/TDS ×7 days	Improved
16	Mr. Ajay kumar	85/M	Shoulder pain extending to fingers; stiffness; forgetful; anxious.	Sycosis	Mental & physical generals	Medorrhinum 200 ×3 doses	Improved

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