

Case Study on Case of Ulcerative Colitis with Homoeopathic Medicine

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Abstract: *This comprehensive article explores the multifaceted aspects of Inflammatory Bowel Disease IBD, with a focus on ulcerative colitis UC and Crohns disease CD. It provides insights into the epidemiological variations of IBD across different regions and the potential environmental factors contributing to its rising incidence. The clinical features and diagnostic challenges of IBD are discussed, emphasizing the importance of a holistic approach to diagnosis. Furthermore, the article delves into a unique case study of a 31 - year - old female IBD patient, shedding light on her emotional struggles and homoeopathic management. Through a meticulous analysis of symptoms and constitutional remedies, this article offers valuable insights into the personalized treatment of IBD patients.*

Keywords: Inflammatory Bowel Disease, Ulcerative Colitis, Clinical Features, Diagnosis, constitutional Homoeopathic remedy.

1. Introduction

Chronic inflammatory bowel disease (IBD) includes ulcerative colitis (UC), a disorder in which inflammation affects the mucosa and submucosa of the colon, and Crohn's disease (CD), in which inflammation is transmural and may involve any or all segments of the gastrointestinal tract. Patients who have features of IBD but cannot be clearly categorised into any of these two diseases are labelled as having indeterminate colitis (IC).

Epidemiology

Both UC and CD are worldwide disorders, although the precise incidence varies considerably in different countries. The United States, Northern Europe and Scandinavian countries have higher rates compared to countries in Southern Europe, South Africa and Australia. In Asia, the disease was thought to be uncommon, but recent reports have highlighted the increasing incidence of the disease. The rapid changes in incidence and prevalence in Asia may point to environmental changes associated with the so - called 'Westernisation' of lifestyle (e. g. dietary changes, smoking, etc.) as potential risk factors. IBD typically affects young people, but may have a bimodal incidence with a second peak in later life. Crohn's disease is frequently diagnosed in late adolescence or early adulthood, with a median age of diagnosis in the third decade. Men are slightly more likely to be affected with UC whereas women with CD.

Clinical Features

Symptoms suggestive of IBD include watery stools, blood or mucus in the stool, diarrhoea persisting for more than 4 weeks, crampy abdominal pain, nocturnal defaecation and fever. Weight loss is significant. Anal fissures, anal fistulae, frank bleeding per rectum and abdominal masses can occur. Symptoms are generally recurrent. Ulcerative colitis is a Recurrent inflammatory disease of the colon and rectum crypt abscess, crypt distortion and crypt branching along with villiform surface characterized by mucosal inflammation and ulceration. The disease starts in the rectum and spreads to a variable extent in a proximal direction. The inflammation is continuous and affects the entire circumference of the mucosal membrane. Pathological and histological features include diffuse inflammation of the

mucosal membrane with ulceration, crypt Abscesses, infiltrates and reduced number of goblet cells. The terminal ileum is rarely involved (backwash ileitis). The disease activity is categorised as active colitis or flare (active disease), remission (quiescent phase) or chronic continuous disease (partially active disease). The disease extent is variable and can be confined to the rectum (proctitis), rectum and sigmoid colon (proctosigmoiditis), may reach upto the splenic flexure (left - sided colitis) or may involve the transverse colon or beyond (pancolitis). Disease severity is categorised as mild, moderate or severe according to Truelove - Witts criteria.

2. Diagnosis

Chronic pattern of symptoms (persisting for more than 4 weeks), abdominal pain, diarrhoea, with or without blood, weight loss or growth disturbance raises a suspicion of IBD. The diagnosis is made on the basis of careful medical history, close observation of the clinical picture, the evaluation of endoscopic, histological and radiological findings and, finally, the results of laboratory investigations. Laboratory abnormalities include elevated ESR and C - reactive protein, chrombocytosis, anaemia, leucocytosis and hypoalbuminaemia. Stool examination is required to look for pus cells, RBC's, infective organism and markers of inflammatory exudation in the bowel like faecal calprotectin, $\alpha 1$ - antitrypsin and lactoferrin. Differentiation of CD and UC on the basis of laboratory parameters alone, however, is difficult. Antibodies such as p - ANCA (increased in UC) and anti - *Saccharomyces cerevisiae* antibody (ASCA, primarily in CD) shows too much overlap in the distribution to permit exact differentiation.

Homoeopathic Management of IBD:

Homoeopathy is holistic science in worldwide where we can treat patient as whole not only disease, so for selection of homoeopathic medicine we have to take entire life history of patient that including mental state of patient, physical general and life situations and circumstance. For homoeopathic medicine selection we have to study CAUSE - EFFECT - RELATIONSHIP between homoeopathic medicine and patient symptoms and make totality of symptoms. In homoeopathic materia medica there is many

Volume 12 Issue 9, September 2023

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polycrest deep acting remedy like Natrium muriaticum, Arsenicum album, phosphorus, Lachesis, lycopodium, nux Vomica, sepia, carnosinum, and tuberculinum Etc.

Name - DDG age - 31year sex - female HW married
Education - B. sc zoology

Fa - 62year mother - 55 year Spouse - devendra 35 year software eng.

Son - 5year Brother - 1 elder, 1 younger

Address - Raipur chhattishgad.

Chief Complain:

Location	Sensation	Modalities	Concomittent
IMMUNITY ↓ GIT INTESTINE COLON Sep.2017 D - CONTINUE I - MODERATE	Started with abdominal pain Tenesmus+2 Watery stool+2 Bleeding+2 Stool 2 - 3 time/day Offensiveness o stool+ Weakness+2 Weight loss - 4kg	A/F - ANGER SUPPRESSION >allopathic rx <thinking of complaint+2 <oily food <outside food Tab - mesocol 1200mg BD	Ravenous hunger+3 hungry at midnight Rheumatic Pain in left hand. Back pain+ Extremity pain before stool Fear of disease/ death+2 Trembling of hand and feet+2
At present January 2019	Abdominal pain before stool Tenesmus+2 Loose semisolid bright red stool. Sometime black brown stool 2 - 3time/day Urging for stool at morning+2 Weakness+2 Weight loss continually 54—49—47kg	<before stool+2 <mornign+2 <out side food+2. Tab - mesocol 1200mg BD Tab - refael 9mg OD	

Physical Geneal

Lean, Fair, Tall

Perspiration – Nose+2, forehead+, back. White staining, offensive+2.

Weight loss with Appetite - ravenous+3 with complain.

Thirsty+2 Craving –paneer+3, vegetable+2, milk+2

Aversion – mashroom+3, pulses+2

< Fasting+2, hunger intorable

Stool – Frequency – 2 - 3 time/day, consistency - ~ semi solid/ bloody. Urine - N

Menstrual Function: normal flow, red, clotted+, offensive+, FMP - 7TH std.

Before menses - back pain, abdominal pain+2

During –back pain+2.

Delivery - FTND

Sleep - normal position - on side, started+2.

Dreams – travelling, frightened, falling in water+, accident+2.

motion sickness - vomiting, no sun aggravation

C3H2. CHILLY PATIENT

P/H: ? fever.

F/H: Mother - father - Nil

O/E: BP - 100/60, Tongue - pink, Nail - pink+, Wt - 46.5

Kg. Throat - N, P/A - NAD

Rs - clear, AEBE,

GIT - Tenderness+ on umbilicus region

CNS - NAD.

Investigation:

30/1/2019 stool routine:

Color - yellow semi solid four smell

Mucus - present

RBC - not detected

Occult Blood - not detected.

14/2/2019 - Colonoscopy:

Seen up to distal 15cm to terminal ileum. Multiple ulcer and cobble stone present in ileum. Rest of colon normal

14/2/2019 Histopathology report:

Microscopy: section show ileal gland, patched with mixed inflammatory infiltration of polymorphs, lymphocyte, plasma cell, eosinophis, and few crypt abscesses.

Life space:

A 31 - year - old female patient consulted me on the phone about IBD for 2 years with continued going on allopathic medicine as gastro physician told them that IBD is treatable but not curable, her weight reduced so she has more anxiety+3 of disease condition.

The family comprises of husband, 1 son 5 yr old, FIL, she did study up to B. sc zoology and HW. Her husband did the job at a software company at B. FIL is a retired bank manager, he is cool and calm by nature he treats her like a daughter. MIL is HW and more attached to her daughter. Sometimes patients have conflicts with MIL as well as SIL.

Childhood: family comprises of father, mother, patient have 4 siblings including patient, 2brother, 1elder, 1younger, 1 elder sister. Father is good in nature mother is cool and calm. The patient is more attached to the father because of all the demands fulfilled by the father even though the mother denial. The patient was more pampered by her father because she is the younger daughter of a sibling. In childhood, she had a good memory and no responsibility as such as her father was doing the government job at B.

Marriage: In - law family comprises of husband and one elder SIL, FIL, MIL. The patient does all housework like cooking, cleaning, and washing as she has a fear of comments from MIL and is finally exhausted by the time she goes to bed. One day patient's parents came to her in - law's home and MIL gave SAARI to her mother but the patient didn't like this SAARI as it was not good according to the patient's view, that incident patient was angry with MIL and asked her why the you given this type of SAARI to my mother, in anger her hand and leg trembling while anger and told her MIL that I am capable to give good SAARI for my mother at that time her SIL also angry on patient. The patient does not reply to these conflicts and weeping in the bedroom. On that day she stopped the conversation with SIL, MIL. She had Constance fear that she would comment on her works so she was doing her best. There was no conversation between MIL and the patient. Her husband

gives her moral support and she shares all things with her husband when he comes from a job in the evening. After a few days of this issue patient had the first episode of bloody diarrhea and severe abdominal pain in Nov.2018.

The gastroenterologist told her diagnosis and told them this disease is not curable only treatable with medicine so her anxiety level has been increasing and she has thought about fear of the disease, fear that she might be converted into cancer and that led to complaints also increasing. Trembling of feet and hand, palpitation while thinking of complaint. Anxiety+3 of children. Thinking that it's in curable disease I will die. That leads to sleeplessness at night. Dream of accident relative+2, falling in water+2 with started during sleep.

Totality of Symtoms

- A/F - Suppression of anger+3.
- Trembling of feet and hand during anger+3
- Palpitation while thinking of complaint+2
- Fear of cancer+3
- Fear of Death+3
- Dreams of accident relative
- Dream of falling in water with starting in sleep
- Ravenous hunger+3 hungry at midnight
- Perspiration – Nose+2, forehead+, back. White staining, offensive+2
- Sleeplessness night due to thinking complaint+2
- Motion sickness - vomiting+2
- Foul smelling stool+2
- Ulceration in intestine+2
- Bleeding per rectum+2.

Homoeopathic medicine selection on basis of Hahnemannian way of totality of symptoms where I find out syco - tubercular Miasm

FINAL CONSTITUTIONAL REMEDY - **Natrium Arsenicum.**

INTERCURRENT REMEDY – **CARCINOSINUM 1M.**

Potency selection on basis of susceptibility of patient – MODERATE TO HIGH SUSCEPTIBILITY.

3. Conclusion

In conclusion, Inflammatory Bowel Disease, encompassing conditions such as ulcerative colitis and Crohns disease, poses complex challenges in terms of epidemiology, clinical manifestations, and diagnosis. The case study presented here highlights the emotional and psychological toll this chronic condition can take on patients. With the right approach, including a thorough understanding of individual symptoms and constitutional remedies, homoeopathic management can play a significant role in alleviating the suffering of IBD patients and improving their overall quality of life. Further research and holistic approaches are needed to address the growing incidence of IBD worldwide.

Follow - Up Criteria

- 1) Anxiety depress mind
- 2) Weight
- 3) Weakness
- 4) Abdominal pain
- 5) Bleeding stool
- 6) Frequency and consistency of stool
- 7) Investigation

Date	1	2	3	4	5	6	7	Action
14/2/19	Case define							
16/2/19	Anxiety depress mind	Weight 44kg	Weakness	Abdominal pain	Bleeding stool	frequency and consistency of stool	14/2/2019 Investigation – colonoscopy - Seen up to distal 15cm to terminal ileum. Multiple ulcer and cobble stone present in ileum. Rest of colon normal	CARCINOCINUM 1M 1 DOSE GIVEN
2/3/19	>+2	Increase - 1kg	>+ Pain in limb		>+	2 - 3 time/day		CARCINOCINUM 1M 1P ARS. ABL 200 1P WEEKLY
4/4/2019	>+2	Increase 2kg	>+ no pain in limb	Before stool pain. In between Second relapse of IBD due to outside food at marriage Abdominal pain+3. Adv. Avoid outside food strictly	Bloody stool+2 Offensive+1	1 - 2 time/day Occasionally 1 time only		MERC COR 30 TDS AND SOS if bleeding and abdominal pain
6/4/2019				>+2	BLEEDING STOOL >+			NAT. ARS 200 1P WEEKLY SL TDS
5/5/2019	>+		Weakness+ No pain	>+2	>+	1 - 2 time/day		NAT. ARS 200 1P WEEKLY SL TDS
6/5/2019	N	Adv. Protein	No weakness	No pain	Yellowish semisolid	1 - 2time/day		NAT. ARS 200 1P WEEKLY

		diets Pulses in morning			stool			SL TDS
2/6/2019	N		No weakness	No pain		SQ		NAT. ARS 200 1P WEEKLY SL TDS
4/6/2019	N		No weakness	No pain	Stool normal	1 time/day		CARCINOCINUM 1M 1P NAT. ARS 200 1P WEEKLY SL TDS
7/7/2019	N	Increase 1 kg	No weakness	No pain	Stool normal	1time/day		NAT. ARS 200 1P WEEKLY SL TDS
2/8/2019	N					1time/day		Adv. For colonoscopy
29/8/2019	N	55 kg		No pain		1time/day	Colonoscopy done on 29/8/19 COLONOSCOCY NORMAL	NAT. ARS 200 1P WEEKLY SL TDS MEDICINE IS CONTINUE
21/9/2019	N	56	No weakness	No pain	Stool normal	1time/day		Adv. SOS Medicine

2023 - Patient and her family still contact with me and she have no any complaint about ulcerative colitis. She refer me many patient from her family. She lives happily with her family now.

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