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Application of the Concept of Homoeopathic Pathogenesis in the Management of Autoimmune Disorders of the Skin – A Series Retrospective Study

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ABSTRACT:

Autoimmune disease occurs when the immune system attacks its own molecules due to impaired immunological tolerance to autoreactive immune cells. Gender, race, ethnic characteristics, and environmental factors are associated with the likelihood of developing an autoimmune disease. Psoriasis and lichen planus are immune skin diseases with characteristic individual features represented by severe itching and scaling. Modern therapies for autoimmune skin disorders rely on general immunosuppressive drugs that disrupt the entire immune system, often with high side effect profiles of broad immunosuppression. This type of study, which is the only one of its kind, will help to better understand the genesis of the disease with an understanding of homeopathic pathogenesis including - clinical manifestations, manifestations of characteristic signs, mental state, miasma, sensitivity, sensitivity, dosage in the treatment of autoimmune skin disorders.

KEYWORDS: Psoriasis, Lichen Planus, Homoeopathic Pathogenesis, Autoimmune Skin Disorders, Skin, Dermatology, Homoeopathy, Anatomy, Homoeopathic Medicine.

INTRODUCTION:

Autoimmune disorders are of fundamental importance in the medical field because the etiopathology of these diseases has multifactorial aspects and most of them are idiopathic in nature. Psoriasis and lichen planus were studied in this study of autoimmune skin disorders. Psoriasis is a chronic inflammatory skin disease with a strong genetic basis, characterized by complex changes in epidermal growth and differentiation and numerous biochemical, immunological and vascular abnormalities. Psoriasis cases have widespread, scaly, erythematous plaques that cause considerable physical and psychological stress to affected individuals. Psoriasis is more sensitive to stress than many other skin conditions. Up to 60% of patients describe stress as a key exacerbater or trigger of their illness.

Psoriasis has a universal occurrence. However, its prevalence varies from 0.1% to 11.8% in different populations. The likely age group for the onset of psoriasis is 15 to 30 years. Psoriasis is also known to be associated with HLA class antigens. Lichen planus is a unique, frequent and chronic inflammatory disease that affects the skin, mucous membranes, nails and hair of the body. It is clear that immunological mechanisms almost certainly mediate the development of lichen planus. The exact incidence and prevalence of lichen planus is unknown, but estimates of the overall prevalence range from 0.14 to 0.80% in the general population. At least 2/3 of cases occur between the ages of 30 and 60. No sexual predilection is apparent.

Autoimmune skin disorders require a multifaceted strategy that goes beyond simply cleaning the skin to improve overall quality of life. While conventional medicine focuses on reducing inflammation and clearing the skin, homeopathy examines the response of an individual's immune system to genetic and epigenetic triggers. Since today most patients suffering from skin disorders of an autoimmune nature also suffer from the side effects of long-term tropical/local applications, homeopathy in such cases proves to be a ray of hope in the dark. This type of study is the only one of its kind and will help to better understand the genesis of the disease.

A study of the pathogenesis including the mental state of patients suffering from these diseases will help to better understand the following points for homeopathic management;

1. Different clinical manifestations of different individuals will help to understand the localization of the disease and its correlation with the sphere of action of the drug.

2. Rate of disease – Different cases can be established with different rate of disease onset and its role in dosage selection.

3. Disease miasma – Pathogenesis and mental state will enable a better understanding of the individualistic nature of the disease as well as the miasmatic understanding of the individual.

4. Mental state of the patient - Homeopathic holistic concept with individualism will help to explore how different manifestations of mental states and characteristics can be induced in different individuals suffering from the same disease diagnosis.

Through this study, it would be possible to identify and appreciate the importance of the disease in the genesis of the disease. Newly developed symptoms in an individual and their reflection in the case as a whole will be of great importance.

5. Differentiation of the axle.

6. Patient sensitivity along with sensitivity and reactivity can be studied and its relationship to dose selection can be deduced. This study is therefore useful in many ways to treat patients with autoimmune skin disorders such as psoriasis and lichen planus. If the above points are studied and analyzed in detail, they will leave rare chances of negligence in providing holistic treatment to the patient. From clinical experience during the treatment of such cases of psoriasis and lichen planus, it was seen that no satisfactory responses were observed with the modern method of treatment.

This study helps in the treatment of autoimmune skin disorders in conjunction with homeopathy for the better well-being of patients, thereby providing them with holistic care.

REVIEW OF LITERATURE:

Autoimmune disease occurs when the immune system attacks its own molecules due to impaired immunological tolerance to autoreactive immune cells. Many autoimmune disorders are strongly associated with genetic, infectious and/or environmental predisposing factors. According to the revised Witebsky criteria of Rose and Bon, a disease is considered autoimmune if

(i) it can be transmitted by pathogenic T cells or autoantibodies,

(ii) it can be induced in experimental animals, or if

(iii) autoimmunity is suggested by indirect evidence from clinical clues. The complex interaction of genetics and environmental factors is one of the key underlying pathogenic mechanisms in skin autoimmune diseases. In addition to genetics, several articles also specifically address certain cell types in skin autoimmune diseases, such as the role of regulatory immune cells in pemphigus and pemphigoid, the contribution of mononuclear phagocyte activation in psoriasis, the contribution of innate immune cells and cytokines in the pathogenesis of chronic skin inflammation. Treatment for autoimmune diseases is typically immunosuppressive drugs that reduce the immune response. Homeopathy treats the whole person. This means that homeopathic treatment focuses on individual and pathological conditions. This includes a detailed history of the patient, family and causative factors. Any underlying predisposition/sensitivity is considered. The disease is studied at the pathogen level as well as factors such as any psychological/physical stressors that might predispose the individual to the disease. Constitutional remedies work wonders in such cases. Any acute exacerbations can be managed with acute medications.

PSORIASIS Psoriasis is one of the most common dermatological diseases, affecting up to 2% of the world's population. It is an immune-mediated disease clinically characterized by erythematous, sharply demarcated papules and rounded plaques covered with silvery mica scales. The skin lesions of psoriasis are variously itchy. Estimates of the incidence of psoriasis in different parts of the world vary from 0.1% to 3%. There is a bimodal age of onset, the first peak at 15–20 years and the second at 55–60 years.

The prevalence of psoriasis in India is 0.44-2.8 percent, according to the Indian Journal of Medical Research. It usually affects individuals in their third or fourth decade, with males being affected twice as often as females.

PATHOGENESIS Various factors believed to play a key role in pathogenesis are T cells, antigen presenting cells (APC), keratinocytes, Langerhans cells, macrophages, natural killer cells, various Th1-type cytokines, certain growth factors such as vascular endothelial growth factor (VEGF), keratinocyte growth factor (KGF) and others. It has been hypothesized that the disease begins with the activation of T cells by an unknown antigen, leading to the secretion of a series of cytokines by activated T cells, inflammatory cells, and keratinocytes. The characteristic lesion of psoriasis is caused by hyperproliferation of keratinocytes. Activated Langerhans cells migrate from the skin to the lymph nodes and present antigen to nodal naïve T cells (cells that have not been previously activated by antigen).

RUNNING AND MODIFICATION FACTORS

Psoriasis can be triggered by a variety of factors, including physical damage to the skin (Koebner's phenomenon), administration of interferons or other inflammatory stimuli, rapid withdrawal of immunosuppressants such as corticosteroids, and systemic infections with streptococci or other bacteria.

• Local factors – site of skin injury (Koebner's phenomenon)

• Emotional stress

• Infection

• Drugs

• Sunlight

• Alcohol and smoking

• HIV

• Obesity

According to an epidemiological study conducted to evaluate psoriasis triggers, it was found that more than 70% of patients reported that stressful events cause their psoriasis to flare up, more than 60% of men and 20% of women were smokers. , about 80% of patients consumed alcohol, about 20% of patients reported recurrent infections, about 20% of our patients used one or more medications, about 36% of women reported the effect of hormonal changes on psoriasis exacerbation.

CLASSIFICATION OF PSORIASIS

• Gut psoriasis – It accounts for 2% of the total number of psoriasis cases. Small erythematous raindrop-like papules erupt suddenly and are distributed bilaterally symmetrically, usually in a concentric fashion, although they may also involve the head and extremities. The palms and soles are usually spared. The scales are not so noticeable in the early stage. The number of lesions can range from five or 10 to more than 100. Guttate psoriasis has the strongest association with HLA-Cw6 of all psoriasis types. The prognosis of guttate psoriasis is usually good and the lesions resolve in 3–4 months.

• Plaque psoriasis – This is the most common type of psoriasis, occurring in 90% of patients. It presents with well-demarcated erythematous-squamous plaques the size of coins to large palms distributed bilaterally. If palm-sized lesions predominate, it is called psoriasis geographica (the borders resemble a map of the country), if coin-sized lesions predominate, it is called nummular psoriasis. The lesions are stable and remain unchanged for a longer period of time than in gut psoriasis. The extensor surfaces of the body (especially the elbows and knees), the lumbosacral region, and the back are usually affected. Each psoriatic lesion begins as a papule and spreads peripherally to form nummular or discoid plaques. Many such discoid lesions coalesce to form large plaques that have a polycyclic border. Sometimes, when the plaque expands peripherally, the central part undergoes clearing, causing the formation of annular lesions (ring psoriasis). Chronic plaque psoriasis can show sudden fluctuations in disease activity.

• Exfoliative psoriasis – It is a generalized form of psoriasis characterized by complete or almost complete erythema and superficial desquamation. Psoriasis accounts for about 16-24% of all cases of exfoliative dermatitis. It can take one of two forms: chronic plaque psoriasis gradually progressing as the plaques become confluent and extensive, but the disease is relatively responsive to treatment; and as a manifestation of unstable psoriasis caused by infection, drugs (eg chloroquine or beta-blockers), sudden withdrawal of systemic corticosteroids,

• Pustular psoriasis – In psoriasis vulgaris, the surface of the plaque is dry with silvery white, loose scales. When it is dotted with tiny, superficial, sterile pustules, it is called pustular psoriasis. Pustular psoriasis is induced by overtreatment with topical tar, anthralin, or strong steroids, or by systemic therapy with progesterone or corticosteroids. It can also be accelerated by foci of infection, pregnancy and hypocalcemia. Pustular psoriasis is broadly classified into a localized form and a generalized form. The true localized form of pustular psoriasis affects the palms and soles and is also known as "pustulosis palmaris et plantaris". The types of generalized pustular psoriasis (GPP) have been described as follows:

• Von Zambusch Type: This is the most severe form of GPP. The skin lesions begin suddenly as multiple erythematous, tender plaques that soon become studded with tiny sterile pinhead-sized pustules that may coalesce to form pools of pus.

• Exanthema type: there is a sudden eruption of erythema and pustules. It usually follows an upper respiratory infection. It often starts on the palms and soles and spreads to other parts of the body. General signs and symptoms of toxicity, although present, are not prominent. The illness usually goes away after the infection is cured.

• Annular type: Eruption consists of annular lesions with erythema, scaling, and pustules at the periphery. Each lesion grows slowly and persists for weeks or months.

• Psoriasis Unguis – Nail changes are seen in about 20% to 50% of patients with psoriasis. Common changes are pitting of the nail plate, onycholysis or separation of the nail plate from the nail bed, subungual hyperkeratosis, and crumbling of the nail plate. Sometimes grooves and ridges on the nail plate, yellowish discoloration and fragmentary bleeding are also observed. Fingernails are affected more often than toenails.

• Psoriatic arthritis – Psoriatic arthritis is an inflammatory arthritis associated with psoriasis usually with a negative rheumatoid factor test. Arthritis occurs in about 5% to 10% of patients with psoriasis. In 10% of cases, its onset is simultaneous with a skin disease, but it can rarely precede it. Like skin psoriasis, psoriatic arthritis is a genetic disorder. HLA studies show that haplotypes B27, DR3, A26 and B38 are significantly associated with psoriatic arthritis. Environmental factors such as trauma can precipitate arthritis. It occurs commonly between the ages of 30 and 55.

INVESTIGATION AND INVESTIGATION

• Psoriasis can usually be diagnosed on clinical grounds and a biopsy is rarely required.

• Parakeratosis

• The presence of (Munro's microabscesses) in the stratum corneum., consist of pyknotic nuclei of neutrophils that have migrated from "squirting papillae" to spongiform pustules and then to the stratum corneum.

• Absence of granular layer

• Regular extension of the Rete combs >>>>

• Regular lengthening of dermal papillae ANOTHER PLAN Lichen planus (LP) is a papulo-squamous disease that can affect the skin, scalp, nails and mucous membranes. The primary skin lesions are pruritic, polygonal, purple flat-topped papules. Careful examination of the surface of these papules often reveals a network of gray lines (Wickham's striae).

Lichen planus (LP) is an inflammatory skin disease with characteristic clinical and histopathological findings that affects 0.5 to 1% of the population. There are also many variants in morphology and location, including oral, nail, linear, annular, atrophic, hypertrophic, inverse, eruptive, bullous, ulcerative, LP pigmentosus, lichen planopilaris, vulvovaginal, actinic, lichen planus-lupus erythematosus overlap syndrome, and lichen syndrome planus pemphigoids. Many of the variants are much less common than the classic LP. The rarity of the variants and their atypical manifestations make their timely diagnosis and treatment difficult in the clinical environment.

CLINICAL FEATURES

Clinical symptoms of Lichen Planus according to ICD-10 criteria: Inflammatory, pruritic disease of the skin and mucous membranes, which can be either generalized or localized. It is characterized by prominent purplish, flat-topped papules that prefer the surface of the trunk and flexors. Lesions may be discrete or confluent to form plaques. Histologically, there is a “sawtooth” pattern of epidermal hyperplasia and vacuolar alteration of the basal layer of the epidermis, together with an intense upper dermal inflammatory infiltrate composed mainly of T-cells. The etiology is unknown. LP lesions are typically symmetrical in distribution and can affect any region of the body, but LP tends to favor the flexural surfaces of the forearms, wrists, and ankles; dorsal surface of hands; shins; suitcase; and sacral areas. Affection of the oral mucosa is also common. Lesions may include other cutaneous (ie, scalp, hair, and nails) and mucosal (ie, genitalia, esophagus, and conjunctiva) lesions, but interestingly, the face is rarely involved. PATHOGENESIS Immunological mechanisms play a key role in the pathogenesis of LP. There is evidence of genetic and exogenous influences. The familial form of the disease is common among human leukocyte antigen (HLA) haplotypes.

There is evidence that HLA-DQ1 may be associated with resistance to the occurrence of LP.9 Infectious agents, drugs, and chemicals are known to be involved in the pathogenesis of LP and lichenoid reactions. Many commonly used medications can cause lichen planus-like lesions. Dental amalgam materials (mercury and gold) are known to cause oral lichenoid reactions. Epidemiological evidence from more than 90 controlled studies worldwide strongly suggests that hepatitis C virus (HCV) may be the etiological factor of OLP.

TREATMENT

The clinical manifestations of psoriasis and lichen planus are different, but both are associated with genetic aspects of HLA. Both of the above diseases do not have 100% treatment methods according to modern medicine. While the common therapy for these disorders is the use of corticosteroids to suppress immunity and another is PUVA therapy (Psoralen + Ultraviolet A), which consists of local or systemic application of psoralen followed by irradiation with ultraviolet light A (320-400nm). Both of these therapies have adverse effects on the systemic and local levels of the body. In addition to side effects, there are many contraindications for using this treatment, such as pregnancy, pediatric age group, individuals suffering from liver or kidney damage, increased likelihood of phototoxicity, etc. On the other hand, there is a large spectrum of homeopathic treatment without any contraindications and side effects. Homeopathy believes in individualization and a holistic approach to each sick person. Where we firmly believe in the role of the patient's mental state, which affects the physical side and results in disease.

PSYCHOGENESIS OF AUTOIMMUNE SKIN DISORDERS

The skin is our furthest physical boundary, but it also connects us to the outside world and brings us into contact with our environment. We present ourselves to the world through our skin... and we cannot change our skin. The skin reflects our nature on the outside – in a very simple way. For starters, it serves as a reflection surface for all of our internal organs. Any disturbance of these organs is reflected in the skin and any stimulation of the relevant area of the skin is transmitted back inwards to the relevant organ. The skin does not only reveal our internal organic state: all our psychological processes and reactions are visible on it and inside. In some ways, it's so obvious that we can all see it with our own eyes: we blush with embarrassment and turn pale with shock, sweat with fear or excitement, our hair stand on end with terror or goosebumps. Physical itching indicates that something is "biting" or "bothering" us on a psychological level. In the case of skin rashes, something is breaching our boundaries – something that needs to get out. In psoriasis, the process by which the skin naturally produces a calloused outer layer is exaggerated.

One cannot help but resemble armor (compare the horned armor of some animals). But in this case, the natural protective function of the skin has turned into a form of armor: the lesions in question close in both directions. They are no longer willing to let anything in or out. Reich's most appropriate term for the effects of psychological defenses and masonry was "character armor". Behind every form of defense lies the fear of injury. The greater our defenses

and the stronger our armor, the greater our inner sensitivity and fear of injury. Based on the research conducted, many international journals assumed and also concluded that there is a direct link between the psychological factors that trigger the onset of an autoimmune reaction in an individual and the clinical picture of the skin (the outermost and less life-threatening organ of the body). In 2005, research was conducted to assess whether emotional factors play a role in the pathogenesis of lichen planus.

The results and conclusions of the study demonstrated the presence of anxiety and depression in patients with oral lichen planus and the negative impact of the disorder on the patient's disease. quality of life as indicated by impairment in physical, vitality, mental health and social aspects.

This suggests that associated psychological treatment may be important in the follow-up of these patients. Another pilot study was conducted to assess the level of depression, anxiety and stress in patients with oral lichen planus. Psychometric evaluation was performed using the Depression Anxiety Stress Scale (DASS)-42 questionnaire. Psychological assessment using the DASS-42 shows that patients with lichen planus showed a higher frequency of psychiatric comorbidities such as depression, anxiety, and stress compared to the control group. Psychosocial stress can induce autoimmune or inflammatory skin disorders through neuroendocrine and neuroimmune dysregulation. Patients with lichen planus experience stressful events before the onset of the disease; Cutaneous lichen planus can precede or worsen serious life events, especially the illness or death of a loved one. Stress events were found to precede the development of oral lichen planus lesions.

This finding was also confirmed by the authors who investigated psychological disorders in patients with lichen planus of the skin. Similarly, there are many research programs conducted to understand the cause of psoriasis. The National Psoriasis Foundation also states that stress can be a major trigger for psoriasis. "Stress can cause the first flare-up of psoriasis or worsen existing psoriasis." An extensive study was conducted and published in “The Clinical and Aesthetic Journal; Dermatology", which mentioned a clear relationship between the skin, which is the interface between the internal and external environments. It is therefore a mature area of research on the mind-body connection. Psoriasis is associated with many mental disorders, both on the psychotic and neurotic spectrum. Chronic stress reduces the axis hypothalamus-pituitary-adrenal and upregulates sympathetic-adrenal-medullary responses, stimulates pro-inflammatory cytokines Through this pathological and hormonal axis, triggers the activation and release of these factors aggravation, improvement and overall prognosis of the disease, which is homeopathically guided as predisposing, maintaining and causative modalities.

A HOMEOPATHIC VIEW OF AUTOIMMUNE DISORDERS OF THE SKIN

According to aphorism 212 6th edition of the Organon of Medicine, the main feature of all diseases is an altered state of disposition and mind. Additionally, aphorism number 215 says that internal and mental dyscrasias will turn into more serious physical illnesses if not achieved.

Homeopathy believes in individualization and a holistic approach to each sick person. Where we firmly believe in the role of the patient's mental state, which affects the physical side and results in disease. The role of the mental state that the body identifies as stress activates 2 main neuronal pathways: the hypothalamic-pituitary-adrenal axis and the sympathetic nervous system. Identification of external stress by the brain results in the activation of the paraventricular nucleus of the hypothalamus and the locus ceruleus. Corticotropin-releasing factor is secreted from the hypothalamus and transported by the portal circulation to the pituitary where it induces the release of adrenocorticotropic hormone from the anterior pituitary into the general circulation. This results in the secretion of glucocorticoids and catecholamines from the adrenal glands. Cortisol acts as a negative feedback to the hypothalamus and inhibits further release of corticotropin-releasing factor. Locus ceruleus cells activate the sympathetic system, resulting in the secretion of adrenaline and norepinephrine. Homeopathic Pathogenesis - The term pathogenesis used in the title means the inclusion of ODP with regard to localization, perception, modalities and accompanying phenomena. (Homeopathic pathogenesis is related to various aspects, i.e. the clinical picture of the aspect of the disease, the localization of the disease or the speed of progression of the disease state, the connection of the emotional/mental state or the changes taking place at the cellular levels of the sick individual.

Sensibility is the innate ability of all living things to respond to stimuli in the environment and is a fundamental characteristic that distinguishes the living from the non-living. An organism in perfect balance represents health; this regulation is possible only when the cell exhibits normal susceptibility. An intelligent understanding of the rules governing dose selection and repetition is only possible if the physician has a solid knowledge of sensitivity and response to treatment and a thorough familiarity with the laws of dynamics. Dr. Hahnemann observed the phenomenon that not all individuals exposed to unpleasant disease-causing agents become ill. Some are not affected at all, while some are severely affected. Thus, even if there is a common cause, the presentations are still different from each other. This is individualization and homeopathy believes in this concept. This individuality therefore correlates with a person's reactivity to external stimuli. But we can perceive an individual's reaction only through signs and symptoms. Based on the different manifestations of autoimmune skin diseases such as psoriasis and lichen planus, we can say that the reactivity of each individual is different. Cell sensitivity is the basic manifestation of genes and is responsible for all manifestations of the system. The sensitivity can thus be evaluated by quantitative and qualitative aspects. There are different parameters to determine the type of sensitivity.

Quantitative aspects of susceptibility are factors such as age, sex, site of disease, pathology, number of common traits or characteristics, etc. Qualitative aspect is manifested by miasmata. The miasmata here include basic and dominant miasmata and their role in the origin and development of disease. Thus, cases of psoriasis and lichen planus differ with respect to age, sex, heredity, etc. By assessing various parameters such as tissue receptivity, pace, pathology, availability of characteristic symptoms, sensitivity, mind symptoms, nerves, suppression, disease stage, immunity, reactivity and vitality can be rated as high, medium or low. In cases of highly susceptible skin disorders, the individual elicits a range of characteristics and limits the extent of changes at the tissue level to a functional or structurally reversible zone.

In cases of moderate sensitivity, there will be a moderate number of characteristic symptoms and changes at the tissue level may not be limited to the functional zone. Sensitivity is the innate ability of all living things to respond to stimuli in the environment at the level of the mind and nerves. It is judged by the intensity and presence of characteristics at both of these levels. This can also be studied from the patient's tendency to respond (mentally and physically) to the anxiety caused by the disease, and data can be obtained by studying the intensity of the symptoms and understanding the mental state and symptoms and the results of the physical examination.

For autoimmune skin disorders, patients are treated with steroids. They suppress the natural manifestation of the vital force, thus reducing the receptivity and sensitivity of the individual. The overall assessment of the physician's performance is analyzed and categorized according to Kent's 12 observations.

1. Prolonged and final decline of the patient.

2. Long deterioration, but eventually slow improvement

3. Deterioration is rapid, short, strong with rapid improvement of the patient

4. Without deterioration of the patient's condition

5. First comes improvement and then deterioration.

6. Relief from symptoms too short.

7. Full-time symptom relief, but no particular relief for the patient

8. Some patients prove every drug they receive

9. The influence of medicine on evidence

10. New symptoms appearing after administration of the drug

11. When old symptoms reappear

12. The symptom took a wrong turn Taking cases requires a great deal of experience and training that cannot be obtained by reading books.

A surefire way to learn the art of case management is to become actively involved in the patient's treatment process with or without the guidance of a consultant. In the event that the inner state of the person before us is gradually revealed. It's just trying to understand the person in front of you, and one can use whatever technique suits one's temperament. Successful case management will provide the physician with all the evidence necessary for proper diagnosis, treatment, and prognosis. In ascertaining the condition of a chronic disease, the particular circumstances of the patient should be well considered and examined with regard to his regular occupation, his habitual ways of life and diet, and his home situation, to ascertain what tends to induce/maintain the disease. . This overall analysis is then disseminated using our homeopathic knowledge and the results blossom in the form of patient healing. Aphorism 83 – 102, 6th edition of the Organon of Medicine.

CONCLUSION:

Autoimmune disorders are of critical importance in the medical field because the etiopathology of these diseases has multifactorial aspects and most of them are idiopathic in nature. Autoimmune disease occurs when the immune system attacks its own molecules due to impaired immunological tolerance to autoreactive immune cells. Many autoimmune disorders are strongly associated with genetic, infectious and/or environmental predisposing factors.

Psoriasis and lichen planus were studied in this study of autoimmune skin disorders. Psoriasis is one of the most common dermatological diseases characterized by erythematous, sharply demarcated papules and rounded plaques covered with silvery mica scales. Its prevalence in different populations ranges from 0.1% to 11.8%. Lichen planus is an inflammatory skin disease with characteristic clinical findings including pruritic, polygonal, flat purple papules and characteristic histopathological findings that affects 0.5 to 1% of the population.

Autoimmune diseases are usually treated with immunosuppressants, which reduce the immune response. Homeopathy treats the whole person. This means that homeopathic treatment focuses on individual and pathological conditions. This includes a detailed history of the patient, family and causative factors. Any underlying predisposition/susceptibility is considered. The disease is studied at the pathogen level as well as factors such as any psychological/physical stressors that might predispose the individual to the disease.

Constitutional remedies work wonders in such cases. In this study, 30 cases were taken according to the inclusion and exclusion criteria. Data were collected as required by the study and follow-ups were analyzed using the Response to Correction Form at appropriate intervals. The data collected was of a qualitative type. All data was collected, compiled and evaluated in detail. Based on the conclusions, it can be summarized that autoimmune skin disorders were more frequent in men with a bimodal age distribution. Palmar and plaque psoriasis were the most common types of psoriasis, while Lichen planus generalized types topped the list in the lichen planus variety. Several factors come into play in shaping homeopathic pathogenesis to achieve similima. The general ODP of the case helps us to decide the dominant miasma, the characteristics of each case - both at the level of mind and body help us to distinguish nearby medicines, the basic and dominant miasma help us to choose the medicine, because the medicine should have a similar miasmatic background to the patient for holistic treatment .

Sensitivity and sensitivity help the physician in dosing decisions. Analysis of response to remedy and application of Kent's observations enables the physician to know the prognosis of the case and helps in making the necessary interventions at appropriate intervals. With regard to these components of homeopathic pathogenesis, the following data were summarized from the above study of 30 cases - In most cases, a gradual onset and gradual progression was observed, which was a feature of the sycotic miasma. Modifying factors have been identified at the mind-body level. Anger, sadness and anxiety played a significant role as mental modifying factors of these diseases. The most common physical modalities found were aggravation from winter and night. Sycosis was seen as the predominant dominant miasma and syphilis as the predominant fundamental miasma.

Common sycotic manifestations identified at the level of pathology were scaling, fissures, lichenification, thickening of the skin and sticky discharge from lesions, at the level of physical generation there were offensive discharges, staining of discharges and craving for fish and meat, and at the level of the mind there were various shades of anger (long-term violent anger, suppression of anger and anger from contradiction), sadness (long-term disappointment and grief from thinking) and chronic states of anticipatory types of anxiety related to family, children, future. In most cases, medium sensitivity was observed, followed by high sensitivity using the centesimal efficiency scale, with 200 being the most commonly used efficiency.

Most cases with low sensitivity received LM potency Most cases had medium or high sensitivity. In almost all cases, the Kent method of the repertoire approach was used. The constitutional remedies commonly prescribed were Lycopodium, Silicea, and Natrium Muriaticum, while Thuja was in all cases used as an intercurrent remedy.

Kent's 12 observations were used to analyze the correction response in each case. These following components are considered to form the homeopathic pathogenesis in the treatment autoimmune skin disorders - characteristic manifestations, modifying factors, miasma, receptivity, sensitivity, dosage and treatment responses, all were significantly beneficial with an overall improvement of around 75% in most cases. While going through the study, it was found that the concept of homeopathic pathogenesis is the same as the concept of individualization discussed by Dr. by Hahnemann in the Organon of Medicine.

REFERENCES/BIBLIOGRAPHY:

1. KRIDIN K, BIEBER K, SADIK C, SCHON M, WANG G, LOSER K, ET AL. SKIN AUTOIMMUNITY. FRONTIERS IN IMMUNOLOGY. 2021 MARCH; 12.
2. JAMESON JL, KASPER DL, LONGO DL, FAUCI AS, HAUSER SL, LOSCALZO J. HARRISON'S PRINCIPLES OF INTERNAL MEDICINE. 20TH ED. NEW YORK: MC GRAW HILL EDUCATION; 2018: P. 329-338.
3. VALIA RG, VALIA A. IADVL'S TEXTBOOK OF DERMATOLOGY. 3RD ED. MUMBAI: BHALANI PUBLISHING HOUSE; 2008: P. 1021-1069.
4. XHAJA A, SHKODRANI E, FRANGAJ S, KUNESHKA L, VASILI E. AN EPIDEMIOLOGICAL STUDY ON TRIGGER FACTORS AND QUALITY OF LIFE IN PSORIATIC PATIENTS. JOURNAL OF THE ACADEMY OF MEDICAL SCIENCES OF BOSNIA AND HERZEGOVINA. 2014 JUNE; 26(3): P. 168-171.
5. ICD-10 CM CODES > L00 - L99 DISEASES OF SKIN AND SUBCUTANEOUS TISSUE > L40 - L45 PAPULO-SQUAMOUS DISORDERS > PSORIASIS L40. [ONLINE].; 2021. AVAILABLE FROM: ICD10DATA.COM/ICD10CM/CODES/L00-L99/L40/L45/L40.
6. WESTON G, PAYETTE M. UPDATE ON LICHEN PLANUS AND ITS CLINICAL VARIANTS. INTERNATIONAL JOURNAL OF WOMEN'S DERMATOLOGY. 2015 AUGUST; 1(3): P. 140- 149.
7. ICD-10-CM CODES › L00-L99 DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE › L40- L45 PAPULOSQUAMOUS DISORDERS › L43- LICHEN PLANUS › 2022 ICD-10-CM DIAGNOSIS CODE L43. [ONLINE].; 2021. AVAILABLE FROM: HTTPS://WWW.ICD10DATA.COM/ICD10CM/CODES/L00-L99/L40-L45/L43-/L43.
8. RAO KU, RANGANATHAN K, N L, P J. ORAL LICHEN PLANUS: AN UPDATE ON PATHOGENESIS AMD TREATMENT. JOURNAL OF ORAL AND MAXILLO-FACIAL PATHOLOGY. 2011 MAY; 15(2): P. 127-132.
9. STASIO DD, LAURITANO D, GRITTI P, MIGLIOZZI R, MAIO C, MINERVINI G, ET AL. PSYCHIATRIC DISORDERS IN ORAL LICHEN PLANUS: A PRELIMINARY CASE CONTROL STUDY. JOURNAL OF BIOLOGICAL REGULATORS AND HOMOEOSTATIC AGENTS. 2018 JANUARY; 32(2): P. 97-100.
10. GAVIC L, CIGIC L, LUKENDA DB, GRUDEN V, POKUPEC JSG. THE ROLE OF ANXIETY, DEPRESSION, AND PSYCHOLOGICAL STRESS ON THE CLINICAL STATUS OF RECURRENT APHTHOUS STOMATITIS AND ORAL LICHEN PLANUS. JOURNAL OF ORAL PATHOLOGY AND MEDICINE. 2014 JULY; 43(6): P. 410-417.
11. HAHNEMANN S. ORGANON OF MEDICINE. 6TH ED. NEW DELHI: B. JAIN PUBLISHERS (P) LTD.; 2002.
12. ALVES MGO, CARVALHO BFDC, BALDUCCI I, CABRAL LAG, NICODEMO D, ALMEIDA JD. EMOTIONAL ASSESSMENT OF PATIENTS WITH ORAL LICHEN PLANUS. INTERNATIONAL JOURNAL OF DERMATOLOGY. 2015 JANUARY; 54(1): P. 29-32.

13. DAHLK R, DETHLEFSEN T. THE HEALING POWER OF ILLNESS. 1ST ED. USA: SENTINENT PUBLICATIONS; 2016: P. 162-170.

14. FERREIRA BIRC, ABREU JLPDC, REIS JPGD, FIGUEIREDO AMDD. PSORIASIS AND ASSOCIATED PSYCHIATRIC DISORDERS A SYSTEMATIC REVIEW ON ETIOPATHOGENESIS AND CLINICAL CORRELATION. JOURNAL OF CLINICAL AND AESTHETIC DERMATOLOGY. 2016 JUNE; 9(6): P. 36-43.

15. CHAUDHARY S. PSYCHOSOCIAL STRESSORS IN ORAL LICHEN PLANUS. AUSTRALIAN DENTAL JOURNAL. 2004 DECEMBER; 49(4): P. 192-195.

16. KALKUR C, SATTUR AP, GUTTAL KS. ROLE OF DEPRESSION, ANXIETY AND STRESS IN PATIENTS WITH ORAL LICHEN PLANUS: A PILOT STUDY. INDIAN JOURNAL OF DERMATOLOGY. 2015 SEPTEMBER; 60(5): P. 445-449.

17. MANSUR AT, KILIC Z, ATALAY F. PSYCHOLOGICAL EVALUATION OF PATIENTS WITH CUTANEOUS LICHEN PLANUS. DERMATOLOGY AND PSYCHOSOMATICS. 2004; 5(3): P. 132-136.

18. JAFFERANY M. PSYCHODERMATOLOGY: WHEN THE MIND AND SKIN INTERACT. PSYCHIATRIC TIMES. 2011 DECEMBER; 28(12).

19. ROBERTS HA. THE PRINCIPLES AND ART OF CURE BY HOMOEOPATHY NEW DELHI: B JIAN PUBLISHERS PVT. LTD.; 1990: P. 83-90.

20. RAM H, KAMBOJ M. EFFECT OF INDIVIDUALIZED HOMOEOPATHIC MEDICINE IN PSORIASIS: A CASE REPORT. NATIONAL HOMOEO RECORDER. 2019 APRIL; 15(2,3): P. 41- 46.

21. DHAWALE DML. PRINCIPLES & PRACTICE OF HOMOEOPATHY NEW DELHI: B. JAIN PUBLISHERS 9P) LTD.; 2017: P. 319-340, 395-405.

22. BIJU DSG. AUTO IMMUNE DISEASES – A HOMOEOPATHIC PERSPECTIVE AND PROTOCOL. HOMOEOBOOK. 2013 JANUARY.

23. CLOSE S. THE GENIUS OF HOMOEOPATHY NEW DELHI: B. JAIN PUBLISHERS (P) LTD.; 2011: P. 76-86.

24. KAPSE DAR. I.C.R OPERATIONAL MANUAL MUMBAI: DR. M. L. DHAWALE MEMORIAL TRUST; 2015: P. 154.

25. KENT DJT. LECTURES ON HOMOEOPATHIC PHILOSOPHY NEW DELHI: B JAIN PUBLISHERS PVT. LTD.; 1990: P. 224-234.