

A Case Report of Psoriatic Arthritis and Homoeopathic Remedial Approach

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Abstract

With the advent of biologic agents in past few years, treatment armamentarium for psoriasis has largely enhanced. Each biologic has their own pros and cons with confusion over the preferred treatment for individual cases. With increase in research in psoriasis, there has been better upgradation in understanding about the pathogenesis of inflammatory psoriatic pathways with dominant interleukins IL-23/IL-17 axis involvement. Our case report begins with introduction about the psoriatic skin and joint disease with its pathophysiology and available treatments followed by the case description of adult male who was initially misdiagnosed as atopic dermatitis later confirmed to be psoriatic arthritis by rheumatologist. There was resolution of symptom after the homoeopathic treatment was started. This case report emphasizes the role of alternative therapy of medicine homoeopathy in treatment of chronic psoriatic skin and joint disease.

Keywords: homoeopathy, psoriasis, arthritis, atopic dermatitis, alternative therapy

Introduction

Psoriasis is a chronic inflammatory skin disease with strong genetic predisposition and autoimmune pathogenic traits. The global prevalence of Psoriasis is about 2% but lower prevalence in Asian and some African populations and up to 11% in Caucasian and Scandinavian populations. The pathognomic features of psoriasis is sustained inflammation leading to uncontrolled keratinocyte proliferation and differentiation while the histology reveals inflammatory infiltrates containing dermal dendritic cells, macrophages, T cells, and neutrophils [1]. Inflammatory Cytokines such as TNF- α , IL-17 or IL-23 are implicated in the pathophysiology of the Psoriasis and can lead to synovitis, enthesitis, axial inflammation, and altered bone homeostasis as observed in psoriatic arthritis hence remains the cornerstone target for its treatment [2, 3, 4]. Mainstay therapy for psoriasis includes 11 US FDA approved biologic options till date with many in the pipeline. These includes biologic agents along with their year of US FDA approval: Tumor necrosis factor alpha inhibitors such as Adalimumab [2002], Entanercept [2004], Infliximab [2006], Certolizumab pegol [2008], Interleukin-17 [IL-17] inhibitors such as secukinumab [2015], brodalumab [2017], Ixekizumab [2017], Interleukin-23 [IL-23] inhibitors Guselkumab [2017], Tildrakizumab [2018], Risankizumab [2019], IL12/23 inhibitor such as Ustekinumab [2009] but individual response to treatment may vary across different population ethnicity. [2]

Moreover, the symptom of psoriatic arthritis are often misdiagnosed with atopic dermatitis. Diagnostic criteria of psoriatic arthritis is based on most commonly used CIASification for Psoriatic ARthritis (CASPAR) Criteria [5, 6].

Patient and Observation

Patient information

A 33-year-old adult male medical professional resident of Palghar, hailing from state Uttar Pradesh, India reported to dermatology OPD at tertiary care referral hospital on 1st of January 2021 with chief complaints of maculo-papular and hyperkeratotic skin eruptions over both hands with involvement of fingers [extremities] affecting mainly the knuckles [Figure 1.] and ulnar aspect of both hands since 30th of December 2021. The symptom was associated with scaling of skin over elbows of both hands. All these skin lesions were itchy in nature exacerbated during evening hours and consumption of fatty meal. Mild itching over dorsum aspect of toes and phalanges involving both lower limbs. Patient observed and also reported about the flexion deformity of left little finger at distal interphalangeal joint [Figure 2.] since 01st January 2021. The other fingers had no deformity and were absolutely normal in structure and anatomy. There was no history of trauma to both hands and fingers [extremities]. Neither there were any skin eruptions/lesions in finger web spaces thus ruling out the possibility of scabies infestation. Patient has history of

seasonal bronchial asthma and allergic rhinitis since 15 years of age. Patient had one episode of bronchial asthma on October 2020 managed by Homoeopathic treatment. Patient also history of seborrheic dermatitis of scalp almost 10 years back. There was no history of wearing gloves in past 6 months nor there any past history of allergy to latex hand gloves. No history of any insect bite [except mosquito bites] or contact with vegetation. No history of any drug allergy or substance abuse. Patient

attributed the skin eruptions to use of poor quality sanitizers. Patient has already self-medicated himself with Permethrin lotion for local application thinking of scabies parasitic infestations. Patient often takes tablet cetirizine or levocetirizine 5 mg for his allergic rhinitis symptom or homeopathic remedy whenever there is bronchospasm episode usually exacerbated due to seasonal change.



Figure 1. Maculopapular rash on Dorsum left hand [Before Treatment]



Figure 2. Left little finger flexion deformity at distal interphalangeal joint [Before Treatment]

Clinical findings & Diagnostic assessment

After careful assessment by dermatologists on 1st January 2021, patient was diagnosed with atopic dermatitis. No biopsy of skin lesion was performed. However, there was concern about the left little finger flexion deformity at distal interphalangeal joint [DIP] joints for which patient was referred to orthopedics. Orthopedic doctor advised for complete blood investigations [Table 1.] and roentgenogram [X ray] for left little finger- anteroposterior and lateral view. Blood investigation done on 6th February 2021 revealed low Vitamin D3 and Vitamin B12 levels with other parameters not clinical significant [Table 1.]. Chest X ray of left little finger did not reveal any bony erosions or fracture, so was referred to rheumatologist for further evaluation of left little finger flexion deformity.

Rheumatologist diagnosed it as psoriatic arthritis, a manifestation of psoriasis that may affect wrist, metacarpophalangeal [MCP] joint, middle interphalangeal [MIP] joint, mainly affecting distal interphalangeal joint [DIP] to start with. Even skin prick test done by the allergy specialist revealed strong sensitivity to house dust mites [Table 1.]. According to the Classification Criteria for Psoriatic Arthritis (CASPAR) [5, 6], the patient had history of seborrheic psoriasis of scalp in the past [score 1], has current active psoriatic lesion at the elbow joint [score 2], dactylitis present [score 1] and was rheumatoid factor was negative [score 1] assigning total score of 5 thus confirming established inflammatory articular disease of psoriatic arthritis. However, there was no family history of psoriasis, no Juxta-articular new-bone formation on X-ray and no sign of nail dystrophy.

Parameters	Value	Parameters	Value
Complete blood count [CBC]		Differential Leucocyte Count [%] (absolute leucocyte count in cells/mm3)	
Hemoglobin	15.4 gm/dl	Neutrophil	45.4 [4494.6]
RBC Count	5.27 million per mm3	*Lymphocytes	40.6[4019.4]

Total WBC Count	9900 cells per mm ³	*Eosinophils	7.3 [722.7]
Platelet count	291000	Monocytes	6.7 [663.3]
Morphology and findings		Basophils	0.0 [0]
RBCs	Normocytic Normochromic	Lipid Profile	
Platelets	Adequate on smear	*Total cholesterol	201 mg/dl
WBC	Eosinophilia	*Triglycerides	170 mg/dl
Hemoparasites	Nil	HDL Cholesterol	45 mg/dl
Urine routine and microscopy	Normal		
Blood glucose levels		*Non HDL Cholesterol	156 mg/dl
Fasting blood glucose	86 mg/dl	*LDL Cholesterol	122 mg/dl
HbA1c, Glycated hemoglobin	5.5%	*VLDL Cholesterol [chol/HDL ratio]	34.0 mg/dl
Estimated average glucose [eAG]	111 mg/dl		
Inflammatory markers			
Erythrocyte sedimentation rate [ESR]	30 mm at the end of 1 hour	C Reactive Protein [CRP]	5.0 mg/L
		RA Factor	Non-reactive [0.5 IU/ml]
Renal Function Tests [RFT]		Liver Function Tests [LFT]	
Serum Urea level	27 mg/dl	Total Bilirubin	0.40 mg/dl
Blood Urea Nitrogen	12.6 mg/dl	Bilirubin-Direct	0.20 mg/dl
Serum Creatinine	0.60 mg/dl	Bilirubin-Indirect	0.20 mg/dl
Serum Uric acid	5.80 mg/dl	*Alkaline phosphatase	129.0 IU/L
eGFR [CKD-EPI]	131.8 ml/min/1.73 m ²	AST/SGOT	24.0 IU/L
Serum Iron studies		ALT/SGPT	23.0 IU/L
Serum IRON	119 mcg/dl	Protein, Total	8.10 g/dl
TIBC	417 mcg/dl	Albumin	4.60 g/dl
% of saturation	28.54%	Globulin	3.50 g/dl
UIBC	298 mcg/dl	A/G ratio	1.31
Thyroid profile		Vitamin levels	
Total T3	1.43 ng/ml	*25-OH Vitamin D [Total]	13.9 ng/ml
Thyroxine [T4, Total]	8.11 mcg/dl	*Vitamin B12	181 pg/ml
TSH	3.05		
Skin Prick Test [SPT]			
*Strong sensitization to House dust mites			
*Sensitization to Pollens, Dog, Pigeon Feather and Latex			
*Sensitization to food allergen such as Toor dal, Massor dal, Moong dal, Urad dal			
Note: asterisk sign [*] indicates significant deviation from normal reference range			

Table 1. Laboratory investigations results.

Therapeutic Intervention

On 1st January 2021, Dermatologist advised Tablet Levocetizine 5 mg twice daily, Venusia derm cream and Mometasone steroidal cream for local application over affected sites on skin for 7 days as treatment for atopic dermatitis. Patient reported on 3rd of February 2021 to dermatologist for non-resolving skin lesions with hyperpigmentation with hyperkeratosis over the knuckles with fissuring. Erythema and excoriations present all over extensors of both forearms and hands. Bilateral elbow scaling was present. The patient was advised for Injection Triamcinolone 40 mg/ml stat intramuscular dose, Tablet Fluconazole 400 mg stat, Tab Levocetizine 5 mg twice daily, Tablet Hydroxyzine 25 mg on SOS basis, Cerasoft cream thrice daily with Fluticasosne E cream for local application for 2 weeks, Fusidic cream local application over the fissured area on knuckles. Patient was started on intramuscular doses of injection methylcobalamin and Vitamin D3 alternate days for 5 days followed by two doses weekly for month along

with oral supplementation with Calcium and Vitamin D3 tablets. Patient preferred taking homoeopathic consultation for psoriatic arthritis in view of non-resolving skin lesions. On the basis of symptom similarity, the patient was treated with homoeopathic medicine named Psorinum 1m, 4 pills stat dose prescribed along with Cosmos 30, 4 pills three times a day. Psorinum 1m was repeated as and when required.

Follow up & Outcomes

After treatment patient observed resolving skin lesions in two-three days. There was drastic healing of skin lesions over both hands and fingers [Figure 3.] with reduction in mild swelling at distal interphalangeal joints. Itching also resolved. Scaly skin lesions over elbows disappeared. Still there is persistence of left little finger deformity with mild hyperkeratotic healing psoriatic skin lesion at knuckles with hypopigmented spots over skin [Figure 4.]. Patients reports better results than before and was satisfied by the treatment.



Figure 3. Resolving skin eruptions on Dorsum left hand [After Treatment]



Figure 4. Persistent Left little finger flexion deformity at distal interphalangeal joint [After Treatment]

Discussion

It is difficult for clinicians to diagnose psoriatic arthritis in first instance and requires expertise in the field of autoimmune disorders. None of the treatment allopathic remedy available guarantee complete recovery. Homeopathic remedies work excellent in cases of chronic diseases and also autoimmune disorders such as asthma, vitiligo, chronic skin diseases, and rheumatoid arthritis with lesser adverse effects. With good results/response, alternative system of medicine homeopathy is gaining its importance with better patient reported outcomes. Witt CM *et al* designed prospective multicentre observational questionnaire based study over two years that revealed improvement in symptoms and health-related quality of life (QoL) in patient with psoriasis [7]. A case series published by Mahesh S. *et al* demonstrated that the classical homeopathy can heal psoriasis and its complications beyond skin care providing better wellbeing explained on the basis of the theory of "Levels of Health." [8]. Perez chada LM *et al* study reported other comorbidities when associated with psoriatic arthritis may be associated with poor clinical outcome hence require careful monitoring at early stage [9].

Conclusion

Psoriatic arthritis is often misdiagnosed. Homeopathic remedy works better in cases of psoriatic skin lesion and psoriatic arthritis if diagnosed appropriately by the physicians. However homeopathic physicians should venture clinical trials with their treatment modalities to establish better evidence and recognition in par with allopathic system of medicine.

Consent:

Written informed consent was obtained from the patient for publication of this case report.

Competing interest:

The authors declare no competing interest.

Reporting guidelines:

CARE guidelines are followed to report our Case Report.

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