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Management of lichen planus and urinary incontinence with homoeopathy: A case report

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Abstract
Background: Lichen planus(LP) is a papulosquamous skin disorder affecting stratified squamous epithelia of skin and mucous membrane. The classical skin changes are pruritic, purple, polygonal, flat-topped (planar) papules crossed by fine white lines, while erosions are seen on the mucous membranes.
Case summary: A female patient aged 40 years came to NIH OPD, with pruritic reddish patches on extensor aspect of both legs and inability to hold urine during urge. The case was diagnosed as lichen planus and urge urinary incontinence. After thorough case taking and Repertorisation *Lachesis mutis* was prescribed in centesimal and LM scale. The itching and redness disappeared. Using ICIQ UI SF questionnaire, the severity of urinary incontinence patient was assessed and patient was able to hold urine after treatment.
Conclusion: The case verifies homoeopathic principles. Only a single medicine was administered throughout the course of treatment. The role of homoeopathy in autoimmune conditions such as lichen planus and surgical diseases such as urinary incontinence stands verified.

Keywords: case report, homoeopathy, *Lachesis mutis*, lichen planus, MONARCH, urinary incontinence

Introduction

Lichen planus(LP) is a papulosquamous skin disorder affecting stratified squamous epithelia of skin and mucous membrane. Histologically, it is characterized by a lichenoid inflammatory infiltrate and vascular degeneration of the basal layer of the epidermis [1]. Though the exact aetiology of lichen planus is unknown, it is linked to autoimmune diseases [2]. Lichen planus is classified as: Cutaneous, mucosal and appendageal LP. The classical skin changes are pruritic, purple, polygonal, flat-topped (planar) papules crossed by fine white lines, while erosions are seen on the mucous membranes. It predominantly affects middle aged adults and there is no gender pre disposition. Diagnosis is done clinically, and histological analysis is done to rule out other pathologies. Band-like lymphocytic infiltrate and interface dermatitis are the histological findings—irrespective of skin location or disease subtype. Although the disease is often self-limiting, the intractable pruritus and painful mucosal erosions result in significant morbidity. The current first-line treatment are topical and/or systemic corticosteroids. In addition, immunosuppressants may be used as corticosteroid-sparing agents [1]. Urinary incontinence is the involuntary loss of urine [3]. It is highly prevalent in women among all age groups. Two types of urinary incontinence include: stress and urge incontinence. Patients having features of both types are said to have mixed urinary incontinence. Potential causes of urinary incontinence include detrusor muscle or pelvic floor muscle dysfunction, dysfunction of the neural controls of storage and voiding[4]. It affects the quality of life. The initial assessment should rule out causes such as pelvic organ prolapse, urinary tract infection and neurogenic bladder [3]. First line management includes pelvic floor exercise, bladder training and lifestyle management [5]. In refractory urinary incontinences, the conservative management includes treatment with onabotulinumtoxin A. But studies showed there is high risk of urinary tract infection [6]. The International Consultation on Incontinence Questionnaire-Urinary Incontinence Short Form (ICIQ-UI SF) is a questionnaire for evaluating the frequency, severity and impact on quality of life (QoL) of urinary incontinence in men and women. It is used to screen for incontinence, to obtain a summary of the level, impact and perceived cause of symptoms of incontinence and to facilitate patient-clinician discussions [7]. Homoeopathy offers an individualised approach to every case of disease. It treats the patient as a whole and stands unique in the holistic

approach of treatment [8].

Case report

PRESENTING COMPLAINT- A female patient aged 40 years came to NIH OPD on 14.6.2024, with complaint of reddish patches on extensor aspect of both legs with itching for 2 months. Itching was aggravated in sleep and during heat. She also complained of inability to hold urine during urge for 1 year.

History of presenting complaint

The complaint started 1 year back as reddish small papules on left knee with severe itching. There was discharge of blood on scratching and desquamation of skin. The papules gradually turned into reddish brown patches with severe itching and it extended to both legs. Urinary incontinence started about 1 year back as difficulty in controlling urine during urge. Now urine leaks before she reaches toilet, wetting cloths.

Past history

No significant past history

Family history

No significant family history

Personal history

The patient was born and brought up in Kaliachak. She lived in a pukka house. She had no addictions. The patient was a homemaker and completed her studies till class 10. She was married at 19 years of age. She had 2 children with no history of abortion. All children were delivered through normal delivery. Obstetric and sexual history reveals nothing significant.

Physical generals-

She had loss of appetite with thirst. She complained of sour taste in mouth, while eating. She had desire for spicy food. She had frequent urge to micturate and could not hold urine during urge. Urine was offensive. Stool was hard and passed once in 3-4 days. Patient could sleep for less than 2 hours at night. Menses was absent for past 6 months.

Particulars

Tongue had purple discolouration on edges

Physical examination-

No significant findings were obtained during physical examination.

Local examination

Red flat patches on both legs from knees to foot. No discharge. No odour. No lymph nodal enlargements. On palpation, pitting oedema was present on both legs.

Provisional diagnosis

1. Cutaneous lichen planus
2. Urge urinary incontinence

Totality of symptoms

1. Red patches on legs with itching and swelling
2. Itching aggravated by heat and sleep
3. Urge incontinence
4. Offensive urine
5. Appetite loss
6. Thirstless
7. Desire spicy food
8. Stool constipated and hard stool
9. Tongue purple edges absence of menses

Repertorial totality
Skin, discolouration, red
Skin, itching
Skin, itching, sleep during,
Skin, itching, warm, on becoming
Urine, odor, offensive
Stomach, Appetite, diminished
Stomach, thirstless
Stomach, desire, pungent things
Rectum, constipation
Stool, hard
Mouth, discolouration, tongue, purple

Repertorial analysis

Remedy Name	Sulph	Puls	Lyc	Merc	Sep	Apis	Op	Phos	Ars	Nat-m	Caust	Lach	Nux-v
Totality	22	19	19	17	17	17	16	16	15	15	14	14	14
Symptom Covered	10	9	8	8	8	6	8	8	8	8	7	7	7
[KT] [Skin]Discoloration:Red:	2	2	2	3	1	3	2	2		2		1	2
[KT] [Skin]Itching:	3	3	3	3	3	3	2	2	3	3	3	2	2
[KT] [Skin]Itching:Sleep:During:	1							2	1		1		
[KT] [Skin]Itching:Warm:On becoming:	3	2	2	3									
[KT] [Bladder]Urination:Involuntary:Desire is resisted,if:	2	2		1	1					1			
[KT] [Urine]Odour:Offensive:	3	2	2	2	3	3	1	2	2	1	2	1	2
[KT] [Stomach]Appetite:Diminished:	1	1	2	1	1		1	1	1	1	2	2	1
[KT] [Stomach]Thirstless:	1	3	2		2	3	2	1	2	1	1		1
[KT] [Stomach]Desires:Pungent things:									1				
[KT] [Rectum]Constipation (see inactivity):	3	2	3	2	3	3	3	3	3	3	3	3	3
[KT] [Stool]Hard:	3	2	3	2	3	2	3	3	2	3	2	3	3
[KT] [Mouth]Discoloration:Tongue:Purple:							2					2	

Management

General management

1. Bladder training and pelvic exercise
2. Avoid foods that exacerbate lichen planus
3. Avoid topical application
4. Avoid scratching

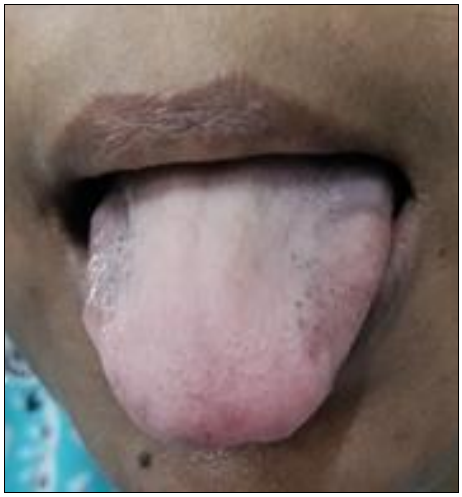
Therapeutic intervention

Lachesis mutis 30/ 3 doses in saccharum lactis. Each dose to be taken in morning on empty stomach for 3 days.

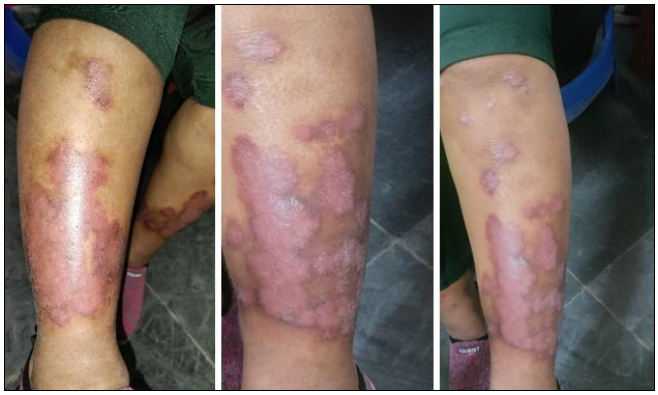
Follow up

Date	Follow up	Medicine prescribed
14.6.2024	Reddish patches on skin with itching. Thermally hot. Menses absent for 6 months. Premenopausal age. Diminished appetite and thirst. Unable to hold urine and offensive odor of urine. Tongue has purple discolouration on edges.	*Lachesis mutis* 30/ 3 doses in saccharum lactis. Each dose to be taken in morning on empty stomach for 3 days.
11.7.24	The patient was symptomatically better. Itching reduced in intensity but reddish brown discolouration spread extensively. Menses appeared once every month. Blood was bright red in colour. Stool was passed regularly.	*Lachesis mutis* 200/ 2 drops in 20ml distilled water. 10ml for 2 days in morning on empty stomach.
23.8.24	Redness reduced. Itching relieved on both legs. Stool passed once in 2-3 days interval. Unable to hold urine	placebo
22.11.2024	Itching recurred. Redness reduced on left leg. Bleeding spots with red patches present on right leg. Stool passed once in 2 days. Unable to hold urine. Sleep reduced.	*Lachesis mutis* 0/1, 16 doses in 100ml distilled water. 5ml of which to be taken every alternate day morning on empty stomach
13.1.24	Itching reduced in intensity. Redness of both limbs persists. Able to hold urine during urge. Sleep reduced. Stool passed once in 2 days.	*Lachesis mutis* 0/2, 16 doses in 100ml distilled water. 5ml of which to be taken every alternate day morning on empty stomach
13. 6. 24	Patient came after 5 months. No itching and redness. Sound sleep. Stool and urine passed without difficulty.	placebo
12.7.25	Hyperpigmentation on legs reduced. No itching. Able to hold urine.	placebo

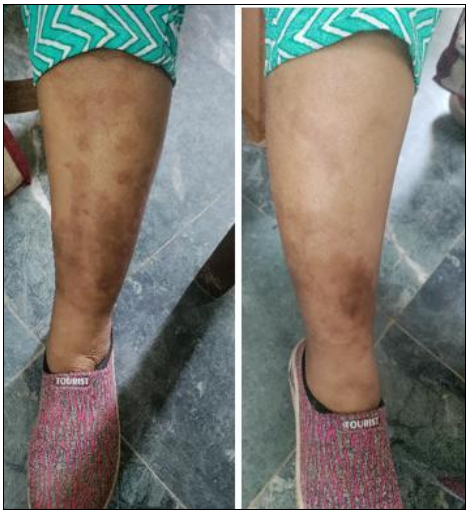
Appearance of tongue



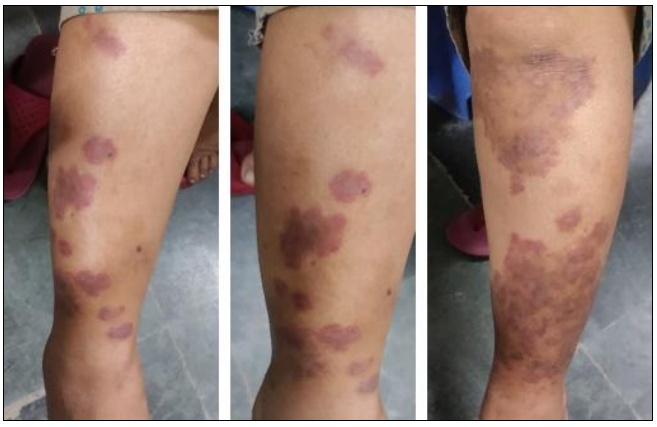
During treatment

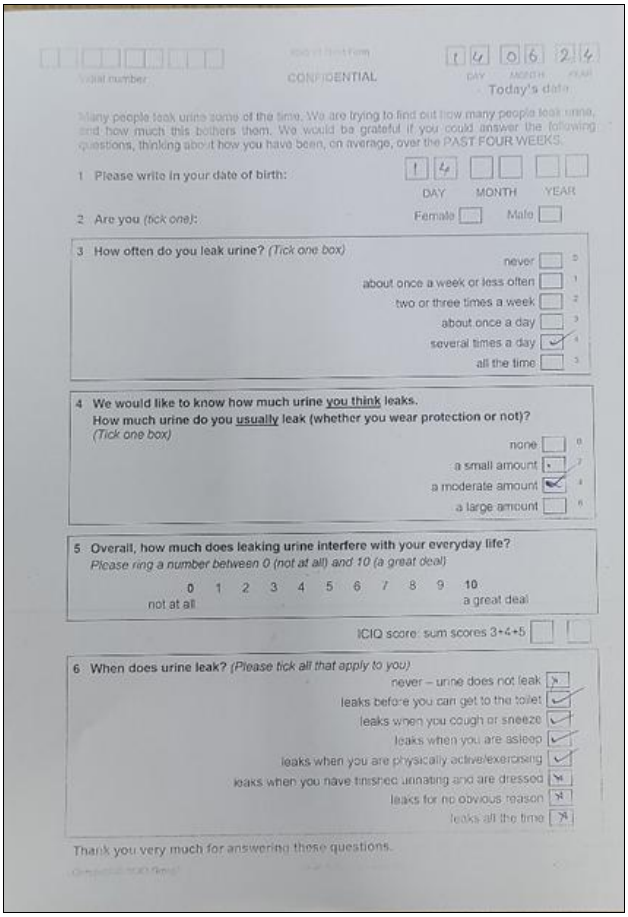


After treatment



Before treatment





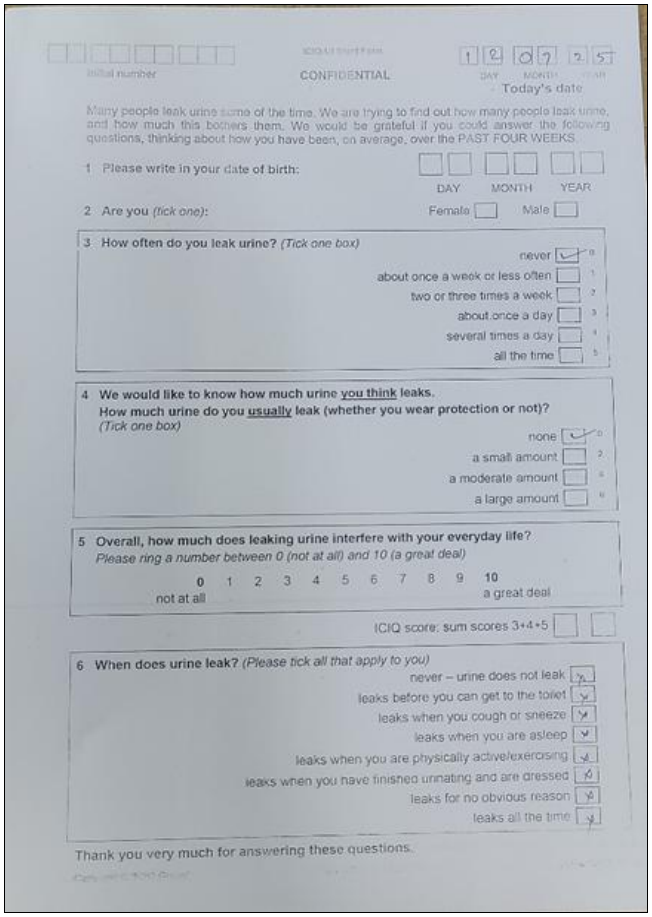


Table 2: Modified naranjo criteria for homoeopathy

Sl no	Question	Yes	No	Not sure or N/A
1.	Was there an improvement in the main symptoms or condition for which the homoeopathic medicine was prescribed?	+2		
2.	Did the clinical improvement occur within a time frame relative to the drug?	+1		
3.	Was there an initial aggravation of symptoms?	+1		
4.	Did the effect encompass more than the main symptom or condition (i.e, were other symptoms ultimately improved or changed)?	+1		
5.	Did overall well-being improve? (suggest using validated scale)	+1		
6.a.	Direction of cure: did some symptoms improve in the opposite order of development of symptoms of the disease?	+1		
6.b.	Direction of cure: did atleast two of the following aspects apply to the order of improvement of symptoms: -from organs of more important to those of less importance? -from deeper to more superficial aspects of the individual? -from the top downwards?	+1		
7.	Did "old symptoms" (defined as non-seasonal and non-cyclical symptoms that were previously thought to have resolved) reappear temporarily during the course of improvement?		0	
8.	Are there alternate causes (other than the medicine) that - with a high probability - could have caused the improvement? (consider known course of disease, other forms of treatment, and other clinically relevant intervention))		+1	
9.	Was the health improvement confirmed by any objective evidence? (eg., laborotary test, clinical observation etc.)	+2		
10.	Did repeat dosing, if conducted create similar clinical improvement?	+1		
	Total score	12		

Discussion

Lichen planus are chronic inflammatory disorders affecting skin and mucous membrane. Although the prevalence of lichen planus is less compared to Western countries, 0.38% of dermatological cases in India accounts to lichen planus [9, 10]. Though cutaneous lichen planus is considered to be self-limiting, but studies suggest that it affects quality of life significantly and is a major disease burden to the society [11, 12]. Also, it is followed by long standing hyperpigmentation [12]. Urinary incontinence in females is associated with fear, shame and stigma. Though numerous conservative managements are available including surgical procedures, none have a complete success rate and many are accompanied by side effects [14, 15]. Studies illustrating the efficacy of homoeopathic medicine in treatment of lichen planus and urinary incontinence are scarce [16, 17]. In the above case, the patient had gradual onset of papular eruptions on extensor aspect of both legs with severe itching. She also complained of urge urinary incontinence. After case taking, analysis and evaluation, Repertorisation with Kent's repertory and with final reference with materia medica, *Lachesis mutis 30* was prescribed. The patient was

symptomatically better with appearance of menses, which was absent for 6 months. Skin redness reduced in intensity turned brownish red. Itching reduced in intensity. But urinary incontinence persisted. *Lachesis mutis 200* was prescribed. After 3 months of treatment, the patient was better though not completely relieved. She discontinued treatment for 3 months and the rash reappeared with scaling and bleeding on scratching. Urinary incontinence was also persisting, despite modifying lifestyle and doing pelvic exercises. *Lachesis mutis* was prescribed in LM potency. After two visits, patient was symptomatically better. Patient came after 6 months with no relapse of skin complaint. The hyperpigmentation of skin reduced and she was able to hold urine during urge. Using the International Consultation on Incontinence Questionnaire(ICIQ UI SF) severity of urinary incontinence was assessed retrospectively. Before treatment the score was 15 and after treatment the score was zero. MONARCH score of 11/13 indicates that the cure occurred due to homoeopathic intervention. A simple single medicine was administered throughout. This highlights the importance of minimum dose and mono-pharmacy as said by Hahnemann [8].

Conclusion

The case illustrates the benefits of homoeopathy in cases such as lichen planus where exact pathology still remains unknown. Surgical conditions such as urinary incontinence are also managed holistically with homoeopathic medicine. A single individualised medicine was only administered throughout the treatment. This verifies that the case was cured based on homoeopathic principles. Further research on the same is suggested.

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Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent.

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Nil.

Conflicts of Interest

There are no conflicts of interest.

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