International Journal of Homoeopathic Sciences

E-ISSN: 2616-4493
P-ISSN: 2616-4485
www.homoeopathicjournal.com
IJHS 2023; 7(1): 501-503
Received: 12-01-2023
Accepted: 22-02-2023

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Management of acute abdominal conditions with homoeopathic medicine: A case of acute appendicitis treated with homoeopathic remedy Bryonia

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DOI: https://doi.org/10.33545/26164485.2023.v7.i1h.797

Abstract
Appendix inflammation is referred to as appendicitis. Right lower abdomen pain, nausea, vomiting, and fever are frequent symptoms. The most frequent unexpected abdominal event, which can happen at any age, is acute appendicitis. If acute appendicitis is suspected, the patient should always be thoroughly examined and the diagnosis not delayed. Later diagnosis can lead to various complications and serious, life-threatening consequences. A case of acute appendicitis in a woman of 60 years old treated with Homoeopathic remedy Bryonia within hours. The patient who had a sudden attack of pain in the abdomen at night was diagnosed as appendicitis and was advised for emergency surgery, came with USG report of abdomen suggestive of acute appendicitis to the Hospital OPD of A.M. Shaikh Homoeopathic College hospital. The patient was stable of her pain, vomiting and fever within few hours in Hospital OPD.

Keywords: Acute appendicitis, homoeopathic remedies, Bryonia

Introduction
Appendix inflammation is referred to as appendicitis. Right lower abdomen pain, nausea, vomiting, and a loss of appetite are typical symptoms. Sepsis and extensive, excruciating abdominal wall inflammation are serious side effects of an appendix rupture. A blockage of the appendix's hollow section results in appendicitis. The most frequent cause of this is a calcified "stone" made of excrement. The obstruction may also be brought on by gallstones, tumors, parasites, inflamed lymphoid tissue from a viral infection, or parasites. This obstruction causes an increase in internal pressure, a reduction in blood supply to the appendix's tissues, and bacterial growth that results in inflammation. Tissue damage and tissue death are brought on by the interaction of inflammation, decreased blood supply to the appendix, and appendix distention. The appendix could rupture, sending bacteria into the abdominal cavity and increasing difficulties if this process is not managed [1].

Causes
A main blockage of the appendix appears to be the cause of acute appendicitis. When this obstruction happens, the appendix swells and fills with mucus. The appendix's lumen and walls are under greater pressure as a result of this ongoing mucus generation. The small veins get occluded and thrombosis as a result of the increased pressure, and the lymphatic flow becomes stagnant. Seldom does spontaneous recovery take place at this point. The appendix becomes ischemic and finally necrotic as the blood artery obstruction worsens. Pus occurs inside and around the appendix as bacteria start to leak out through the decaying walls (suppuration). The end result is appendicular rupture, or a "burst appendix," which causes peritonitis and, in rare instances, sepsis and death.

Signs and symptoms
The symptoms of acute appendicitis include fever, nausea, vomiting, and severe abdominal pain. The adjacent abdominal wall starts to itch as the appendix swells and inflames further. This causes the discomfort to be concentrated in the right bottom quadrant. Children under the age of three might not experience this typical transfer of pain. Signs that can seem sharp can be used to induce this sensation. Appendicitis discomfort may start as a dull ache near the navel. Pain frequently shifts after a few hours to the right lower quadrant, where it becomes confined. Localized observations in the right iliac fossa are among the symptoms.

When lightly pressed, the abdominal wall becomes extremely sensitive (palpation). The rapid release of deep abdominal tension (Blumberg's sign) causes pain. Even deep pressure in the right lower quadrant may not cause soreness if the appendix is retrocecal (located behind the cecum) (silent appendix). This is so that the gas-filled cecum can shield the inflamed appendix from pressure. Similar to this, there is often no abdominal rigidity if the appendix is totally contained within the pelvis. A digital rectal exam in these circumstances reveals soreness in the rectovesical pouch. Dunphy's sign, often known as point tenderness, is brought on by coughing in this region (McBurney's point) [3].

Diagnosis

Appendicitis is primarily diagnosed based on a person's indications and symptoms. Close observation, medical imaging, and laboratory tests might be useful when the diagnosis is ambiguous. A computed tomography scan and an ultrasound are the two most often used imaging procedures (CT scan). The medical history (symptoms) and physical examination serve as the foundation for the diagnosis, which may also be validated, if necessary, by imaging studies and an increase in neutrophil white blood cells. The two types of histories are conventional and unconventional.

The typical symptoms of appendicitis are anorexia, nausea, and vomiting along with broad abdominal pain that lasts for many hours and starts at the umbilicus. The discomfort intensifies as the pain then "localizes" into the right bottom quadrant. In individuals with sites inversus totalis, the discomfort may concentrate in the left lower quadrant. The characteristic constellation of fever, leukocytosis, anorexia, and pain.

Atypical histories don't follow the usual pattern and sometimes start with right lower quadrant pain. An irritated peritoneum (the inner lining of the abdominal wall) may cause increased discomfort while moving or jolting, such as when driving over speed bumps. Unusual histories frequently call for imaging with an ultrasound or CT scan [4]

Treatment:

The most frequent unexpected abdominal event, which can happen at any age, is acute appendicitis. The patient should always undergo a comprehensive examination if acute appendicitis is suspected, and the diagnosis should not be postponed. Delayed diagnosis can result in a variety of issues and grave, potentially fatal consequences.

Acute appendicitis is often treated with surgical removal of the appendix. Laparotomies, an open abdominal incision, or a series of smaller incisions with the use of cameras may be used to accomplish this (laparoscopy). Acute appendicitis is often treated with surgical removal of the appendix [4]

Case Report

A female patient, 60yrs old, came to the hospital OPD in the morning 9.00 am with agonizing pain in the abdomen, fever and h/o vomiting. The history was that she had sudden attack of pain in the abdomen at around 5 am for which she was taken to nearby doctor, after examining the doctor gave her an injection and she was advised to do USG abdomen and get admitted for surgery as clinically she was diagnosed as acute appendicitis as shown in (Fig 1).The case history was taken according to homoeopathic case history format of an acute case.

Patient had mild pain in the abdomen located at right iliac fossa and in the umbilical area, since one week but suddenly got worsened at night, pain was worsened after eating, aggravated by motion, even breathing in. she could only lie quietly with her legs folded on the abdomen for relief of pain as well as vomiting. There was h/o vomiting 3 to 4 time at night and vomiting an hour before. H/o constipation since last 2 months.

On examination patients general condition was not good, bit anxious with puffiness of face there was fever of 102 degrees, on thorough abdominal examination there was tenderness all over the abdomen and maximum tenderness at Burney's point. There were no signs of peritonitis. Mild signs of septicemia was positive.

Considering the peculiar modality of her symptoms i.e. Patient was better of her complaints of pain and vomiting only by lying with her legs folded the following reference of Dr. J T Kent's was remembered under the Drug Bryonia.

The Bryonia patient with these inflammatory conditions will often be seen lying perfectly quiet in bed with the knees drawn up; lying with the limbs flexed in order to relax the abdominal muscles; he does not want to be talked to, does not want to think; every movement is painful, and increases the fever and often causes alternation of chilliness with heat; high fever.

The Bryonia patient, when lying perfectly quiet, is sometimes quite free from nausea, but the instant the head is raised from the pillow the dreadful sickness returns, so that he cannot sit up. He cannot be raised up in bed because of the nausea, and if he persists in rising up, the nausea comes on more than ever, with burning in the stomach [5].

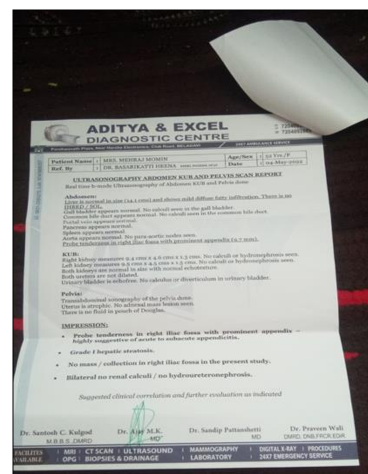
Prescription

Bryonia 30 water dose was started 1 spoonful every 15 minutes.

Follow up

Patient slowly started feeling better and after 4 hours patient was kept in IPD for a day. Next day patient was discharged and advised to continue with the same Bryonia for next 2 days and follow up after 2 days. At the time of discharge patient was afebrile and the abdominal tenderness was reduced considerably.

A post treatment USG abdomen was done showing no evidence of any pathology in right iliac fossa shown in (Fig 2).


ADITYA & EXCEL
DIAGNOSTIC CENTRE

Patient Name : MRS. MEHRAJ MOMIN
Ref. By : DR. BASARIKATTI HEENA

ULTRASONOGRAPHY ABDOMEN KUB AND PELVIS SCAN REPORT

Real time b-mode Ultrasonography of Abdomen KUB and Pelvis done

Abdomen:
Gall bladder appears normal. No calculi seen in the gall bladder.
Common bile duct appears normal. No calculi seen in the common bile duct.
Pancreas appears normal.
Spleen appears normal.
Aorta appears normal. No para-aortic nodes seen.
Probe tenderness in right iliac fossa with prominent appendix.

KUB:
Both kidneys are normal in size with normal echotexture.
Both ureters are not dilated.
Urinary bladder is echofree. No calculus or diverticulum in urinary bladder.

Pelvis:
Transabdominal sonography of the pelvis done.
Uterus is atrophic. No adnexal mass lesion seen.
There is no fluid in pouch of Douglas.

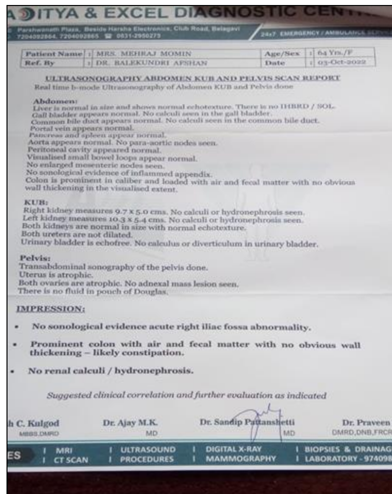
IMPRESSION:
- Probe tenderness in right iliac fossa with prominent appendix – highly suggestive of acute to subacute appendicitis.
- Grade I hepatic steatosis.
- No mass / collection in right iliac fossa in the present study.
- Bilateral no renal calculi / no hydroureteronephrosis.

Suggested clinical correlation and further evaluation as indicated

Dr. Santosh C. Kulgod, M.B.B.S. DMRD — Dr. Ajay M.K., MD — Dr. Sandip Pattanshetti, MD — Dr. Praveen Wali, DMRD, DNB, FRCR, EDiR

FACILITIES AVAILABLE: MRI | CT SCAN | ULTRASOUND | MAMMOGRAPHY | DIGITAL X-RAY | PROCEDURES | OPG | BIOPSIES & DRAINAGE | LABORATORY | 24X7 EMERGENCY SERVICE

Fig 1: Before



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24x7 EMERGENCY / AMBULANCE

Patient Name	: MRS. MEHRAJ MOMIN	Age/Sex	: 64 Yrs./F
Ref. By	: DR. BALEKUNDRI AFSHAN	Date	: 03-Oct-2022

ULTRASONOGRAPHY ABDOMEN KUB AND PELVIS SCAN REPORT

Real time b-mode Ultrasonography of Abdomen KUB and Pelvis done

Abdomen:
Liver is normal in size and shows normal echotexture. There is no IHBRD / SOL.
Gall bladder appears normal. No calculi seen in the gall bladder.
Common bile duct appears normal. No calculi seen in the common bile duct.
Portal vein appears normal.
Pancreas and spleen appear normal.
Aorta appears normal. No para-aortic nodes seen.
Peritoneal cavity appeared normal.
Visualised small bowel loops appear normal.
No enlarged mesenteric nodes seen.
No sonological evidence of inflammed appendix.
Colon is prominent in caliber and loaded with air and fecal matter with no obvious wall thickening in the visualised extent.

KUB:
Right kidney measures 9.7 x 5.0 cms. No calculi or hydronephrosis seen.
Left kidney measures 10.3 x 5.4 cms. No calculi or hydronephrosis seen.
Both kidneys are normal in size with normal echotexture.
Both ureters are not dilated.
Urinary bladder is echofree. No calculus or diverticulum in urinary bladder.

Pelvis:
Transabdominal sonography of the pelvis done.
Uterus is atrophic.
Both ovaries are atrophic. No adnexal mass lesion seen.
There is no fluid in pouch of Douglas.

IMPRESSION:

- **No sonological evidence acute right iliac fossa abnormality.**
- **Prominent colon with air and fecal matter with no obvious wall thickening – likely constipation.**
- **No renal calculi / hydronephrosis.**

Suggested clinical correlation and further evaluation as indicated

h C. Kulgod MBBS,DMRD | Dr. Ajay M.K. MD | Dr. Sandip Pattanshetti MD | Dr. Praveen DMRD,DNB,FRCR

ES | MRI | CT SCAN | ULTRASOUND | PROCEDURES | DIGITAL X-RAY | MAMMOGRAPHY | BIOPSIES & DRAINAGE | LABORATORY - 974098

Fig 2: After

Discussion

An acute inflammation of the vermiform appendix is known as acute appendicitis. Acute abdominal discomfort that begins in the middle of the abdomen and eventually localizes to the right lower quadrant is how it typically manifests. Fever, anorexia, nausea, vomiting, and an increase in the neutrophil count are all related to it. Most diagnoses are made clinically. If further research is needed, a computed tomography scan or ultrasonography may reveal dilated appendix. Appendicitis is a common surgical emergency with a wide range of symptoms, significant overlap with other clinical syndromes, and high morbidity, which rises with delayed diagnosis. In these situations, a careful clinical evaluation is helpful. A lot of cases of acute or sub-acute appendicitis responded better to homoeopathy since it is based on individualization and a holistic approach than to modern medicine and surgeries. This case study, in which the patient presented with agonizing abdominal pain, a fever, and h/o vomiting, is further proof of the usefulness of the homoeopathic drug Bryonia alba in treating acute appendicitis. Considering the peculiar modality of her symptoms and using Dr. J. T. Kent's Bryonia as a reference. Within four hours of receiving the remedy, the patient reported feeling better, eliminating the need for an appendectomy.

Conclusion

Sub-acute appendicitis is a condition where some episodes of acute appendicitis apparently subside spontaneously before they reach the acute stage. A 60 yrs. old female patient presented with agonizing pain in the abdomen, fever and h/o vomiting. Patient had mild pain in the abdomen located at right iliac fossa and in the umbilical area, since one week but suddenly got worsened at night. USG scan report suggested a case of acute to sub-acute appendicitis. On the basis of peculiar modality of her symptoms the patient was treated with Bryonia Alba 30 potency, with repetitions. The patient slowly started feeling better and was discharged the next day. The follow up was with favorable improvement of the generalities along with the underlying pathology compared with reports suggesting evidences. So this case report is suggestive that homoeopathic medicines management in acute abdominal conditions.

Declaration of patient's consent: Taken

Financial support & sponsorship: Nil

Conflicts of interest: None declared

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How to Cite This Article
Balekundri A. Management of acute abdominal conditions with homoeopathic medicine: A case of acute appendicitis treated with homoeopathic remedy Bryonia. International Journal of Homoeopathic Sciences. 2023;7(1):501-503.

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