

Homeopathy in the Treatment of Dermatitis Herpetiformis—A Case Presentation

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Abstract

Keywords

- ▶ Dermatitis herpetiformis
- ▶ Duhring disease
- ▶ Gluten-sensitive enteropathy
- ▶ Immunoglobulin A
- ▶ Bullous dermatosis
- ▶ *Aurum metallicum*
- ▶ *Rhus toxicodendron*

Dermatitis herpetiformis (DH) is a chronic bullous disease thought to be the consequence of an immune reaction in the skin. There are strong associations with gluten-sensitive enteropathy (GSE) and the elimination of gluten from the diet has been shown to improve the disease. Various treatment modalities are available for the suppression of the clinical manifestations of the disease, including the elimination of gluten-containing foods, dapsons, colchicine, azathioprine and prednisolone. A case of histopathologically confirmed DH, successfully treated with homeopathy, is presented. The homeopathic medicine *Aurum metallicum* at MK potency was used.

Introduction

Duhring disease (DH) was first described by Dr. Louis A. Duhring from Philadelphia in 1884.¹ He coined the name dermatitis herpetiformis (DH) in his paper. DH is classified as a bullous dermatosis characterised by grouped bullae, papules, plaques and excoriations, located on the extensor surfaces of the elbows, knees, back and buttocks.²

DH appears to have a slight male predominance and tends to affect northern European populations, while being rare in Asian and African populations,² with onset of disease usually in the second to fourth decades.

It is thought to be the result of an immunologic reaction caused by the deposition of immunoglobulin A (IgA) in the papillary dermis.

Histopathologic features include dermal papillary collections of neutrophils at the papillary tips (microabscesses), as well as fibrin deposition.^{2,3} The gold standard for diagnosis is considered to be granular deposition of IgA at the dermoepidermal junction of clinically uninvolved skin.^{2,3} This was first demonstrated by van der Meer through a series of 12 patients.⁴ DH is associated with gluten-sensitive enteropathy (GSE).³ More recent work suggests that serum levels of IgA anti-epidermal transglutaminase autoantibodies may be useful in distinguishing untreated DH from other pruriginous

eruptions and also may distinguish it from those treated with a gluten-free diet.⁵

Interestingly, patients with DH appear to have a reduced mortality compared with the normal population, and though there is a strong association with celiac disease, bowel lymphoma does not appear to occur with an increased prevalence in the DH population.^{6,7}

The Case

A 57-year-old female patient presented with a 35-year history of pruritus with occasional eruptions. The itching was aggravated by heat, by certain foods (which she could not specify) and in the evenings and nights. She also suffered from poor sleep, beginning from a time when she had to care for a sick relative and dreamt frequently of dead relatives, as well as constipation. She was averse to heat and to narrow places.

Mental symptoms included the following:

- Preference for solitude (she could then do crossword puzzles)
- Intolerance for contradiction
- Fastidiousness for order and time
- Perfectionist
- Conscientiousness (must always keep her word and do things as well as possible)

- Desire to lead others (domineering)
- Dwells on past disagreeable events

No lesions were noted on initial examination.

The patient received the homeopathic medicine *Aurum metallicum* MK potency, weekly.

She returned 10 days later with an increase in intensity of pruritus, as well as papular and vesicular lesions in a grouped pattern, located on the chest, shoulders, lower back and extensor aspects of the limbs (► Fig. 1A, B) with a predisposition for the left upper and lower limbs, as well as the flexor forearms.

At this visit, she also finally admitted to having been treated with dapsone for a presumed diagnosis of DH and was on a gluten-free diet. The reasons for initially withholding this information were not made clear by the patient and undue effort was not made to obtain this information as this might have caused the patient to close up once more.

A biopsy was proposed, the patient was reassured about the benign and beneficial nature of the aggravation (already explained to her at the first visit) and the initial treatment was continued with the addition of Calamine lotion and *Rhus toxicodendron* C30 potency for the itching.

Histopathology was indicative of DH, but direct immunofluorescence could not be done, as the patient could not afford it.

By 8 weeks, the patient was much better. There were few new lesions and the pruritus was very much diminished. Her sleep was much improved, with no more dreams of dead relatives. Examination showed few active lesions and some residual lesions.

At this point the patient hadn't turned up for a follow-up until she was invited by me to come for a follow-up, 15 months

later. At this visit, she stated that she had been free of her complaints for over 1 year, and because of financial constraints, she could no longer come for visits. She also stated that she could also consume the old gluten-containing foods with no adverse effects.

She was further invited for a follow-up visit 14 months later at which she stated her satisfaction with the treatment and the fact that she had had no new lesions in spite of eating an unrestricted diet, including lots of wheat bread (► Fig. 2A, B).

Not only has the patient been in remission for the past 2 years, but she has also been able to return to consuming gluten-containing foods without return of her cutaneous pathology.

One may conclude that homeopathy may be a useful treatment modality for DH and that it may also improve the bowel disorder associated with this disorder. This suggests a path to treatment of this disease, as well as to freeing patients from the restrictions and burdens that a lifetime of gluten avoidance may bring.

More case presentations and clinical trials may be needed to establish the place of homeopathy in the treatment of DH.

Discussion

DH is a chronic bullous disease associated with GSE. The differential diagnosis includes the following:

- Eczema
- Atopic dermatitis
- Urticaria
- Bullous pemphigoid
- Linear IgA dermatosis

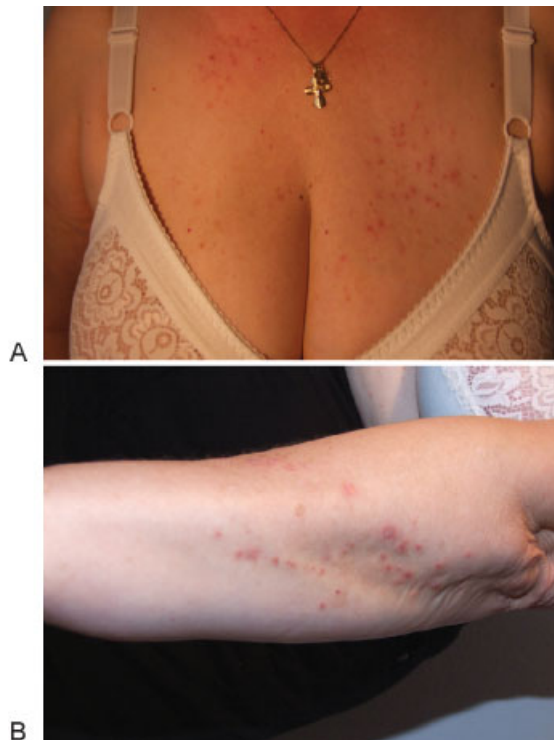


Fig. 1 (A, B) Papular and vesicular eruptions located on the chest and extensor aspects of the upper limbs.

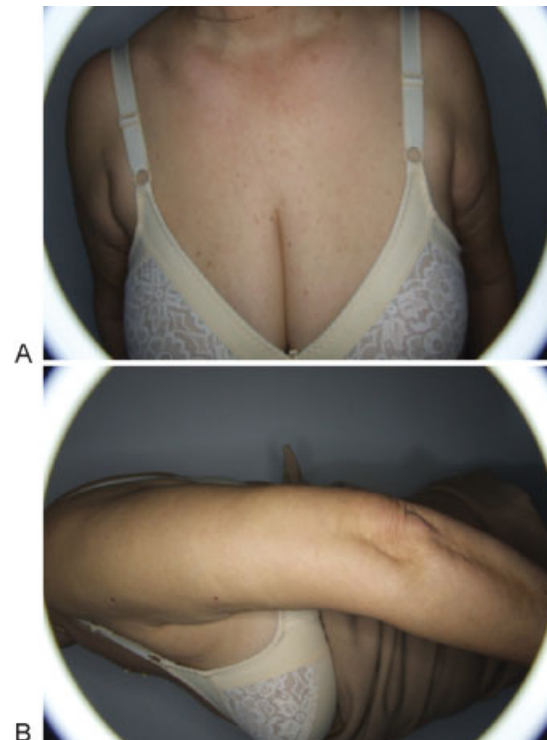


Fig. 2 (A, B) Fifteen months after the remedy, in spite of eating an unrestricted diet including lots of wheat bread, no more lesions.

- Pemphigoid gestationis
- Neurotic excoriation
- Scabies

A history suggestive of GSE (found in many patients with DH), as well as the characteristic histopathology and direct immunofluorescence, will help distinguish DH from the other disorders outlined above.

Management of this disorder includes elimination of gluten-containing foods from the diet, as well as the use of suppressing medication. Some authors suggest the use of dapsone until the gluten-free diet has taken hold.⁸ Dapsone is the first-line medication for DH. Sulfasalazine and sulphamethoxypyridazine, corticosteroids, azathioprine and antihistamines may be used.^{2,3,8}

The case presented was diagnosed without the use of direct immunofluorescence (the gold standard). Histopathology of involved skin can also be characteristic and, together with the clinical picture—including the GSE, sufficed in this case for a proper diagnosis. The patient was not only managed without the use of suppressive medication, but she has been able to return to a gluten-containing diet without harmful effects. This begs the question whether homeopathy may act not only to manage the cutaneous lesions of DH but also as a 'desensitiser' for GSE. This question requires research, as the potential benefits for sufferers of GSE can be enormous. There is also a great potential for savings for the health system as the cost of homeopathic medication was approximately 10 euros.

Homeopathy has been found to be useful in a variety of cutaneous disorders including atopic dermatitis,^{9–11} eczema,¹² lichen striatus,¹³ verruca vulgaris,¹⁴ psoriasis,¹⁵ seborrheic dermatitis,¹⁶ melasma¹⁷ and rosacea,¹⁸ amongst others.

Conclusion

Homeopathy may be useful in the management of the cutaneous and gastrointestinal manifestations associated with DH. The treatment in terms of homeopathic medicines came to under approximately 10 euros, a very small amount compared with the typical costs of medication for this disorder and the costs of finding alternatives to gluten-containing foods.

The patient has since been on diet with gluten-containing foods without adverse effect and this may lead one to the conclusion that homeopathy may be a safe and inexpensive 'desensitiser' for GSE, in much the same way as it appears to work in some hypersensitivity disorders. This is especially important as no other 'desensitiser' for GSE is known, which would allow the patient to return to consuming gluten-containing foods without adverse outcome.

Homeopathic gold (Aurum metallicum) was given in high dilutions. The principle was to find the medication with a personality picture that came closest to her personality picture. This medication then becomes her constitutional medicine and covers other problems also such as the constipation and poor sleep. This requires that patients receive a tailor-made treatment based primarily on their psychological makeup. Aurum metallicum is described as a perfectionist, fastidious, domineering

personality, with little tolerance to contradiction,¹⁹ characteristics that showed themselves in this patient.

In some ways, this constitutional approach is very akin to psychosomatic medicine, which is growing in popularity and acceptance amongst physicians. Many dermatoses are recognised as having a psychological basis, which therefore provides a logical reason for using homeopathy in dermatology. The successful treatment indicates the potential value of this approach in dermatologic and medical treatment in general.

Further research is certainly required and welcome to confirm or refute the findings reported in this paper.

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