HOMOEOPATHIC AGGRAVATION – A MYTH OR A FACT?

(An attempt to explain the same in Dermatology)

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In our day to day practice, many patients narrate their experiences of aggravation of the symptoms after taking homoeopathic medicines. This is observed more so in skin cases. In fact some patients avoid homoeopathic drugs due to **fear of aggravations**.

The homoeopathic aggravation, that is the slight intensification of the symptoms that follows the administration of the remedy is merely the reaction of the organism, that may have been inactive or partially active due to a lowered susceptibility. It is transient and always followed by recovery.

The main reason for this fear of aggravation is **wrong interpretation of aggravation of disease as homoeopathic aggravation** or *vice versa* and waiting unnecessarily or changing medicine too frequently.

The aim of this paper is to highlight the differences of **'disease aggravation'** and **'homoeopathic aggravation'** in specific disease conditions in dermatological practice.

This study is based solely on the proper assessment of the cases actually seen in the skin O.P.D. of the Institute, and is related to:

1. Knowledge about disease diagnosis.
2. Knowledge about natural history of disease.

'Homoeopathic aggravation' which is a curative aggravation should therefore confirm to the natural curing process of the body in a particular disease. It means that cases under homoeopathic treatment should improve in accordance with the natural history of the disease and should leave long lasting immunity.

It is different for every disease diagnosis, and depends upon the nature and extent of the disease. Here, in this paper certain examples of some of the common diseases of the skin and their features differentiating the disease and homoeopathic aggravation are being given:

DISEASE AGGRAVATION	HOMOEOPATHIC AGGRAVATION
1. **Pyoderma** (Bacterial infection of skin) Folliculitis, Boils, Impetigo contagiosa, Carbuncle etc.	
New lesions over other parts of the body; spreading of old lesions; cellulitis appearance of systemic reaction such as fever, eczematous reaction.	Increase in discharge with reduction in erythema; and no further spread with improvement in cellulitis and systemic symptoms i.e. fever, eczematous reaction.
2. **Dermatophytosis** (Fungal infection)	
Peripheral spread with central healing, increase in erythema.	Increase in itching with reduction in erythema and no further peripheral spread.
3. **Molluscum contagiosum** (Viral infection)	
Increase in number and size.	Redness and inflammatory response in and around the lesion.

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DISEASE AGGRAVATION	HOMOEOPATHIC AGGRAVATION
4. **Herpes zoster** (Viral infection)	
Increase in erythema, ulceration and pus in the lesions.	Crusting with disappearance of erythema and pain.
5. **Wart** (Viral infection)	
Increase in number and size.	Pain and inflammatory reaction in and around the wart.
6. **Scabies** (Parasitic infection)	
Papules are converting into pustules with eczematous reaction over other parts of body.	No new lesions: all the lesions and itching subsides.
7. **Vitiligo**	
Increase in depigmented lesions with peripheral spread of old lesions.	Erythematous reaction with no peripheral spread and new lesions; perifollicular repigmentation.
8. **Psoriasis**	
Depends upon the stage of illness.	
I Early cases with classical signs and symptoms	
Increase in erythematosquamous plaques in size and number usually during winter. Pustular lesion over scaly plaques, nail and joint involvement.	Non-itchy lesion starts itching, with central clearing without peripheral spread and decrease in number of lesions in winter.
II Thickened lesions of chronic cases	
Increase in thickening of skin.	Erythematosquamous lesions over thick lichenified lesions.
III Erythroderma	
Increase in erythema; pustular lesion over erythema.	Increase in scaling with subsiding erythema.
IV Psoriatic arthropathy	
Involvement of joints, with or after disappearance of skin lesion.	Inflammatory reaction in deformed joints or subsiding inflammatory reaction of recently involved joints with temporary increase in skin lesions.
9. **Pityriasis rosea**	
Increase in papulosquamous lesions, after appearance of herald patch; this is to complete the self limiting course of 8-10 weeks.	No aggravation observed.
10. **Lichen planus**	
Involvement of mucous membranes, and nails.	Involvement of skin with recovery of mucous membrane and nail lesions.
11. **Lichen simplex chronicus** (Neurodermatitis)	
Increase in thickening and itching.	Inflammatory reaction over the thickened lesion followed by recovery.
12. **Infectious eczematoid dermatitis, Pompholyx, Nummular dermatitis**	
Can be divided in two groups:	
I. Cases not yet treated by immunosuppressive drugs (Steroids, local as well as systemic)	
Increase in eczematous reaction, frequency, duration and intensity of disease, in subsequent episodes.	No aggravation as a rule is observed, erythema and discharge subside with temporary increase in itching.

II. Cases treated with immunosuppressive drugs

	Increase of old, suppressed lesion with no recovery and poor general condition. New lesions over other parts of the body.	Increase of old, suppressed lesion with self-limiting course and reduction in frequency, duration, and intensity of disease in subsequent exacerbations.
13.	**Alopecia Areata** Increase in falling of hair from other parts of body and scalp.	Falling of hair should stop with reappearance of hair over already affected area.

A proper understanding of the **'nature'** of aggravation observed after the administration of an indicated remedy, as to whether it is the **'disease aggravation'** or **'homoeopathic aggravation'** will help a great deal in the judicious management of the case and an early recovery. As the **'homoeopathic aggravation'** does not need any further medication, and the prescriber shall be confident of the recovery phase, whereas the **'disease aggravation'** will tell the prescriber to select alternative indicated medicine for the timely recovery of the ailment.

(Contd. from page 21)

TABLE IV

Pathological findings

Urine examination	**Total**	**No. of cases given**			**No. of cases mitigated**	
	T	M	F	T	M	F
Sugar	24	14	10	13	5	8
Blood Examination	**Before treatment**			**During treatment**		
Fasting	**T**	**M**	**F**	**T**	**M**	**F**
80 — 120 mg%	28	12	16	43	23	20
120 — 180 mg%	56	28	28	38	17	21
180 — 250 mg%	44	18	26	14	3	11
250 mg% and above	18	7	11	5	2	3
Post Prandial						
120 — 180 mg%	43	24	19	43	21	22
180 — 250 mg%	50	19	31	27	12	15
250 — 300 mg%	29	14	15	12	7	5
300 mg% and above	24	8	16	18	5	13

TABLE V

Response to treatment regarding symptoms

	Total	**No. of cases given**		**No. of cases mitigated**		
	T	M	F	T	M	F
Polyuria	32	15	17	24	12	12
Polydypsia	27	13	14	16	7	9
Hunger excessive	18	7	11	8	3	5
Pruritis vulvae	6	—	6	6	—	6
Itching	6	4	2	4	3	1
Cramp in legs	9	3	6	11	4	7
Lassitude	33	18	15	27	13	14
Weakness	39	33	16	29	18	11
Fatigue	37	21	16	25	14	11