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Case Report

An Idiopathic Thrombocytopenic Purpura Patient Treated With Homeopathy: A Case Report

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Abstract

Introduction: Homeopathy can be applied to treat various diseases and conditions such as cancer, allergy, mood disorders, headache and pain. This case showed that homeopathic medicine can be a treatment modality for idiopathic thrombocytopenic purpura (ITP), an autoimmune-mediated hematologic disorder.

Case Presentation: The patient was a 5.5–year-old child with ITP who referred to the homeopathic clinic with extensive petechiae and purpura on her body. Her platelet count was 15000/mcL and her anti-dsDNA and ANA were negative on her first visit. Her disease had first been diagnosed at the age of 2.5 years. She had undergone routine therapy for ITP; however, despite 15 months of corticosteroid therapy and IVIG injections, her platelet count was still low. After treatment with homeopathic remedies, her platelet count increased and signs of ITP disappeared.

Conclusion: Homeopathic remedies can be considered as complementary and alternative medicines for ITP treatment protocols.

Keywords: Homeopathy, Idiopathic Thrombocytopenic Purpura, Thrombopoietin Receptor, Hematologic Diseases

1. Introduction

Homeopathy, based on the ancient 'principle of similar,' is one of the most frequently used forms of complementary and alternative medicine (CAM). In homeopathy, highly-diluted preparations of substances that cause symptoms in healthy individuals are used to stimulate healing reactions in patients who display similar symptoms when ill [1]. Homeopathy is applied to treat various diseases and conditions such as cancer [2-7], allergies [8-16], mood disorders [17-19], cardiovascular diseases (CVD) [20, 21], osteoarthritis [22], hemophilia [23], headache [24, 25], and pain [26, 27].

Idiopathic thrombocytopenic purpura (ITP), one of the most common causes of symptomatic thrombocytopenia in children, is an autoimmune-mediated hematologic disorder in which the destruction of platelets occurs resulting in isolated thrombocytopenia, generally defined as a platelet count of less than 100000/mcL, and normal results on a bone marrow examination (except possibly for increased megakaryocytes) [28-30]. About 60% of all pediatric cases have a prior history of infection, and most of them experience cutaneous bleeding. ITP is usually a self-limiting, childhood bleeding disorder, and spontaneous recovery is reported in about 50% to 70% of patients [28, 30]; however, some cases do require treatment. At present, most treatment protocols concentrate on reducing platelet destruction, and the drugs are usually immunosuppressive [28]. Various treatment modalities applied to treat ITP are corticosteroid therapy [29, 31, 32], IVIg injection [30, 31], splenectomy [29, 31-33], thrombopoietin receptor agonists (TPO-RAs) such as romiplostim, [29, 31, 32, 34], and rituximab [29, 32, 35].

Interestingly in this case, homeopathic medicines were used to treat idiopathic thrombocytopenic purpura after routine treatments of corticosteroid therapy and IVIg injection failed.

2. Case Presentation

The patient was a 5.5-year-old child from Jahrom in the Fars province of Iran who was referred to a homeopathic clinic for extensive petechiae and purpura on the abdomen, back, chest, upper and lower limbs, face, and eyes and sporadic ecchymosis on her upper and lower limbs. She had experienced high fever, vomiting, and petechiae on her back when she was 1 year and ten months old. The signs disappeared spontaneously without treatment, and viral infection was diagnosed. Two months later, she experienced more petechiae sporadically located on her body after fever. Coagulation tests produced normal results. Her parents reported that she experienced extensive bruising caused by very normal strikes when she was 2 years and 3 months old. Again when she was 2.5 years old, she experienced many petechiae and purpura on the abdomen, legs, back, eyes, and other sites after fever. Her complete blood count (CBC) showed a platelet count of 440000/mcL. Idiopathic thrombocytopenic purpura (ITP) was suspected, and a bone marrow biopsy was performed on September 22, 2012. The results showed normal cellular marrow with increased megakaryocyte cells. Some days later, lab tests showed thrombocytopenia (platelet count = 104000/mcL). Based on the bone marrow results and reduced platelet count, she was treated first with injectable and then with oral prednisolone for 6 months with dosages of 10 mg, 10 mg, and 5 mg at morning, evening, and night, respectively. Despite corticosteroid therapy, her platelet count decreased and extensive bruising and ecchymosis

reappeared. The trend of platelet count decrease is shown in Table 1. Due to her very low platelet count (platelet count=10000/mcL), she was admitted to hospital on September 11, 2013 and received RhoGAM in addition to corticosteroid therapy. Her platelet count increased to 17000/mcL after injection. Two months later, she was admitted again for a very low platelet count (platelet count=9000/mcL) and received IVIG 0.5 gr qd; her platelet count was 14000/mcL at discharge time. With the second IVIg injection, the patient experienced severe headache and vomiting and a brain CT scan was performed; results were normal. Despite 15 months pf corticosteroid therapy and IVIG injection, the patient's platelet count remained low. She referred to the homeopathic clinic on February 18, 2014. Extensive petechiae and purpura covering her abdomen, back, chest, upper and lower limbs, face, and eyes and sporadic ecchymosis on her upper and lower limbs were evident in the clinical examination. The patient's platelet count was 15000/mcL and anti-dsDNA and ANA were negative in laboratory tests performed on February 8, 2014. The patient experienced diaphoresis on her head and neck area and thirst during sleep. Her feet were painful in cold weather and she was frequently affected with Common Cold. At her first visit, Sulph 6 c, Phos 6 c, Ham 30, and Arnica 30 were prescribed for the patient, and her parents were advised to continue Ars 30, Ham 30, and Cal 30 after termination of the mentioned drugs. The patient's parents tapered the prednisolone automatically after the first visit, and the hemato-oncologist stopped it on April 2014 because of clinical signs of improvement. At her second visit on June 14, 2014, most of the petechiae and purpura had disappeared; the patient had no nose bleeding, the diaphoresis on her head and neck area was decreased, and her overnight thirst had disappeared. Foot coldness and foot cold sensitivity was also decreased. Ars 30, Ham 30, and Cal 30 were re-prescribed. At her third visit on October 14, 2014, her platelet count had risen to 36000/mcL. Only sporadic petechiae was seen on her abdomen. Other body areas were intact and had no petechiae, purpura, or ecchymosis. A brief halo of the previous ecchymosis was detectable on her limbs. The patient experienced no nasal or gingival bleeding. Sulph 30, Phos 30, Bell 6, Ham 30, and Arnica 30 were prescribed on this visit. On the fourth visit in December 2014, the patient's platelet count had increased to 140000/mcL according to lab tests performed on December 28, 2014. All petechiae and purpura had disappeared. She experienced no new ecchymosis, bleeding, petechiae, or purpura. These results were obtained while she had received no chemical drugs and the prednisolone had been stopped 9 months earlier. During this 11-month period while the patient had only homeopathic drugs, her platelet count increased from 15000/mcL to 140000/mcL and all clinical signs disappeared. In the fourth visit, Sulp 30, Phos 30, and Ham 30 were prescribed. On her last visit on July 6, 2015, no clinical signs were detected. The patient's parents reported that bruising upon falling was within a normal range and disappeared after a few days. Sulp 30, Phos 30, Ham 30, and Arnica 30 were prescribed again. During the final two telephone contacts with the patient's parents in August and October 2015, they reported that the patient was completely healthy and had no dermal or mucosal signs.

3. Discussion

Pediatric ITP is considered to be self-limiting, and spontaneous recovery is reported in the majority of patients [28, 30]; however, in this case, no spontaneous recovery was seen.

Table 1. Trend of platelet count over time

	Time of Lab Test	Plasma Count Per mcL
1	August 22, 2012	440000
2	October 8, 2012	104000
3	October 29, 2012	89000
4	November 26, 2012	75000
5	December 29, 2012	131000
6	January 22, 2013	15000
7	January 26, 2013	133000
8	February 11, 2013	75000
9	May 2, 2013	20000
10	September 11, 2013	10000
11	September 18, 2013	17000
12	October 23, 2013	9000
13	October 30, 2013	14000
14	January 11, 2014	30000
15	February 8, 2014	15000
16	October 14, 2014	36000
17	December 28, 2014	140000

Corticosteroid therapy is recommended as the first-line treatment [28], but the patient did not respond to prednisolone. As mentioned in some studies, a splenectomy may be recommended as another treatment [29, 31-33]; a splenectomy was not recommended as treatment in this case. Moreover, IVIg is prescribed for treatment as mentioned in some studies [30, 31]; this patient did not respond to it. Other studies have recommended the use of thrombopoietin receptor agonists (TPO-RAs) such as romiplostim [29, 31, 32, 34], but rituximab [29, 32, 35] was not recommended for her as the third line of ITP treatment.

It has been reported that homeopathy as a CAM can be applied to treat various diseases and conditions [2-7], however, no study has reported the use of homeopathy in treating ITP. Only one study has reported the role of homeopathic medicines in a patient with hemophilia (23).

4. Conclusion

Homeopathic remedies can be considered as complementary and alternative medicines for ITP treatment protocols because of their mechanisms of action. As noted, homeopathic remedies can be suggested as cost-effective secondary or tertiary treatment modalities.

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Authors' Contributions

BG visited and followed-up with the patient. BG recorded patient data and prepared the case presentation. MSI reviewed the literature and prepared the introduction, discussion, and conclusion sections of this paper. BG and MSI performed the final review of this manuscript and approved it for publication.

Conflict of Interest

None declared.

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