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University
of Brasov

HABILITATION THESIS

TITLE: COMPLEMENTARY AND ALTERNATIVE MEDICINE (INTEGRATIVE MEDICINE) IN DERMATOLOGY

DOMAIN: MEDICINE

Author: Dr. Nwabudike Lawerence Chukwudi

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REZUMATUL TEZEI DE ABILITARE
TITLU: MEDICINĂ COMPLEMENTARĂ ȘI ALTERNATIVĂ (MEDICINĂ INTEGRATIVĂ) ÎN DERMATOLOGIE
ABSTRACT OF THE HABILITATION THESIS
TITLE: COMPLEMENTARY AND ALTERNATIVE (INTEGRATIVE MEDICINE) MEDICINE IN DERMATOLOGY

UNIVERSITATEA TRANSILVANIA, BRAȘOV, 2022

Teza cu titlul **"Medicină complementară și alternativă (medicină integrativă) în dermatologie"** este structurată în **cinci părți,** unde **în prima parte** am detaliat contribuțiile mele științifice avute după susținerea tezei de doctorat. În cadrul acestei părți sunt prezentate contribuțiile mele și, de asemenea, rezultatele obținute, folosind metodele complementare și alternative în dermatologie. Metoda cea mai des folosită în tratarea pacienților este **homeopatia** și, de altfel, au mai fost folosite tratamentele cu enzime și din surse fitoterapeutice (în cazul ulcerelor), iar rezultatele demonstrează ce efecte pozitive se pot obține în practica reală observațională (Real World Evidence/Data) prin aceste metode, ce devine tot mai acceptată ca o formă de cercetare validă, fiindcă nu toate rezultatele obținute prin meta-analize și trialuri randomizate pot fi aplicate în practica clinică obișnuită la toți pacienții.

Homeopatia este o metodă, ale cărei principii au fost discutate încă de pe vremea lui Hipocrat. Studiile arată în mod constant că ea este printre cele mai folosite metode de tratament integrativ de către pacienți, fiind recunoscută de OMS. În România, Ministerul Sănătății acordă certificate de competență în homeopatie medicilor, iar Colegiul Medicilor din România o recunoaște. Principiul ei de bază, "*similia similbus curentur"* este unul, care se regăsește în medicină convențională. Din păcate, relativa lipsă a încrederii în rândul corpului medical în homeopatie, face că obținerea fondurilor pentru cercetările de amploare, precum și publicarea rezultatelor să fie dificile, ceea ce face, ca fiecare rezultat obținut să fie obținută cu mai multă trudă decât in mod obișnuit. Au mai fost folosite și metodele fitoterapeutice în tratamentul ulcerelor la nivelul membrelor inferioare.

Lucrările au fost publicate în revistele **ISI** cu factor de impact și în revistele cotate **BDI.**

În **partea a doua** a tezei de față sunt prezentate activitătii mele academice, realizate fără a fi afiliat unei universități. În **partea a treia** este prezentat parcursul meu profesional, de la absolvirea facultății până în prezent, iar în **partea a patra**, direcțiile pe care îmi propun sa le parcurg, după susținerea tezei de abilitare. **Partea a cincea** a tezei cuprinde bibliografia folosită în prima parte a tezei, precum și lista publicațiilor mele din revistele de specialitate, de după susținerea tezei de doctorat.

În ceea ce urmează voi prezenta succint câteva dintre studiile ce cuprind datele și rezultatele obținute în urma tratării pacienților cu metoda *medicina complementară și alternativă (medicina integrativă),* care sunt prezentate în detaliu în teza mea de abilitare.

Prima serie de cazuri cuprinde un studiu cu 32 de pacienți adolescenți, cu vârstă medie de 15,5 ani, durată medie a bolii 2,6 ani, proporție egală pe sexe (***Nwabudike LC,*** *Congres CEDH, Praga, 2015*). În acest studiu, **81,25% din pacienți** au intrat **în remisie** cu tratament, **3,13% din pacienți au avut eșec** și **15,62% din pacienți nu au mai venit la control. La cel de-al doilea studiu,** au fost 83 pacienți, cu vârstă medie de 21,5 ani, durata medie a afecțiunii fiind de 5,5 ani, iar proporția pe sexe a fost 2:1(F:M). Rezultatele au arătat că **81,9%** din cazuri **au intrat în remisie** cu tratament, **15,7% din pacienți nu au mai revenit la control**, iar **2,4% din pacienți au fost eșec** la tratament (***Nwabudike LC,*** *Congres EADV, Vienna, 2016,* ***Nwabudike LC,*** *Homeopathy, 2021*). Un studiu de caz (n=2), arată efectul tratamentului homeopat individualizat în acnee severă. Acești pacienți au fost urmăriți pe perioade lungi după încetarea tratamentului și au rămas în remisie (***Nwabudike LC****, Complement Med Res. 2018*).

Am studiat efectul tratamentului homeopat asupra verucilor vulgare într-o serie de cazuri, realizând și un studiu de caz. Seria de cazuri (***Nwabudike LC****, Congres EADV, Geneva, 2017*) a cuprins 8 pacienți cu veruci vulgare, care nu au răspuns la tratamente clasice, timp de minim un an. Proporția pe sexe a fost 1F:7M, vârsta medie 34,1ani, durată medie a verucilor de 4,8 ani. Comorbiditățile au inclus diabet zaharat, neuropatie periferică, chist la nivelul pleoapei, dermatită seboreică, psoriazis și sinuzită. Rezultatele au arătat că **87,5% (7 pacienți) au intrat în remisie,** durata medie până la remisie a fost de 5,6 luni, iar 50% dintre comorbidități au fost remise. Într-un studiu de caz (n=2), am prezentat efectul homeopatiei asupra verucilor vulgare. Ambele au fost de sex feminin și au avut diabet zaharat tip 1. Sub tratamentul homeopat individualizat, pacientele au intrat în remisie și au avut și o scădere a nivelului de hemoglobină glicată, cu o ușoară creștere a nivelului

peptidului C. Aceste rezultate sugerează că tratamentul homeopat individualizat în veruca vulgară poate duce la remisia bolii, precum și ameliorarea sau vindecarea comorbidității.

Cercetarea mea asupra efectului homeopatiei în terapia psoriazisului a avut ca rezultat 3 studii de cazuri clinice. Primul studiu (***Nwabudike LC**, Proc Rom Acad, 2011*) a avut 4 pacienți, cu vârstele cuprinse între 14-66 ani, 1F:3M. Manifestările lor de psoriazis au fost fie generalizate (2 cazuri), fie localizate după cum urmează: la nivelul scalpului (1 caz) sau unghial (1caz). Fiecare a primit un tratament homeopat individualizat și în toate cazurile remisia a fost totală și de lungă durată. Pacienta cu psoriazis unghial a revenit ulterior pentru tratamentul fiicei ei, născută după remisia psoriazisului, fără recidivă în acel interval de aproximativ 10 ani. Un pacient (14 ani vârstă în momentul tratamentului) cu psoriazis al scalpului a ajuns la facultate în străinătate, fără să mai aibă remisii, conform relatării mamei sale. Un alt studiu de caz (***Nwabudike LC,** Our Dermatol Online,* 2017) a cuprins 3 cazuri de psoriazis palmoplantar, de lungă durată, toate tratate homeopat. Au fost 2F:1M, cu vârstele între 55-66 ani și o durată a psoriazisului de până în 30 ani. Fiecare pacient a primit tratament homeopat individualizat și a intrat în remisie. Rezultatele sugerează că homeopatia poate fi utilă în producerea remisiei pe termen lung ale psoriazisului. În fine, un studiu de caz recent (n=2), primul pacient, în vârstă de 56 de ani, cu psoriazis de 17 ani, prezenta eritrodermie, a primit tratamentul homeopat individualizat, cu ameliorare completă a leziunilor cutanate, precum și cele unghiale. Iar cea de a doua pacientă, în vârstă de 32 ani, cu leziuni de psoriazis vulgar și unele inversate (în zona inghinogenitală) a fost tratat cu homeopatie individualizată și leziuni s-au remis (**Nwabudike LC**, *Am J. Homeopathic Medicine, 2020*). De menționat faptul că pacienta rămăsese însărcinată în primele luni de tratament și nu a avut nevoie să oprească tratamentul homeopat. Aceste 3 studii au demonstrat efectul homeopatiei pe termen lung în tratamentul psoriazisului și că poate fi folosită în timpul sarcinii, fără să fie efecte teratogene.

Efectul homeopatiei în cazul bolii lichen plan a fost prezentat într-un studiu de caz (***Nwabudike LC**, Miulescu M, Tatu AL, Exp Ther Med, 2019*), care a cuprins 4 pacienți. Au fost 2F:2M, cu vârstele între 41 și 65 ani, durata bolii între 7 luni și 27 ani. Toți pacienții aveau o formă generalizată a bolii, iar 2 pacienți aveau leziuni la nivelul mucoaselor. Toți au fost tratați homeopat cu medicamentele individualizate și au intrat în remisie. Un pacient suferea și de anosmie, care s-a ameliorat sub același tratament homeopat individualizat pentru lichen plan. Același pacient s-a întors, 3 ani mai târziu, cerând un tratament pentru copilul său, el fiind încă în remisie, iar pozele din acea vizită sunt prezentate și în teza de abilitare. Rezultatele sugerează că homeopatia individualizată poate fi de folos în tratamentul

lichenului plan generalizat de lungă durată, precum și în manifestările mucoaselor, cu remisie de lungă durată.

Am publicat un studiu de caz asupra efectului homeopatiei individualizată în tratamentul micozisului fungoides (***Nwabudike LC,*** *J. Am Acad Dermatol, 2017;* ***Nwabudike LC,*** *Homeopathy, 2019*). Studiul a cuprins 3 pacienți, vârstele acestora fiind între 22-84 ani, cu micozisul fungoides confirmat prin imunohistochimie. Fiecare pacient a primit tratament cu un medicament homeopat individualizat, după care aceștia au intrat în remisie. Aceste rezultate indică posibilitatea că micozisul fungoides poate fi tratat cu homeopatie, iar rezultatele sunt mai semnificative, dat fiind faptul că boala nu remite spontan.

Infecțiile urinare recidivante sunt o problemă importantă și des întâlnită. Am publicat un studiu de caz, cu 3 paciente, cu infecții urinare recidivante (***Nwabudike LC****, Proc Rom Acad, 2017*). Vârstele lor au fost între 4 luni și 54 ani. Toate au avut uroculturi pozitive, iar după tratamentul homeopat, rezultatele acestora au ieșit negative. Două cazuri au avut *E coli,* iar un caz a avut *Klebsiella spp*. Rezultatele sugerează că homeopatia ar putea fi de folos în tratamentul infecțiilor urinare recidivante, scutind folosirea antibioticelor, mai ales la cei cu vârste fragede, pentru care efectele secundare ale antibioticelor pot constitui o problemă serioasă.

Rozaceea este o tulburare cutanată des-întâlnită. Poate fi o cauză importantă a diminuării calității vieții. Am publicat un studiu de caz ce cuprinde 3 pacienți cu rozacee, vârsta acestora fiind între 32-53 ani (***Nwabudike LC,*** *Proc Rom Acad, 2012*). Doi dintre ei au fost de sex feminin. Fiecare pacient a primit un tratament homeopat individualizat și toți au intrat în remisie, fără recidivă. Acest lucru a sugerat că homeopatia poate contribui la remiterea bolii rozacee. Un alt studiu de caz a fost prezentat în capitolul scris de mine, ca autor unic - *Homeopathy in the Therapy of Acne and Rosacea.* In: Rupani R.N., Lio P.A. (eds) *Integrative Dermatology*. **Springer, Cham**., 2021. Cazul privea o pacientă cu erupție cutanată facială, evoluând de 3 ani, manifestându-se cu eritem, erupție și uscăciune cutanată, fără afectarea oculară. Clinic, pacienta avea eritemul și edemul feței, cu papule și pustule. A fost tratată cu medicamentul homeopat *Platinum metallicum,* la potență MK. La 6 săptămâni, pacienta a fost deja ameliorată, cu puține leziuni noi. După 5 luni, era aproape fără leziuni și a rămas în remisiune la consultație de control, 15 luni după începerea tratamentului.

În ceea ce privește dermatita atopică, am publicat un studiu de caz, cu 3 pacienți, cu vârste cuprinse între 10 luni și 22ani (***Nwabudike LC,*** *Our Dermatol Online, 2012*). Două

paciente de sex feminin (10 luni și 22ani vârstă) și celălalt (11 luni vârstă), de sex masculin. Aceștia au primit tratament homeopat individualizat și emoliente. Pacienții au intrat în remisie și au rămas în remisie. Homeopatia s-a dovedit a fi utilă în tratamentul dermatitei atopice, ceea ce ar putea scuti sau diminua nevoia de folosirea tratamentului steroidian, astfel, devenind un "steroid-sparing" agent.

Un alt studiu de caz, cuprinzând 2 femei, de 25 și 42 ani, cu dermatită seboreică severă de lungă durată (***Nwabudike LC,*** *Our Dermatol Online, 2011*), tratate cu homeopatie individualizată a fost publicat de mine. Pacienții au intrat în remisie, arătând potențialul homeopatiei în tratamentul dermatitei seboreice de lungă durată.

Am arătat potențialul homeopatiei în producerea remisiei în tratamentul dermatitei herpetiforme (***Nwabudike LC,*** *Homeopathic Links, 2015*), într-un caz tratat cu homeopatie individualizată. Acest caz a fost urmărit la o perioadă de câțiva ani după ce intrase în remisie și atât leziunile cutanate, cât și tulburări intestinale nu au recidivat. Pacienta a putut să se hrănească fără dietă specială.

De altfel, homeopatia individualizată a fost folosită și pentru un caz de melasmă (***Nwabudike LC,*** *Homeopathic Links, 2012*), care a intrat în remisie unde a rămas și după vizita la controlul anual.

Recent, am publicat un studiu de caz în care medicamentul homeopat *Apocynum cannabinum* combinat cu furosemid în doză de 120mg/zi, a fost utilizat cu succes în tratarea unui caz de elefentasis nostras verrucosa. De amintit că, această maladie nu se remite spontan, iar diuretice precum furosemid nu sunt foarte utile, din cauza lipsei lor de eficacitate în astfel de situații (***Nwabudike LC*** *et al., Exp. Ther. Med., 2022)*

Ulcerele cutanate sunt o problemă mare de sănătate. Ele sunt des întâlnite, cerând costuri mari și timp mult pentru tratamentul lor. Este necesară o echipa multidisciplinara pentru terapia acestui tip de ulcer. Diagnosticul diferențial al lor este vast și include ulcere maligne. Am semnalat doua cazuri – un caz de epiteliom spinocelular la nivelul plantar, ce sugera un ulcer neuropat și a fost tratat ca atare timp de 3 ani în alte servicii clinice (***Nwabudike LC***, Gutu D, *Clin Exp Dermatol, 2021*). Cel de-al doilea caz, a fost un caz de melanom malign, la nivelul calcanean al unui pacient cu diabet, tratat tot de câțiva ani ca un caz de ulcer diabetic. Biopsia a demonstrat ca acea leziune a fost un melanom (***Nwabudike LC,*** et al. *Clin Cosmet Investig Dermatol, 2022*). Lipsa unei colaborări multidisciplinare a contribuit, poate, la tratamentul nepotrivit, de lungă durată a acestor pacienți, iar aceste cazuri ne și învață că atunci când un ulcer la nivelul piciorului unui pacient cu diabet nu

răspunde la tratament după un timp rezonabil, trebuie luat în considerare și alte diagnostice diferențiale.

Terapiile naturopate sunt utile în managementul ulcerelor cutanate. Am prezentat câteva studii de caz, care arată efectul pomadei Miculicz – care conține balsamul de Peru – (***Nwabudike LC,*** *Tatu AL Am J Ther 2018*) și efectul mierii de albine asupra ulcerelor (***Nwabudike LC,*** *Maruhashi E, Wounds Int 2017*; ***Nwabudike LC,*** *Maruhashi E, Wounds Middle East 2017*; ***Nwabudike LC,*** *Maruhashi E, EWMA Congres, 2018*).

Folosind pomada Miculicz, care conține balsamul de Peru, a fost posibilă vindecarea unui ulcer cronic, cu durata de evoluție de 6 luni înaintea prezentării, la piciorul unui pacient în vârstă de 50 ani, cu diabet zaharat tip 2, cu arteriopatie severă și astfel a putut fi evitată amputarea. Tratamentul a fost aplicat zilnic de către pacient, iar monitorizarea evoluției pacientului a fost făcută la cabinetul meu (***Nwabudike LC****, Tatu AL, Am J Ther. 2018*).

Mierea de albine a fost folosită de noi în terapia ulcerelor picioarelor pacienților cu diabet zaharat. Primul caz a fost al unui pacient, în vârstă de 85ani, cu diabet zaharat tip 2, insuficiență renală, cardiopatie ischemică și un ulcer pe fața anterioară a piciorului drept. Ulcerul s-a vindecat în decurs de 3 săptămâni (***Nwabudike LC,*** *Maruhashi E, Wounds Int. 2017*; ***Nwabudike LC,*** *Maruhashi E, Wounds Middle East, 2017*). Lucrarea a fost publicată în revista *Wounds International* și, la cererea Editurii, republicată în *Wounds Middle East.*

De asemenea, am folosit miere de albine și pentru tratamentul unui ulcer postamputare la un pacient necompliant. Pacientul refuza antidiabeticele convenționale, preferându-le pe cele din plafare și alte surse agreate lui, refuza să facă test de hemoglobină glicată și nu se pansa bine. În pofida necomplianței sale, pacientul a răspuns bine la terapia locală cu miere de albine (***Nwabudike LC,*** *Maruhashi E, EWMA, Krakow, 2018*).

Fenomenul Koebner – fenomenul isomorfic – este arhicunoscut dermatologilor, ca un semn diagnostic clinic. Există forma clasică de Koebner (văzută la vitiligo, lichen plan și psoriazis); forma de pseudo-Koebner, prin însemânțarea leziunilor (veruci vulgare, molluscum contagiosum); formă în care s-au găsit leziuni ocazionale, dar bine documentate (cum ar fi boala Behcet sau pioderma gangrenosum) și, în fine, formele cu asociere rară (pemfigus, lichen nitidus). Fenomenul Wolf însă, este considerat fenomenul isotopic, unde o boală apare la locul vindecării unei alte boli vechi. Am discutat ambele fenomene prin mecanismele și modul lor de apariție și am pledat pentru a nu fi tratate ca fenomene separate, ci să fie considerate o entitate, iar fenomenul Wolf, a cincea formă de fenomen Koebner (***Nwabudike LC,*** *Tatu AL, J Eur Acad Dermatol Venereol, 2018*).

La forma de Koebner rar menționată – tipul IV – am semnalat un caz, care nu a mai fost semnalat în literatură până la data publicării sale. Este vorba de un caz de fenomen Koebner la o pacientă cu pitiriazis rozat. Leziunile au apărut în locurile cu înțepătura de venopunctură, la nivelul coatelor, împreună cu leziuni clasice de pitiriazis rozat (***Nwabudike LC,*** *Our Dermatol Online, 2013*).

Răspunsul inflamator față de virusul SARS-CoV-2, precum și creșterea citokinelor locale ar putea sta la baza erupțiilor veziculare, precum și manifestarea lor ca fenomenul Koebner, în special tipul V Koebner (Tatu AL [….] ***Nwabudike LC***, *Clin. Cosmet Investig Dermatol, 2021; Tatu AL, Nadasdy T,* ***Nwabudike LC****, J Eur Acad Dermatol Venereol, 2021*).

Field cancerisation este un fenomen inițial descris de Slaughter în 1953. Se referă la posibilitatea de a produce tumori într-o arie de imunosuprimare. Am lansat ipoteza de field cancerisation generalizat pentru a explica posibilitatea apariției de tumori departe de tumora primară, fără a fi metastaze (***Nwabudike LC,*** *Tatu AL, J. Eur Acad Dermatol Venereol, 2018*). Am și speculat că ar putea fi posibil ca field cancerisation să fie cauzată și de medicamente mai puțin cunoscute ca imunosupresoare, cum ar fi tetracicline (***Nwabudike LC,*** *Tatu AL, J. Eur Acad Dermatol Venereol, 2018*), hidroclorotiazide (*Tatu AL, Ciobotaru OR, Miulescu M, Buzia OD, Elisei AH, Mardarea N, Diaconu C, Robu S,* ***Nwabudike LC,*** *Rev Chim, 2018*) și statine (***Nwabudike LC,*** *et al. Rev Chim, 2018*). Astfel, am încercat să arătăm cum ratele tot mai crescute a bolilor canceroase ar putea să-și găsească originea în tratamentele folosite pentru alte tulburări. Acest lucru este tot mai discutat astăzi.

În cea de-a doua parte, am expus domeniile mele de interes, care includ dermatologia integrativă (medicină complementară și alternativă în dermatologie), ulcerele piciorului diabetic, precum și istoria și filozofia dermatologiei și a medicinei, în general.

Menționez faptul că, în prezent **am scor Hirsch** de **13 (ISI)**, factor cumulat de impact autor principal **23,985.**

Am început să scriu capitole în cărți legate de temele relatate anterior, înainte de terminarea tezei de doctorat și am continuat după terminarea acesteia. Capitolele scrise după terminarea tezei de doctorat au fost *A Tale of Diabetic Neuropathy* (incluse in cartea *Istoria neuropatiei diabetice în România,* 2013, C. Ionescu-Tîrgoviste, [ed.] Editura Sanatatea Press Group. ISBN 978-973-0-15565-5), în care am schițat istoria cercetărilor românești în domeniul neuropatiei diabetice, inclusiv contribuțiile proprii.

În capitolul *Diabetic Foot Ulcers* (incluse in cartea *Diabetic Complications. New Insights and Solutions*, 2014, Cheta D, [ed] Editura Agir**,** București**.** ISBN 978-973-720-545-2) am

adus la zi datele legate de etiologie, patologie și tratamentul acestei afecțiuni, inclusiv experiențele mele proprii din domeniu.

Unele capitole scrise de mine, in colaborare cu alți colegi, vizează melanomul malign, după cum urmează –

F.C. Bujoreanu, D.S. Radaschin, **L.C. Nwabudike**, A.L. Tatu *Cutaneous melanoma from the anterior thorax: a case report* (inclus in cartea *Clinical Cases in Melanoma* Lotti, Torello; Tirant, Michael; Wollina, Uwe 2020, (Eds.). Springer Nature Publishers ISBN 978-3-030-50820-3

L.C. Nwabudike, A.L. Tatu, A.M. Oproiu, M. Costache *When Dermoscopy exonerates a suspect and "indicts" another lesion* (inclus in cartea *Clinical Cases in Melanoma* Lotti, Torello; Tirant, Michael; Wollina, Uwe 2020, (Eds.). Springer Nature Publishers ISBN 978-3-030-50820-3

Alte capitole vizează tulburări pigmentare, după cum urmează -

A.L. Tatu, D.S. Radaschin, F.C. Bujoreanu, **L.C. Nwabudike.** *Homogeneous black, pigmented lesion of the fifth toe* (inclus in cartea *Clinicul Cases in Pigmentary Disorders* Lotti, Torello; Tirant, Michael; Parsad, Davinder 2020, (Eds.). Springer Nature Publishers ISBN 978-3-030-50823-4

L.C. Nwabudike, A.L. Tatu, D.S. Radaschin, V Ardeleanu *The dermatologist's fingernail* in Clinical Cases (inclus in cartea *Clinicul Cases in Pigmentary Disorders* Lotti, Torello; Tirant, Michael; Parsad, Davinder 2020, (Eds.). Springer Nature Publishers ISBN 978-3-030-50823-4

Iar alte capitole legate de homeopatie includ urmatoarele -

L.C. Nwabudike, A.L. Tatu. *Dark facial spots and a rash* (din cartea *Clinicul Cases in Pigmentary Disorders* Lotti, Torello; Tirant, Michael; Parsad, Davinder 2020, (Eds.). Springer Nature Publishers ISBN 978-3-030-50823-4

L.C. Nwabudike *Homeopathy in the Therapy of Acne and Rosacea*. (din cartea *Integrative Dermatology*, Rupani R.N., Lio P.A. 2021, (eds). Springer, Cham.

Am predat la cursuri de competență în homeopatie, organizate sub egida UMF Iași și Ministerul Sănătății.

Am fost invitat ca Speaker la mai multe conferințe internaționale și naționale, unde am susținut lucrări din domeniile de medicină complementară și alternativă (medicină integrativă) cum ar fi la Beijing, 2009; Paris 2018; Madrid 2019; Barcelona 2019; Madrid 2019; precum și în țară, conferințele Societății Române de Dermatologie (2017, 2019).

Sunt Guest Editor pentru ediții speciale ale revistelor Dermatologic Therapy (**factor impact 2,851**). De asemenea, activez și în calitate de Associate Editor pentru Dermatologic Therapy.

Am fost Peer Reviewer pentru revistele (verificabile pe Publons) Alternative Therapies in Health and Medicine, Diagnostics, Journal of Integrative Medicine, Homeopathy, Clinical and Experimental Dermatology, Dermatologic Therapy, International Journal of Dermatology, Children, Atmosphere, Biomedicines, Clinical, Cosmetic and Investigational Dermatology.

Sunt membru al boardului editorial pentru revistă internațională Our Dermatology Online (www.odermatol.com), din 2011 până în prezent.

Sunt membru de catedră pentru 5-CC (5-Continent Congress), iar aici am susținut mai multe prezentări, inclusiv un curs (Residents and Fellows Symposium, 2019), unde am predat cursul despre Homeopatie și rolul ei în tratamentul bolilor dermatologice.

Toate acestea arată capacitatea mea, fie singur, fie în frunte sau parte a echipelor de cercetare, de a întreprinde cercetări, care să soldeze în lucrările științifice publicate și acceptate la foruri internaționale de seamă. De asemenea, arată și activitatea mea didactică.

În cea de-a treia parte, am detaliat parcursul meu profesional, de la absolvirea University of Lagos (**MBBS, 1989**), la stagiile de pregătire în dermatologie la spitalul Colentina **(1992-1995)**. În același timp am absolvit cursurile de competență în acupunctură și homeopatie (ambele în **1995**). În **1998** am trecut cu succes licența de medic american (USMLE/ECFMG).

În **2007** am devenit **doctor în medicină**, iar în **2009** am devenit **medic primar**. În **2012** am absolvit cursul de **formator în acupunctură** al Ministerului Sănătății, iar în **2017** am trecut cu succes examenele Royal College of Physicians (UK) de **medicină internă generală**, fiind astfel ales la titulatură **MRCP(UK).**

În prezent, sunt membru al Societății Române de Dermatologie (SRD), Asociației Române de Homeopatie Clinică (ARHC), American Academy of Dermatology (AAD),

European Academy of Dermatology and Venereology (EADV), Royal College of Physicians (RCP) și Secretar (actualmente Președinte-ales) al European Society for the History of Dermatology and Venereology (ESHDV).

Posed drept de practică dat de Colegiul Medicilor din România și Colegiul Medicilor din București, General Medical Council (UK), Nigerian Medical Council (Nigeria).

În partea a patra a tezei mele, am expus intențiile personale de a continua cercetările mele și direcțiile deja începute. Astfel, voi continua să public și să întreprind cercetări în domeniile de medicină complementară și alternativă (medicină integrativă) în dermatologie, în domeniul ulcerelor piciorului diabetic cu speranța de a contribui la diminuarea numărului de amputații ale membrelor inferioare, în istoria și filozofia medicinei, ceea ce ne vor permite să privim în trecut pentru a ne pregăti pentru viitor.

În partea a cincea am expus bibliografia pe care am folosit-o în elaborarea primei părți a tezei de abilitare. Tot în partea a cincea se găsește lista lucrărilor mele publicate în extenso – reviste **ISI și BDI** –, care au fost publicate de mine după ce am dobândit titlul de doctor în medicină.

Sper să am oportunitatea să conduc teze de doctorat în domeniile menționate, astfel să contribui la pregătirea unor noi generații de medici, care vor continua munca respectivă, ducând-o la nivele tot mai mari. De asemenea, sper să am ocazia să pregătesc noi generații de medici și studenți, care să aibă o altă atitudine și abordare, mult mai deschisă față de aceste domenii, înlesnind astfel accesul publicului larg la ele. În fine, mă voi folosi de renumele deja dobândit în mass-media, precum și posibilitățile date prin abilitare, să promovez medicina integrativă, abordarea corectă a ulcerelor piciorului diabetic, precum și filozofia și istoria medicinei.

PART I

SCIENTIFIC ACHIEVEMENTS

Introduction:

Following the successful defence of my Ph.D. thesis, I continued working in the direction of complementary and alternative medicine, diabetic foot ulcers, as well as the history and the philosophy of medicine.

I published the results of the work done by me in various national and international journals and at national and international conferences. In consequence I have received invitations to give lectures and to speak at international conferences. I have also taught courses at international conferences and have received national and international awards.

Financial support for the work has come almost exclusively from personal resources, since research funding is difficult to obtain for some fields, especially homeopathy. Aside from this, it is much easier to obtain financial support for projects, if the researcher is affiliated to a higher institution or to a research institution. It is my hope that this habilitation thesis will help open the doors to this possibility.

Since financing has been very limited, a lot of the results have been clinical and limited to case series and case studies. This disadvantage means the research I publish has less impact than larger, well-funded studies, but they have the obvious advantage that my results speak to real world data and offer proof of the effects of my different methods in real world situations.

1 Homeopathy in the therapy of acne

Introduction:

Acne is a severe cutaneous disorder primarily affecting the pilosebaceous unit. It is a very commonly encountered disorder and it affects about 9.8% of the population worldwide[1,2]. Acne may be complicated by psychiatric disorders, especially depression and suicide[1]. It is a significant source of diminished quality of life. The therapy of acne involves a variety of topical and systemic agents. There is some weight given to complementary and alternative or integrative treatment methods in some therapeutic guidelines[3].

I studied the effect of the homeopathic treatment on acne and published two case series and one case report [4-6]. The case series were presented at the CEDH (Centre for Education

and Development of Homeopathy) international conference at Prague, in 2015 and in the peer-reviewed journal *Homeopathy* (Web of Science Impact Factor 1.444 at the time of publication)[4,5], while the case report was published in peer-reviewed journal *Complementary Medicine Research* (Web of Science impact factor of 1 at the time of publication)[6].

1.1"Homeopathy in the therapy of acne in juveniles" [4]

The first case series is titled *"Homeopathy in the therapy of acne in juveniles"* In this case series, 32 patients, all aged below 18 years, who had received individualised homeopathic medicine for the treatment of acne were retrospectively reviewed by me[4].

Materials and methods of the study:

A group of 32 individuals, aged <18 years presenting with acne who had been treated with classical homeopathy were retrospectively reviewed. Each patient was prescribed a single homeopathic medicine, given at CH200 or MK potency, weekly dosing and was followed up at 6-8-week intervals. Photographic documentation was carried out with appropriate informed consent.

The characteristics of the study group were:

Average patient age was 15.5 years (range 11-17 years), the male:female ratio was 16:16 (50%:50%), therefore there was no sex predominance. The average duration of acne prior to presentation was 2.6 years (range 0.25-5 years). The patients were divided into three categories according to grades of severity - mild (n=3 or 9.4%), moderate (n=13 or 40.6%) and severe (n=16 or 50%). No lesion counts were carried out, as they had been seen during routine homeopathic consultations and were only retrospectively reviewed using case notes and photographs. Based on this, it could be seen that most patients had severe, i.e., predominantly pustular, cystic or nodular lesions. Lesions of this degree of severity frequently do not remit without concomitant systemic therapy.

The clinical characteristics of the study group are summarized in Table 1.1a below.

Table 1 Characteristics of study group

Patient characteristics	Average age (years)	Female(F):Male(M) ratio	*Average duration (years)	**Severity
Numerical values	15.5 (range 11-17)	16F:16M (50%F:50%M)	2.6 (0.25-5)	Mi (n = 3/ 9.4%) Mo(n=13/40.6%) Se (n = 16/50%)

(*Average duration of acne prior to presentation; **Mi = mild, Mo = moderate, Se=Severe)

Results of the study:

The results of the study showed that ten different homeopathic medicines were used to treat this group of 32 patients. This was to be expected, as the homeopathic treatments were individualised.

The homeopathic medicines used were *Natrum muriaticum, Palladium metallicum, Platinum metallicum, Aurum metallicum, Lachesis*, *Lycopodium, Phosphorus*, *Pulsatilla, Nux vomica* and *Kalium phosphoricum.*

The largest proportion of homeopathic medicines used was *Lycopodium* (13 cases or 40.6%). The proportion for other medicines was *Palladium metallicum* (8 cases or 25%); *Natrum muriaticum* (3 cases or 9.4%); *Platinum metallicum* (2 cases or 6.3%), with the remaining medicines each having 1 case or approximately 3.1%.

The summary of the homeopathic medicines used and number of patients for each medicine is given in table 1.1b

Table 2.1.2 Homeopathic medicines used

*Homeopathic medicine	Nat mur	Pal	Plat	Aur met	Lach	Lyc	Phos	Puls	Nux vom	Kali Phos
Patient number	3	8	2	1	1	13	1	1	1	1

*(Nat mur = Natrum muriaticum, Pal = Palladium metallicum, Plat = Platinum metallicum, Aur met = Aurum metallicum, Lach = Lachesis, Lyc = Lycopodium, Phos = Phosphorus, Puls = Pulsatila, Nux vom = Nux vomica and Kalium phosphoricum)

A total of 26 (81.25%) patients went into remission, 5 (15.62%) patients were lost to follow up and 1 (3.13%) patient failed to improve. Lost to follow up was defined for this study as patients that failed to show up for the first follow up visit and for any subsequent follow up visits. Of the patients who failed to achieve confirmed remission (i.e. 18.75% - lost to follow up and failure of treatment), 3 cases were moderate and 3 severe acne. The medicines used in this group include *Lycopodium* (3 cases), *Kalium phosphoricum* (1 case), *Aurum metallicum* (1 case), *Palladium metallicum* (1 case).

For the patients that went into remission, the following results were obtained: Three cases of mild, 10 cases of moderate and 13 cases of severe acne went into remission. They comprised *Natrum muriaticum* (3 patients); *Palladium metallicum* (7 patients), *Lycopodium* (10 cases), *Platinum metallicum* (2 cases), *Lachesis*, *Phosphorus*, *Pulsatilla* and *Nux vomica* each with 1 case.

Discussion and conclusion:

The results of the present study suggest that homeopathy might be of value in the treatment of all grades of severity of acne in patients under the age of 18 years. Most patients in this study had moderate and severe types of acne and these can often be recalcitrant to conventional medical therapy. The response to homeopathy was good and follow up periods of up to 2 years after cessation of treatment showed no relapse of acne in these patients. No side-effects were seen.

Although the study group is not large and a control group was not present, these results suggest that homeopathy is effective in the treatment of acne of all degrees of severity in patients under the age of 18 years. The therapy of acne using homeopathic medicines does not require maintenance treatment and its effect appears to be long-lasting.

Often, in conventional medicine, maintenance therapy following topical or systemic conventional therapy, in order to preserve the results obtained in acne, is recommended. The medications recommended are not without side effects, sometimes severe. They may also be very costly. These data suggest that homeopathy might be advantageous in these situations.

1.2"Homeopathy in the treatment of acne" [5]

The second case series bears the title "*Homeopathy in the treatment of acne*".[5] In this case series, 83 patients with acne, treated with individualised homeopathy, were retrospectively reviewed.

The characteristics of the group are summarised in Table 1.2a

Table 1.2a The characteristics of the study group

Criterion	Average age (yrs)	Sex ratio (F:M)	Pre-treatment duration (yrs)	Acne severity
	21.5 (11-45)	55:28	5.5 (0.25-22)	8.4% (mild) 44.6% (moderate) 47% (severe)

The spectrum of the age group of patients was broad, 11-45 years, and this appeared to have been reflected in the pre-treatment duration of acne 0.25-22years. Majority of the patients in this study were female, with the female:male ratio being approximately 2:1. Most cases were of moderate and severe grade acne, suggesting that most were difficult to treat cases in this study.

Materials and methods of the study:

I retrospectively reviewed a series of cases of acne (n=83), that had been treated by me with individualised homeopathy. Each patient was graded as mild, moderate or severe and each received a single homeopathic, medicine usually administered weekly and was followed up at 6- to 8-week intervals. Photographic documentation was carried out with appropriate informed consent in each case. There was no control group, as this was a retrospective observational study. The data used to determine grading and treatment response were derived from the case records and from the photographic evidence.

Results of the study:

The results of the study are summarised below in Table 1.2b

Table 1.2b – Results of the study

Criterion	Remission	Average time to remission (months)	Treatment failure	Lost to followup
	81.9% (68 cases)	1.9 (1.5-6)	2.4% (2 cases)	15.7% (13 cases)

The results showed that 81.9% of patients went into remission, 15.7% were treatment failures and 2.4% were lost to follow-up. The group of patients that were lost to follow-up comprised individuals that did not return for the first follow-up or for subsequent follow-up consultations. The average time to remission was 1.9 (range 1.5-6) months.

The medicines used in the treatment of the study patients were *Causticum, Tuberculinum, Silicea, Lachesis, Sepia, Calcarea carbonica, Arsenicum album, Carcinosinum, Staphysagria, Ignatia, Natrum muriaticum, Lycopodium, Palladium metallicum, Platinum metallicum, Aurum metallicum, Nux vomica, Kalium phosphoricum, Phosphorus* and *Pulsatilla.*

There were no reported side-effects of treatment using homeopathy. The reasons for treatment failure and loss to follow-up were unknown, but I can only conjecture that financial considerations may play a prominent role as these patients were seen in my outpatient private practice and therefore did not benefit from medical insurance coverage.

Discussion:

The results of this study show that acne may respond to individualised homeopathic treatment in 81.9% of cases. Although there was no placebo group (this was a retrospective observational study), the proportion of treatment success suggests that homeopathy may be

a viable, efficacious treatment option for patients with moderate to severe acne in adult and juvenile patients.

Treatment failure comprised a small proportion – 2.4% - of patients. The high proportion of patients – 15.7% - lost to follow-up may reflect either a lack of patience with regards to the relatively gradual pace of recovery with this treatment or a lack of financial wherewithal to continue with a treatment, which had to be paid out of pocket.

1.3 "Case reports of acne and homeopathy". [6]

Introduction:

In this case study (n=2), I presented cases of severe, long-standing, papular and pustular acne. One patient was male and the other female. Both were prescribed individualised homeopathic medicines and were monitored, with photographic documentation for 1 and 2 years after full remission, respectively. Both cases showed no relapse during the follow up period, after remission and there were no side effects from treatment. The homeopathic medicines used were *Palladium metallicum* for the female patient and *Natrum muriaticum* for the male patient.

Case 1 – A 16-year old male presented with a 7-month history of facial rash. He also reported that the rash had been on and off since the onset of adolescence but had only become severe 7 months prior to presentation. Oral and topical antibiotics, as well as topical retinoids provided only limited, temporary relief. Physical examination revealed a facial eruption comprised of erythematous papules and pustules, as well as depressed scars. He was prescribed homeopathic *Natrum muriaticum* at MK potency and reported a significant reduction in number of lesions, as well as diminution in new lesions. By 5 months he was sufficiently confident to contemplate a holiday trip. His face remained clear at two years after onset of treatment (one year after cessation of treatment) and his scars were much less visible.

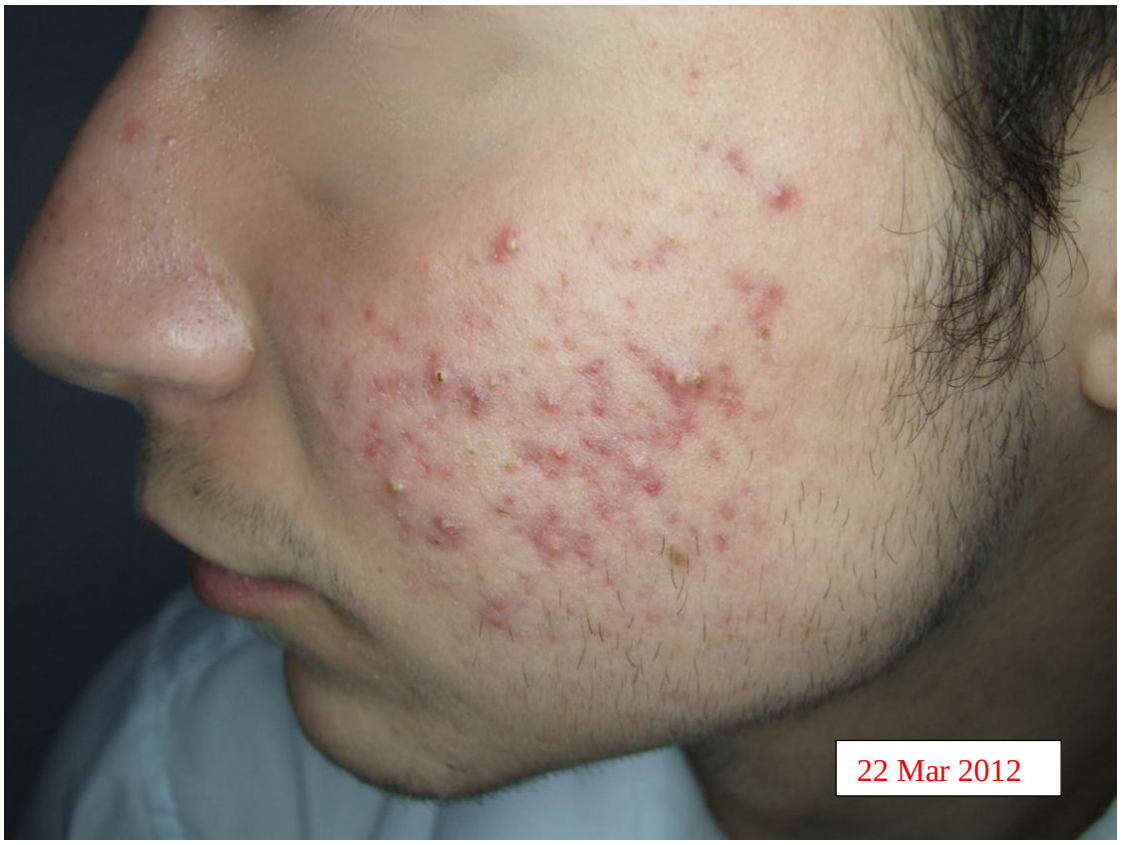
Case 2 – A 14-year old female presented with a 3-year history of facial rash. She reported feeling pain in the deeper lesions and worsening of lesions with stress, menses, sunshine and with consumption of fast foods had been observed. She had not achieved satisfactory results from topical and oral medications. Examination revealed erythematous papules, pustules, as well as open and closed comedones, associated with scarring, located predominantly on the cheeks. The patient was prescribed a weekly dose of homeopathic *Palladium metallicum* at CH200 potency, weekly. She improved continuously and remained

lesion-free at 2 years after onset of therapy with marked improvement of the appearance of scars.

Conclusions:

Acne is a primarily cutaneous, pleomorphic disorder affecting the sebaceous gland. Various treatment modalities can be used for acne and they all have potential side-effects, some of which can be severe. My two case series (n=32 and n=83) and one case study suggest that homeopathy, especially individualised homeopathic therapy, may be a viable and efficacious treatment option for acne of all grades of severity in juvenile and adult patients. This is especially significant as the homeopathic treatments produced no side-effects. They were also cheaper and easier to administer (weekly dosing). The improvement of the acne certainly would translate into an improvement of quality of life, although objective scoring was not done, as this was a retrospective case review. These observations are significant to public health. Larger, controlled studies, may confirm these observations and pave the way for homeopathy to become a part of the therapeutic options for acne treatment in dermatology.

Figure 1.3a and b – Patient before treatment - Papular and pustular lesions on both cheeks. This patient received *Natrum muriaticum*[6]



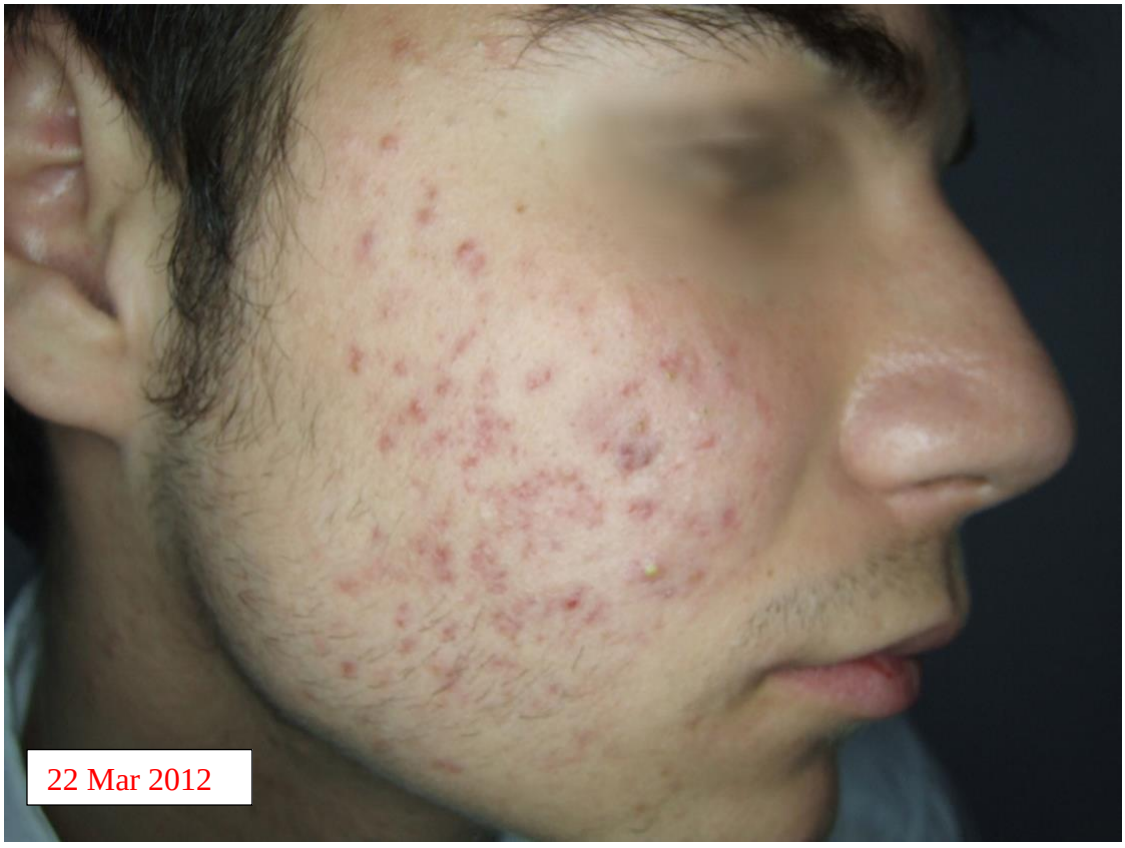
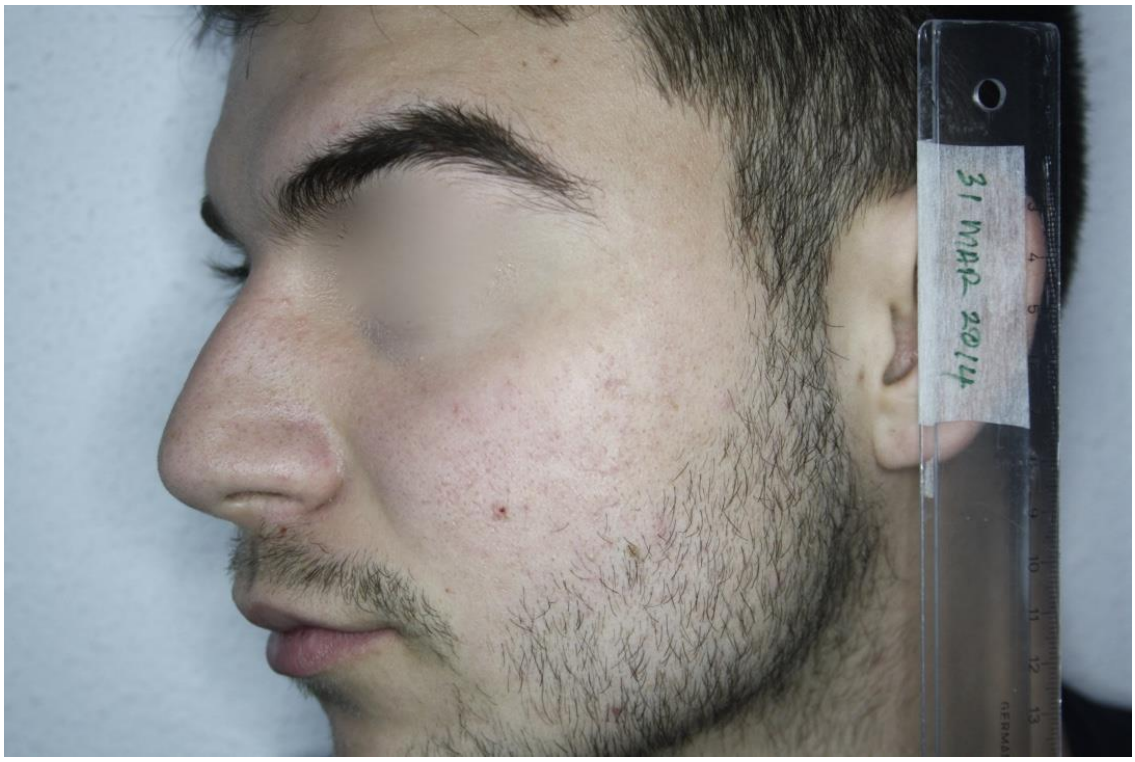


Figure 1.3 c and d – After treatment - complete remission of lesions with no post acne scarring.[6]



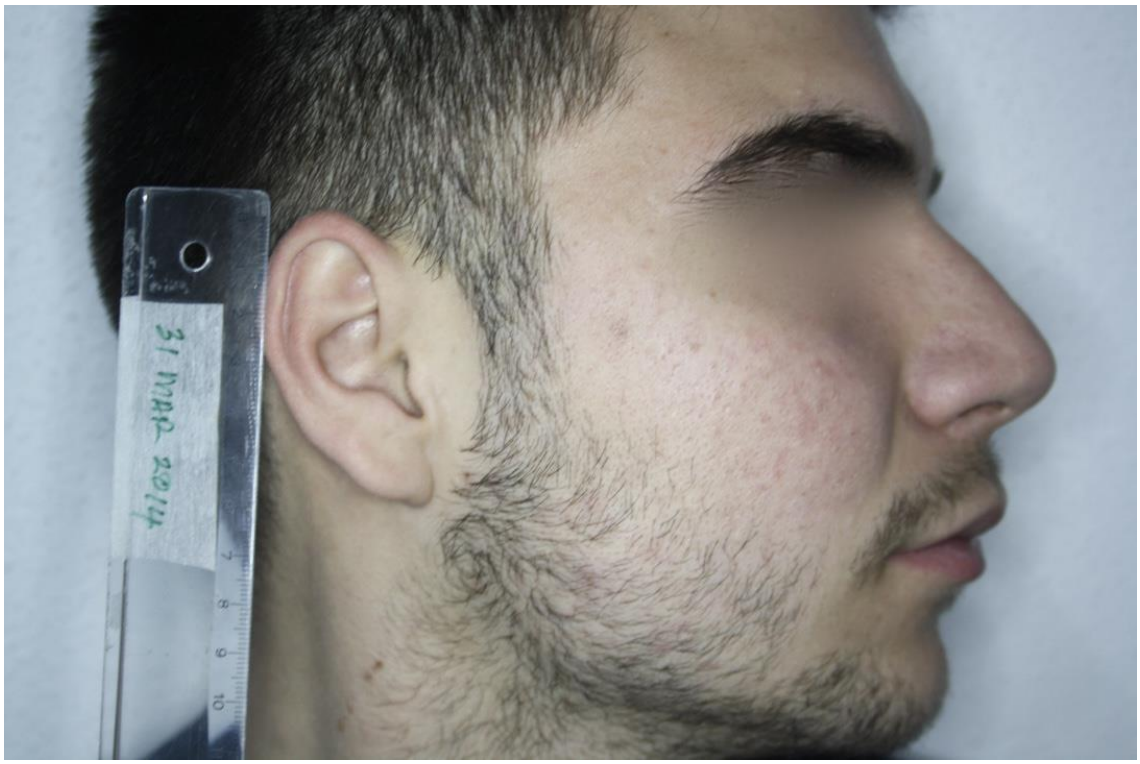


Figure 1.3e and f – before treatment – Papular and pustular lesions with some closed comedones more pronounced on the right cheek. This patient received *Palladium metallicum*[6]

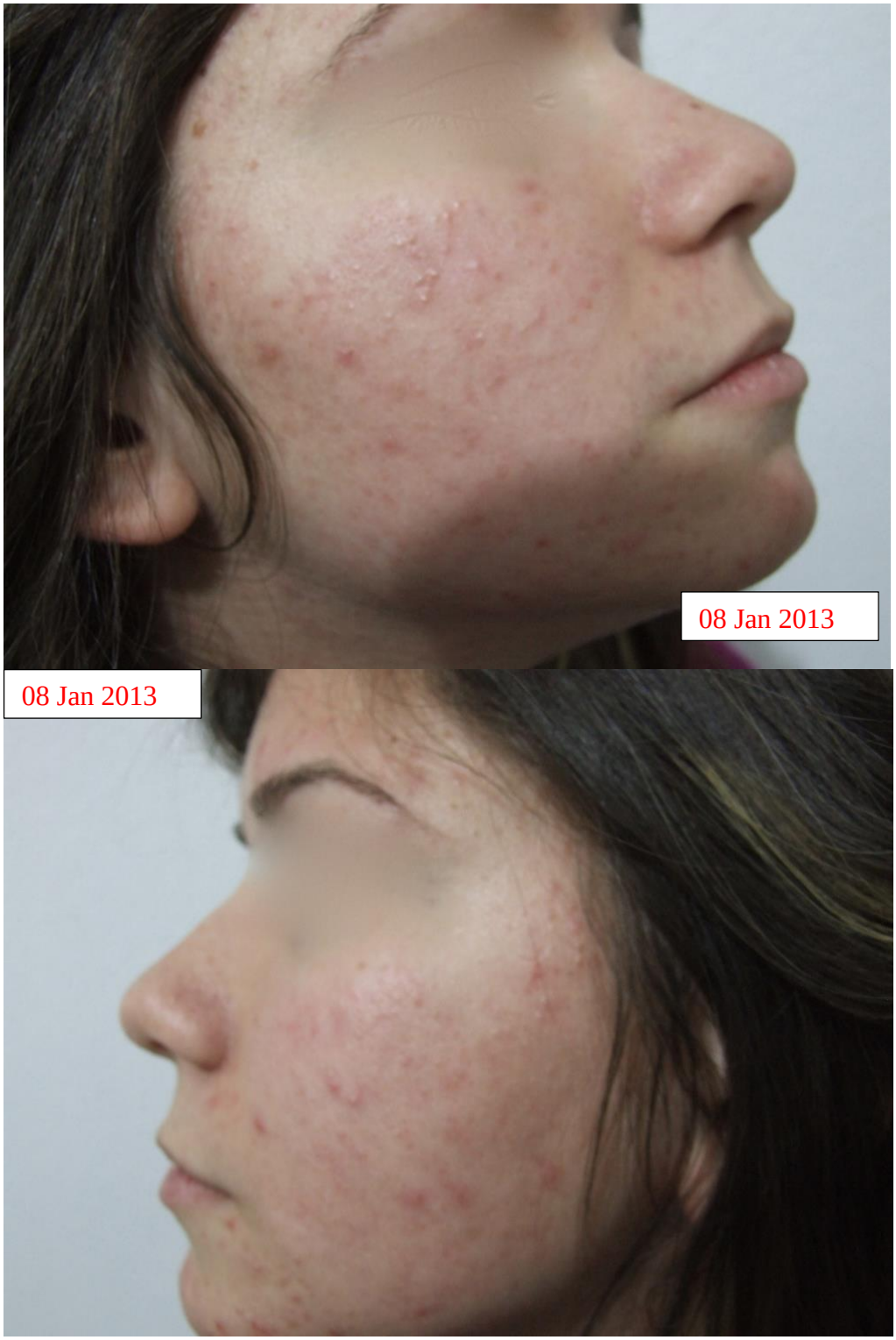
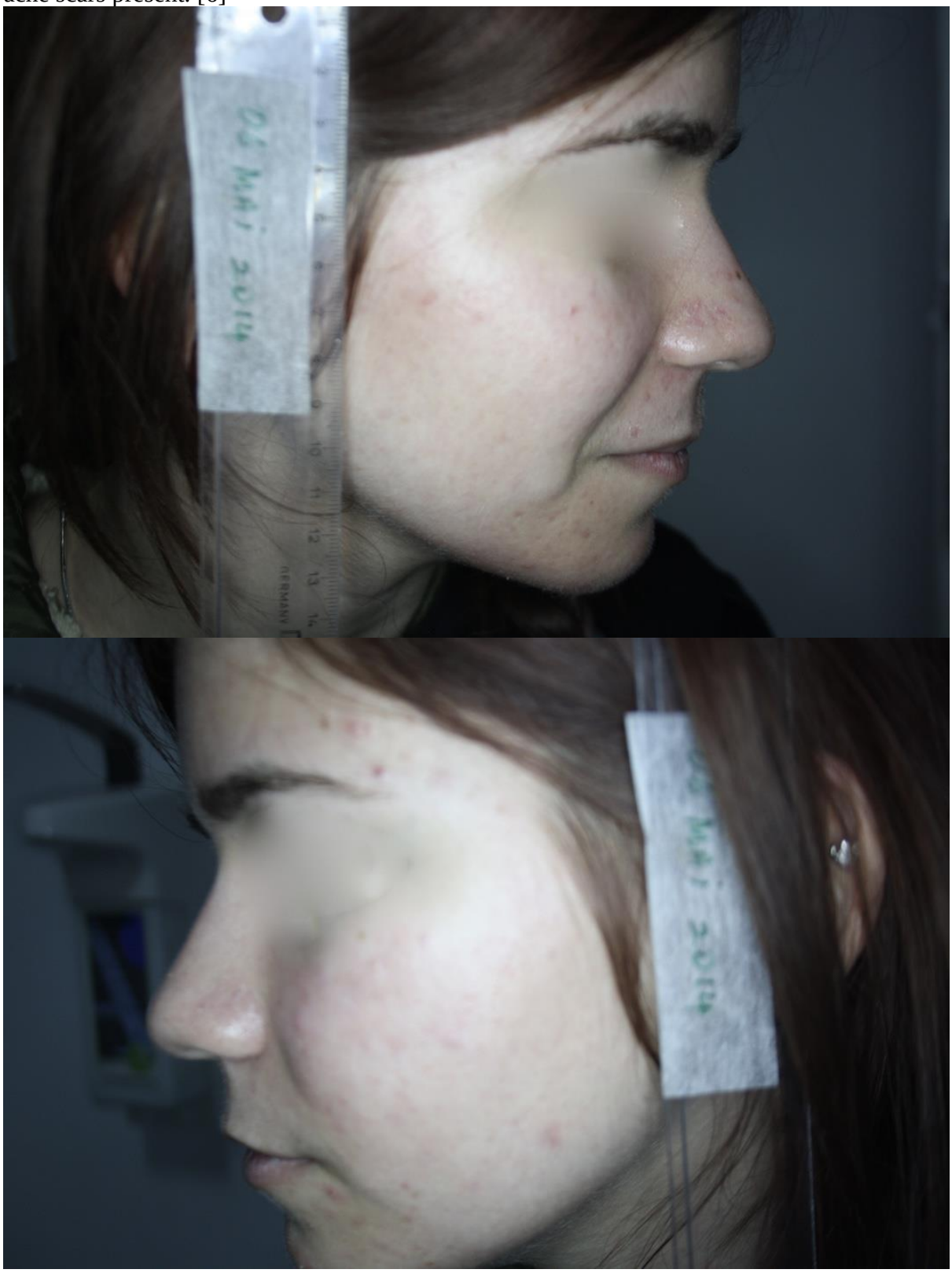


Figure 1.3g and h – after treatment – patient in remission, no acne lesions seen, with no post acne scars present. [6]



2 Homeopathy in the treatment of verruca vulgaris

Introduction:

Verruca vulgaris or viral warts is a common viral infection that is caused by the human papilloma virus. It is a benign disorder that commonly remits spontaneously. As it can sometimes be painful and may present aesthetic problems, treatment is frequently recommended. The latter is of importance in children, who may be excluded from group events at school, for fear of spread to other children, with potential adverse psychological consequences. Unfortunately, in some cases, infections may be resistant to treatment and, in such scenarios, other therapies such as homeopathy may prove to be useful.

2.1 "Homeopathy remits long-standing, recalcitrant warts"[7]

This study was a retrospective review of patients with long-standing (over 1 year) warts, which had not remitted despite standard therapy. The patients had failed to respond adequately to standard conventional therapy. They were then treated with individualised homeopathy. The response of co-morbidities to individualised homeopathic treatment was also evaluated. Photographic documentation was used for assessment of therapeutic response.

Remission of warts was the primary endpoint. The secondary endpoint was improvement of other cutaneous/systemic pathologies/co-morbidities.

Materials and methods:

A total of 8 patients with long-standing, non-remitting viral warts, treated with classical, individualised homeopathy, were included in the study. Photographs of lesions were taken before, during and after treatment. These, together with the review of the case files, were used as the data source for the study.

The characteristics of the study group were –

average age 34.1 years (range 14-42 years),

sex ratio 1F:7M,

average duration of warts 4.8 years (range 1-19 years)

Location of lesions was

- hands (3 cases), feet (3 cases), face (1 case), inguinal (1 case), genital (1 case), with some patients having multiple sites of pathology. The location of the lesions on the limbs

suggested a major factor for pathology, as these areas, especially the feet, have painful lesions and may cause embarrassment in social situations such as with hand shaking, as a result, potentially impacting negatively on the quality of life of the patients. Therefore effective and rapid treatment is often a priority.

Co-morbidities were encountered in
5(62.5%) patients, including rosacea (1 case), eyelid cyst (1 case), seborrheic dermatitis (1 case), psoriasis (1 case), sinusitis (1 case), type 1 diabetes (1 case), diabetic neuropathy (1 case), with multiple co-morbidities in some patients.

Location of the lesions is summarised in Figure 2.1a below [7]

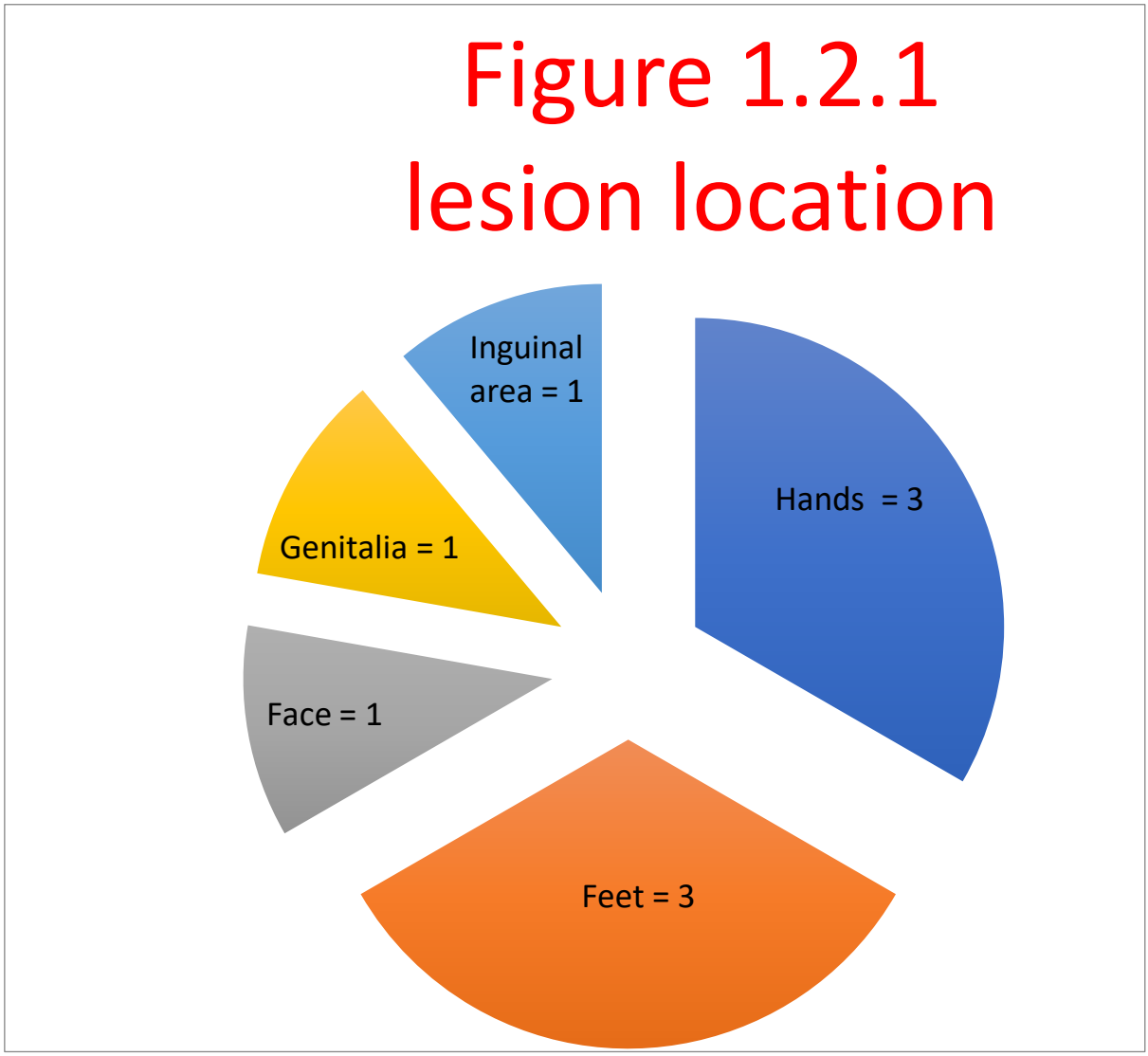


Table 2.1a Co-morbidities in the studied group (5 patients with co-morbidities) [7]

Co-morbidity	Number
Rosacea	1
Eyelid cyst	1
Seborrheic dermatitis	1
Psoriasis	1
Sinusitis	1
Type 1 Diabetes	1
Diabetic neuropathy	1

Results:

A total of 7 (87.5%) patients experienced complete remission of lesions. Average time to full remission was 5.6months (1.5-24 months). Only one case (12.5%) failed to respond.

Concomitant improvement in comorbidities was observed in 4(80%) patients, including improved glycaemic control and remitted psoriasis.

The failed case had sinusitis as a co-morbidity, which also failed to respond.

Table 2.1b Results of Homeopathic Treatment

Criterion	Remission Number (%)	Average time (months)	Failed Number (%)	Co-morbidity improvement
	7(87.5%)	5.6 (1.5-24)	1 (12.5%)	4(80%)

Discussion:

Although a small cohort, these patients had long-standing, recalcitrant warts, which had failed to respond to traditional therapies and they had responded positively to individualised homeopathy (81.5% of cases). An 80% improvement in co-morbidities was observed. Individualised or classical homeopathy is known to be holistic in effect, thus ameliorating the target pathology as well as other co-morbidities.

Verruca vulgaris is recognised as a viral infection. There were genital and inguinal lesions seen in my study group. There were no side-effects reported in this study. This study showed that homeopathy may be a useful systemic antiviral, without the downside of potentially severe side-effects of conventional antivirals. In this study, individualised homeopathic therapy also showed its potential for efficacious treatment of potentially sexually transmissible diseases such as genital and inguinal warts.

In conclusion, my results suggest that recalcitrant, long-standing warts may benefit from individualised homeopathic treatment.

2.2 "Homeopathy in the treatment of verruca vulgaris – an experience of two cases" [8]

I published a case study (n=2) of patients with recalcitrant verruca vulgaris and Type 1 diabetes mellitus, treated with classical individualised homeopathy.

The first case was a 42-year old female with a 5-year history of verruca vulgaris in the periungual area of her left thumb and her right first toe, which recurred in spite of repeated topical therapy. Her medical history was significant for insulin-dependent diabetes mellitus

and peripheral neuropathy. The latter disorder was being treated with oral alpha-lipoic acid. On physical examination she had a hyperkeratotic lesion on the lateral side of her left thumbnail and on the medial side of her right large toenail. There was partial onycholysis of the toenail (Fig 2.2 a+b). General examination revealed nothing clinically significant and her glycated haemoglobin (HbA1c) was 10%. She was prescribed a weekly dose of the homeopathic medicine *Sepia* at the potency of MK, on a weekly basis and the lesions healed completely at 6 weeks after commencement of treatment(Fig 2.2c+d). At 3 months after commencement of treatment her HbA1c had dropped to 9%, without any change in her anti-diabetic treatment. She also had a small change in her C-peptide levels (0.733ng/ml from 0.799 ng/ml).

The second case was that of a 19-year old female high school student who presented with painful left plantar warts of 4-months duration that recurred after topical treatment. Her medical history was significant for Type 1 diabetes mellitus for 10 years and peripheral neuropathy. She was receiving oral benfothiamine for the latter disorder. Physical examination showed a single, tender, hyperkeratotic papule on her left sole(Fig 2.2e), over the area of the 1st metatarsophalangeal joint. General examination showed no significant abnormalities. Her HbA1c was 9.1%. She was prescribed a weekly dose of the homeopathic medicine *Aurum metallicum*, at a potency of MK. At the follow-up visit 2 months after the onset of her homeopathic treatment, her lesion was significantly improved, while at 6 months, completely remitted(Fig 2.2f). Her HbA1C level at 6 months after treatment had dropped to 6.8%, with no change in her anti-diabetic therapy.

No adverse effects of treatment were recorded in either of these two cases.

I was able to conclude that homeopathic treatment has the potential to be a useful form of therapy for recalcitrant viral warts in patients with diabetes mellitus and may also concurrently help to improve diabetes control.

Large, controlled studies would be useful to help confirm these conclusions and may indicate a role for homeopathy in the treatment of verruca vulgaris.

Fig 2.2a and b – Hyperkeratotic papule on medial margin of the right first toenail, with partial onycholysis.[8] Hyperkeratotic papule on margin of the left thumb

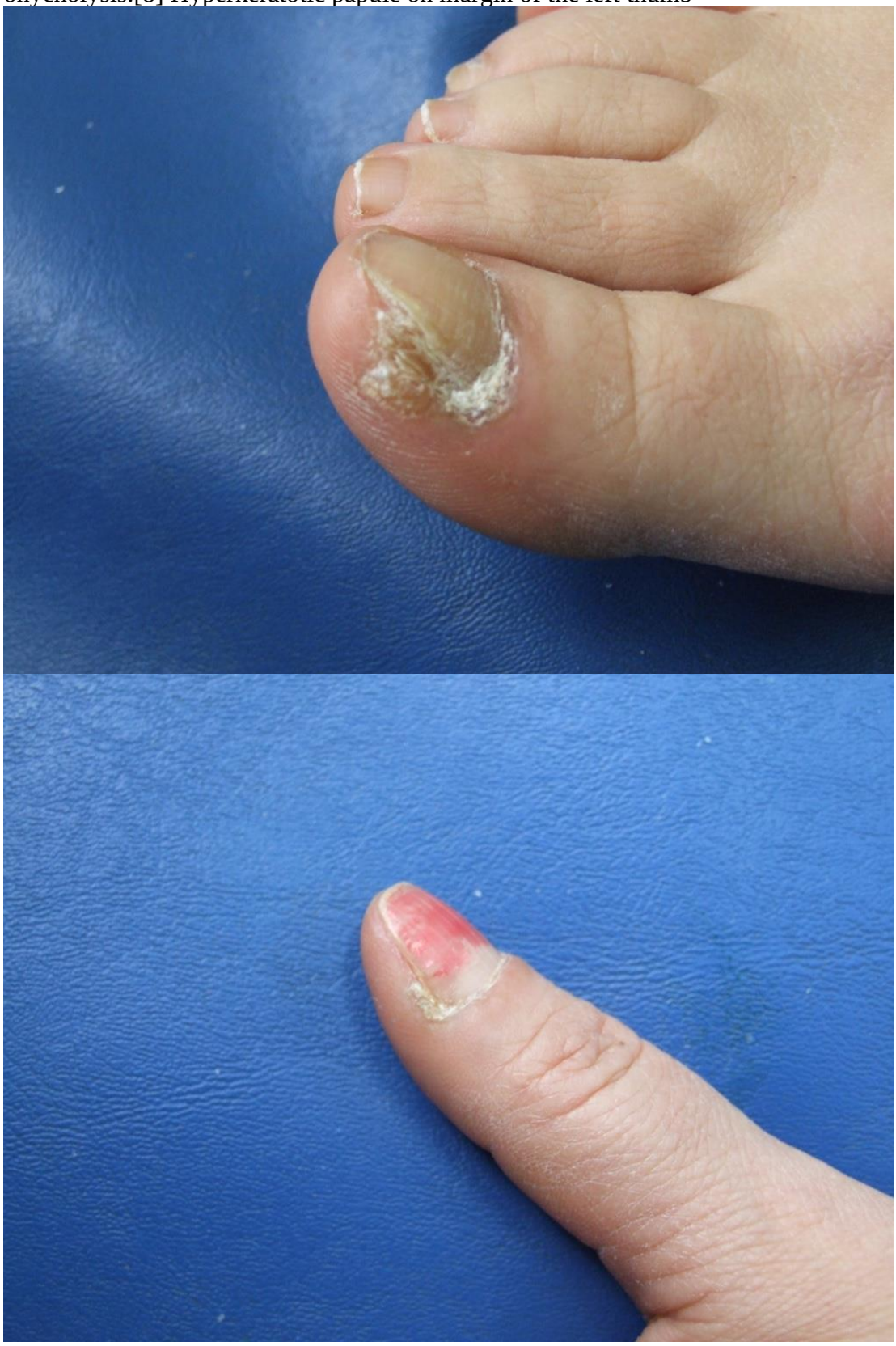


Fig 2.2c and d Healed fingernail and toenail lesions [8]

Figure 2.2e – Hyperkeratotic papule on the plantar surface over the left first metatarsophalangeal joint. [8]

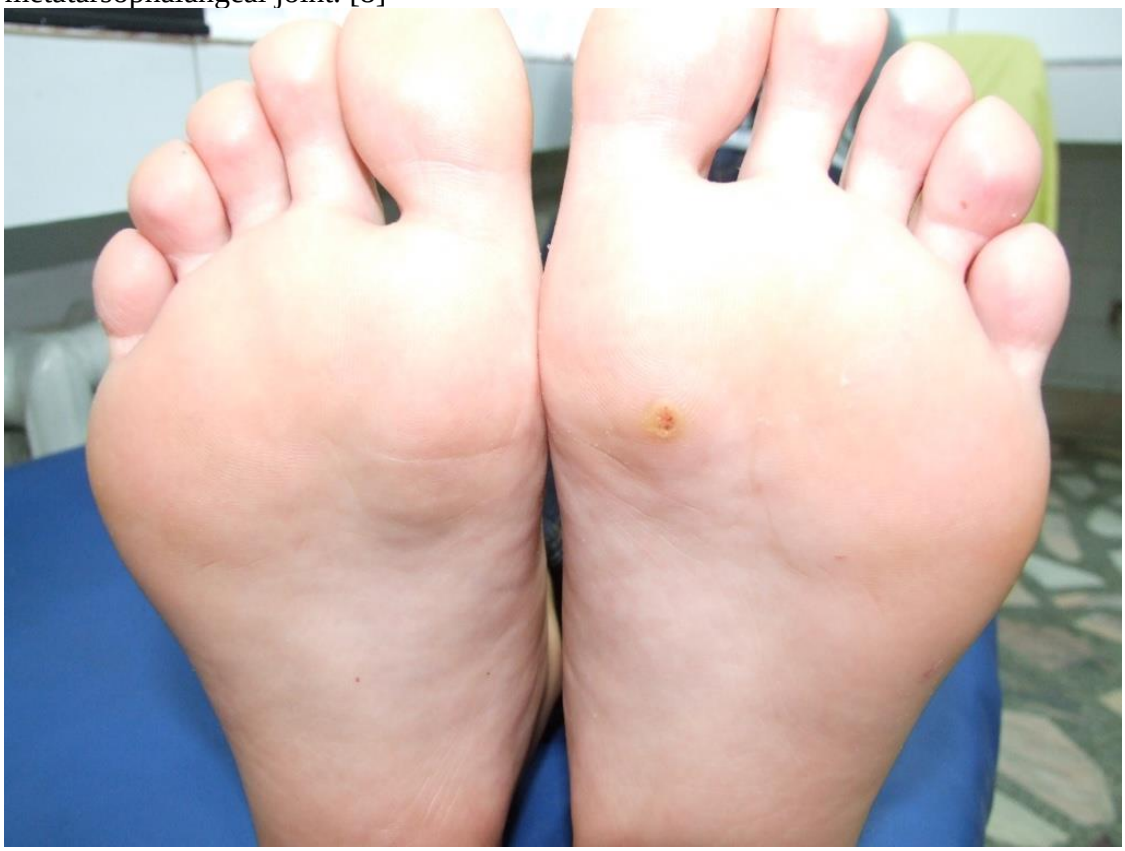
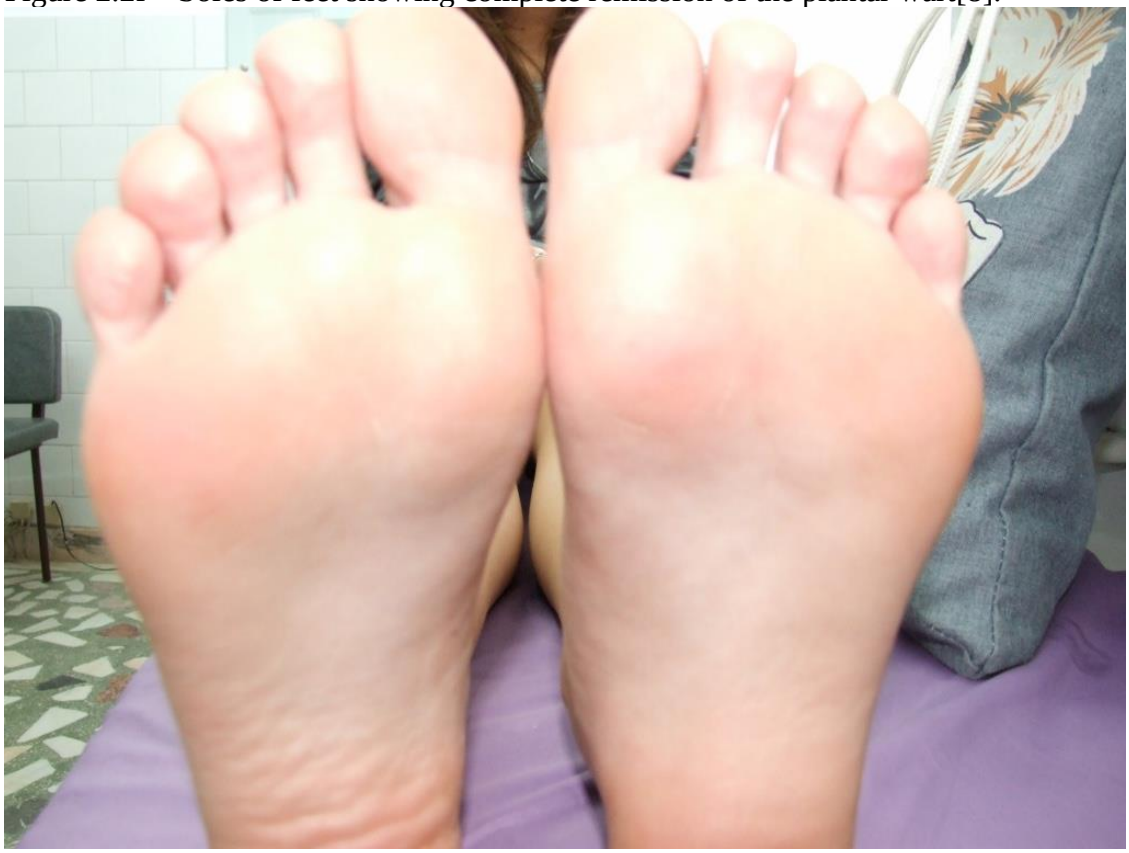


Figure 2.2f – Soles of feet showing complete remission of the plantar wart[8].



Discussion

Verruca vulgaris is a commonly encountered viral infection. Treatment modalities vary, including topical keratolytics, excision, electrotherapy and laser therapy, amongst others. Recurrence and spontaneous remission with relapse are frequently encountered. Longstanding, recalcitrant lesions may present therapeutic challenges. My case series and my case report suggest that homeopathy may be a useful therapy in the therapy of recurrent/recalcitrant verruca vulgaris, which is itself a viral infection. This raises the question of whether there is an antiviral effect of homeopathy. The patients suffered no adverse effects and co-morbidities improved. These are significant advantages, which should be taken into account in the choice of treatment modality for viral warts.

3 Homeopathy in the therapy of psoriasis

Introduction:

Psoriasis is an inflammatory, predominantly skin disorder and is also considered an autoimmune disorder by many workers. It has a worldwide frequency of about 2-3%. It is associated with a number of comorbidities such as cardiovascular disease, diabetes mellitus, hepatitis B and C, renal failure, asthma, malignancy and peptic ulcers [9].

3.1 "Psoriasis and homeopathy" [11]

I published a case series (n = 4) on the response of patients with different forms of psoriasis to classical homeopathic treatment[11]. The forms of psoriasis treated were scalp psoriasis, nail psoriasis and generalised psoriasis vulgaris.

Case 1 - A 14-year old male patient, brought by his mother, presented with a skin rash involving the scalp and ears. It had begun 11 years prior to presentation. It had initially affected the left ear, with relapses and remissions and remained stable in the 1 year preceding this presentation. The scalp rash appeared about 1 month before presentation. He had been on topical steroids with temporary relief. His medical history was significant for a penicillin allergy. On examination, a well-defined erythematous plaque was visible on the left preauricular area. Thick, white, adherent squames, covering the central scalp could also be seen. General examination was insignificant. The patient was recommended homeopathic *Lycopodium* at C200 potency, to be administered weekly and a bland hydrating cream.

Follow-up three weeks later showed an aggravation of the lesions with fissuring in the area of the left lobe, which worried his mother. His prescription was changed to homeopathic *Lachesis* at C200 potency, also administered weekly. He began to show improvement by weeks 1 and 2 after initiation of *Lachesis* and by 2 months following *Lachesis*, the patient was already almost lesion-free in the scalp area and much improved in the preauricular area. At 4 months post-treatment both scalp and periauricular lesions were almost in full remission. At 5 months after onset of *Lachesis* there appeared to be a mild relapse. The treatment was repeated. The patient improved, became fully remitted and remained lesion-free. According to his mother, at our last conversation, this patient had been sent abroad for his university studies, but had remained in remission.

Case 2 - A 66-year old male presented with a three-month history of generalised rash following the shock of the news of the accidental self-poisoning by his daughter. The lesions

were occasionally itchy. His medical history was significant for mild hypertension for which he was on observation only. Physical examination showed well-defined, erythematosquamous plaques, with a generalised distribution as well as adherent squamous plaques on his scalp. Nothing significant was observed on general examination. He was prescribed homeopathic *Sulphur* at MK potency, to be administered weekly and a sulphur-based cosmetic cream for his itch. At his follow-up visits at 1 and 2 months, he showed marked improvement and, at 4 months, he showed almost complete clearing. He was still in full remission 2 years after cessation of treatment, with the exception of a few mild erythematous lesions in his elbow areas.

Case 3 - A 42-year old male presented with a 10-year history of a generalised skin rash, which also involved the scalp. It had responded variably to a number of topical and systemic therapies. His past medical history was insignificant. Physical examination revealed generalised, well-defined, erythematosquamous plaques, as well as diffuse, erythematous and squamous lesions on the scalp. He received homeopathic *Lachesis* at MK potency, weekly administration. At his 1-month follow-up, his general state was improved and there was an aggravation of his lesions. For financial reasons – the patient resided in another city – he did not return for follow-up, but reported an amelioration of his skin lesions and he sent photographs by email. He remained lesion-free, with the exception of occasional mild, transitory relapses at the onset of winter.

Case 4 - A 29-year old female presented with a 1-year history of nail disease and skin rash. The patient described the nail disease as small, fluid-filled, periunguual lesions associated with thickening and discolouration of nails. She had previously suffered from palmar, squamous lesions and had been treated with topical steroids for a diagnosis of psoriasis. Her medical history was significant for an appendicectomy at 12 years of age, left facial palsy 3 months before onset of psoriasis, duodenal ulcer and left femoral hernia, 3 months after the onset of psoriasis. Examination revealed yellowish nail dyschromia with thickening and dystrophy of some fingernails and toenails. There was also accompanying periunguual hyperkeratosis, but no vesicles or pustules. Mycology showed rare fungal hyphae. She was prescribed homeopathic *Arsenicum album*, MK potency, weekly and a 10% urea cream to be applied around the nails. At her 6-week visit she reported substantial improvement in her general state and felt able to resume many activities, although there was a mild worsening of her palmar lesions. There was improvement observed with each subsequent visit. She reported pregnancy (6 weeks gestation) at 5 months after onset of treatment, with nail growth and improvement of her periunguual lesions, although she had

ceased treatment 2 weeks prior to this visit. The patient was still not satisfied with her progress and her treatment was reviewed and changed to homeopathic *Lycopodium* at MK potency. She returned 9 months later and reported that her nail lesions were completely healed, with the exception of her right ring fingernail, which, though improved, was still not completely healed. She became lost to follow-up and returned about 3 years ago (2019), for treatment for her daughter. She herself had not had any new episodes of psoriasis in this period (about 10 years).

Figure 3.1a – Patient (Case 2) with erythematosquamous plaques on trunk and limbs (date of photograph 13 Jul 2009)[11]

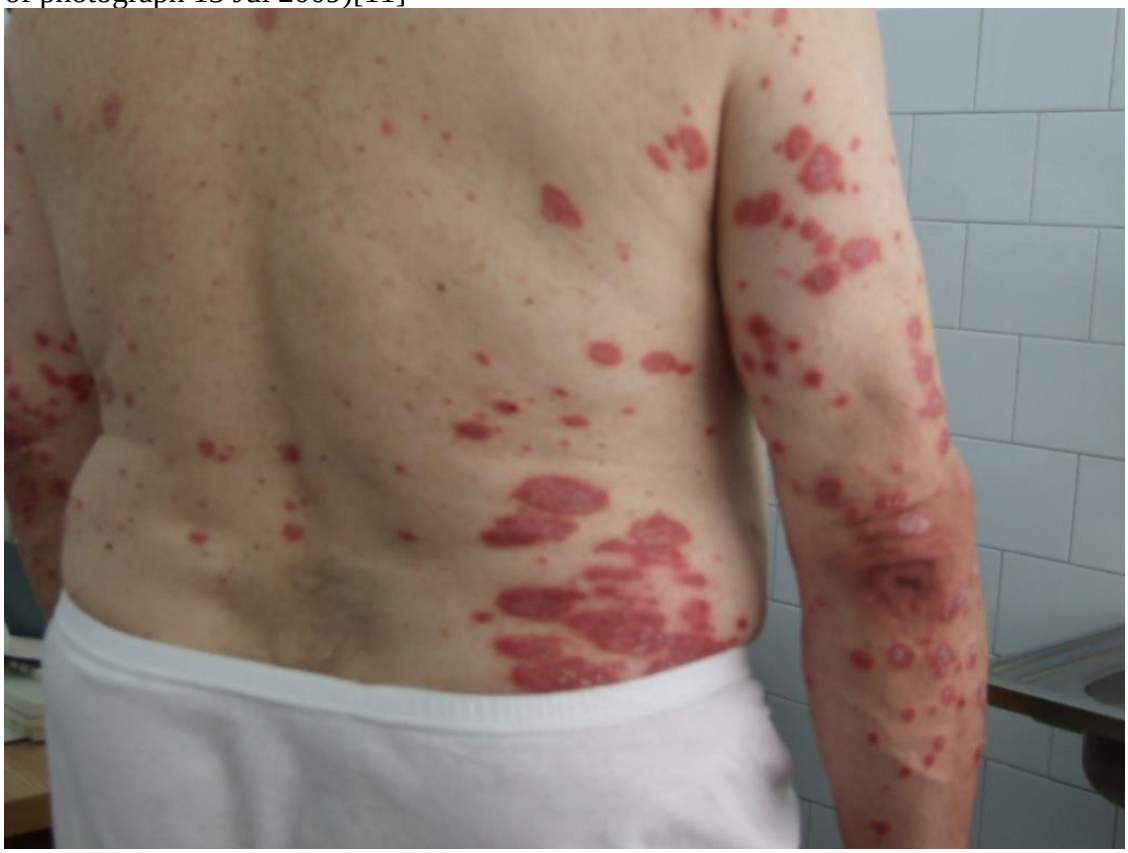


Figure 3.1b – Patient (Case 2) in remission at 4 months treatment (date of photograph 27 Nov 2009)

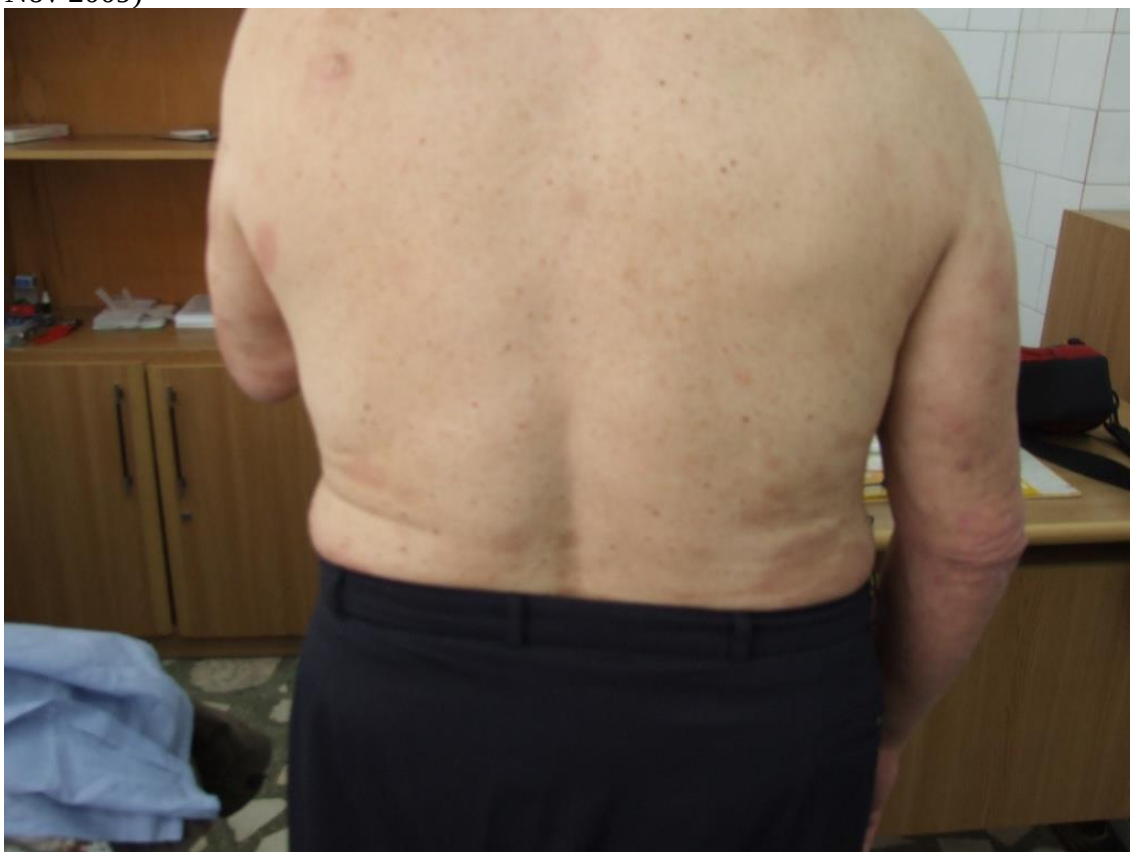
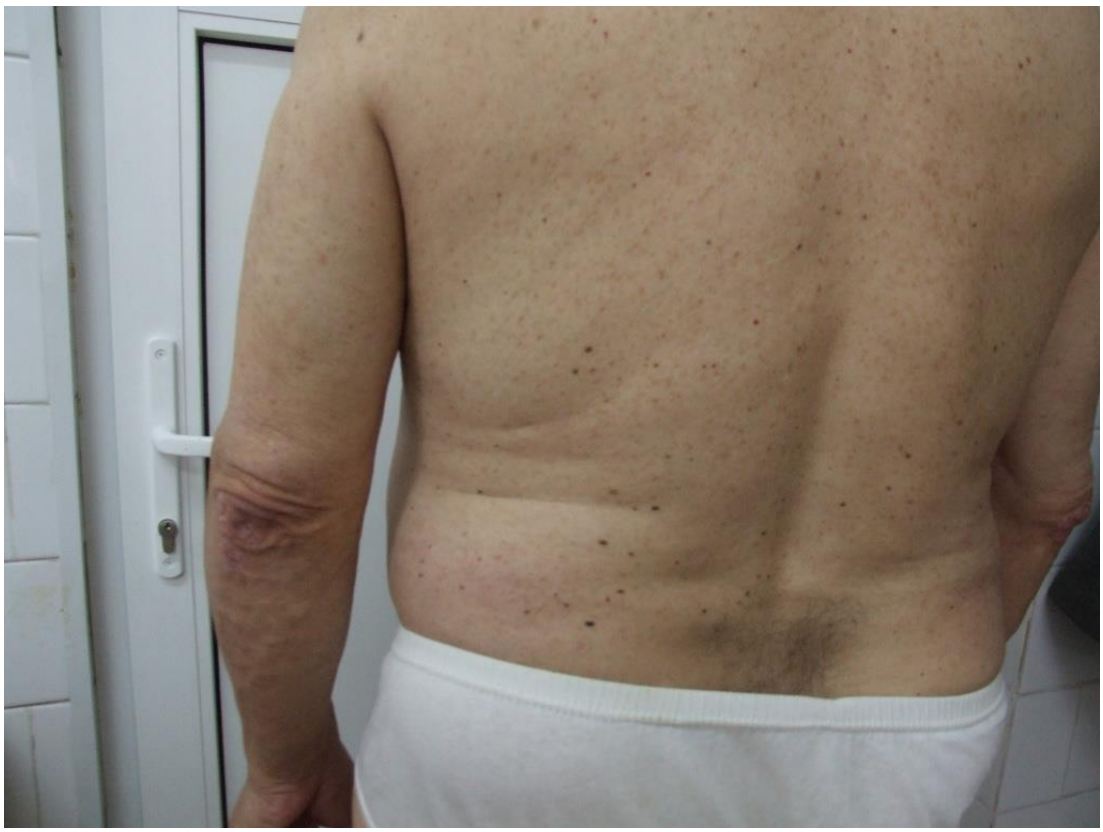


Figure 3.1c – Patient (Case 2) in remission at 2 years after cessation of remission (date of photograph 24 Nov 2011)[11]



3.2 "Palmar and plantar psoriasis and homeopathy – case reports" [12]

Introduction:

This subset of psoriasis is thought by some to be a distinct phenotype and to affect about 3-4% of patients with psoriasis[13]. It presents distinct problems for patients as it has an impact on mobility and the ability to work. There are also obvious therapeutic challenges, that result from the nature of the affected area, as not all therapies for psoriasis are suited to the palmar and plantar areas.

I published a case series (n=3) of patients with long-standing palmar and plantar psoriasis treated with individualised homeopathic medicine[12] and followed up for up to 2 years.

Case 1 - A 55-year old female presented with a 4-month history of rash on her left sole as well as left large toenail dystrophy. Medical history was significant for Type 2 diabetes mellitus and hypertension. Examination revealed a single, hyperkeratotic plaque, with vesicles on her left sole. She also had a hyperkeratotic area of skin on her left big toe, with nail dystrophy. Fungal examination was negative. She had been treated unsuccessfully with a topical steroid cream, followed by a herbal preparation. She was prescribed homeopathic *Staphysagria*, at MK potency, weekly. She went into remission in 6 months, but relapsed. Review showed that she had been on angiotensin converting enzyme (ACE) inhibitors. After discussion, the cardiologist changed her medication to verapamil and she went into remission once again, with growth of nails and clearance of the toe and plantar lesions.

Case 2 - A 65-year old female presented with a 4-year history of palmar rash, which had been unsuccessfully treated as eczema and fungal infection. Examination revealed erythematous plaques on palms of hands. Biopsy confirmed psoriasis. The patient received homeopathic *Lycopodium*, MK potency, weekly, with remission within 3 months. She remained in remission 2 years later.

Case 3 - A 64-year old male presented with a history of generalized rash of 30 years duration. It was associated with intense itch. The rash was also present in the palmar and plantar areas, manifesting as hyperkeratosis and fissuring with erythema and mild swelling. The palmar and plantar involvement was a source of distress for him both personally and professionally as the patient was a driver by occupation . A punch biopsy was done, which confirmed the suspected diagnosis of psoriasis. He was prescribed homeopathic *Tuberculinum* at MK potency, weekly dosage, homeopathic *Sulphur* at CH30 potency to be taken as needed for the itch, as well as bland soaps and emollients. The patient improved

gradually with marked improvement of the palmar and plantar areas at 4 months after the commencement of treatment and improvement of other skin areas, together with reduction in intensity of the itch. The palmar and plantar lesions were in full remission at 1 year, together with most body areas and he became lost to follow-up

Figure 3.2a – (Case 3) palmar hyperkeratosis, with erythema and fissuring. [12]

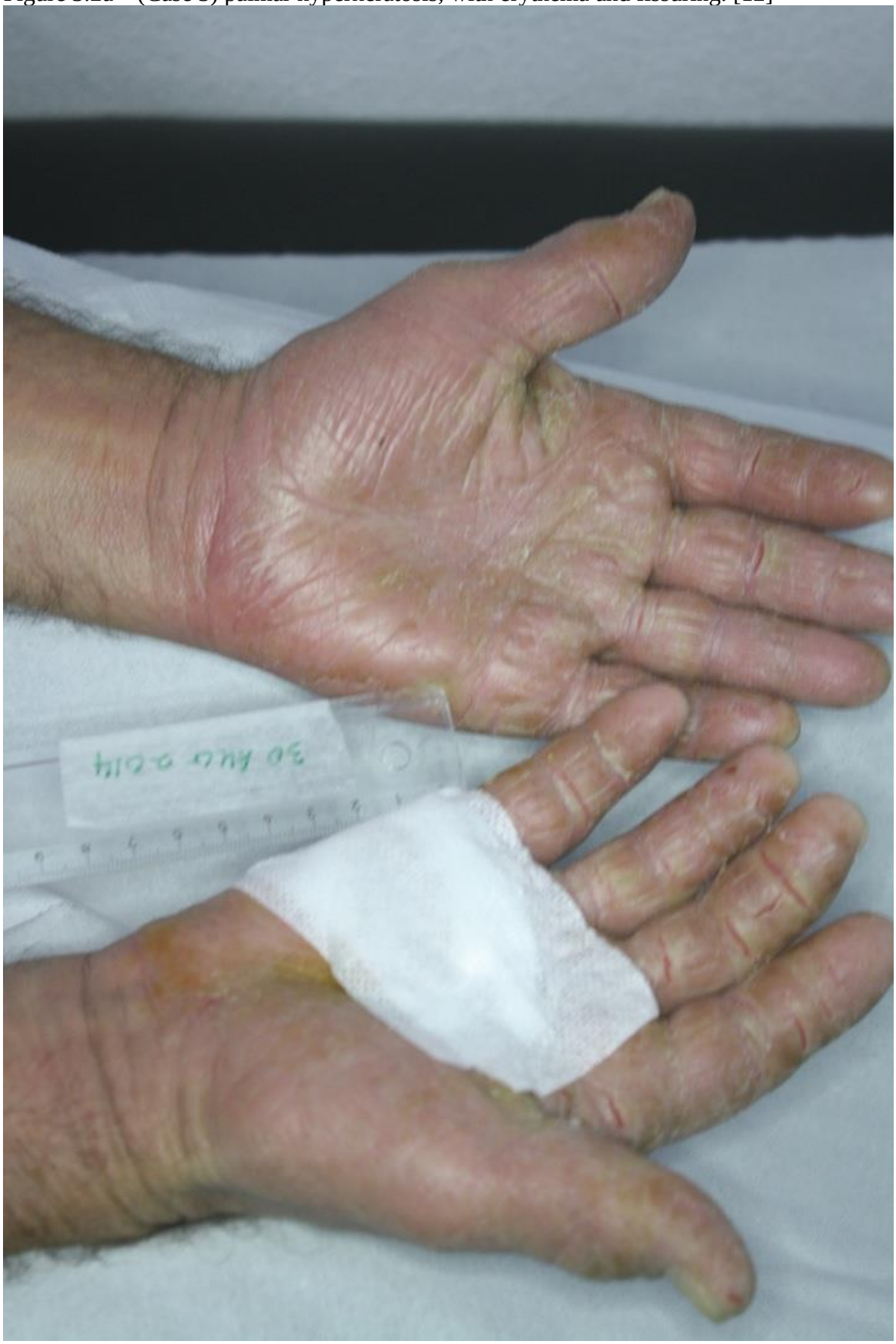


Figure 3.2b – (Case 3) Plantar hyperkeratosis of left foot with fissuring[12]

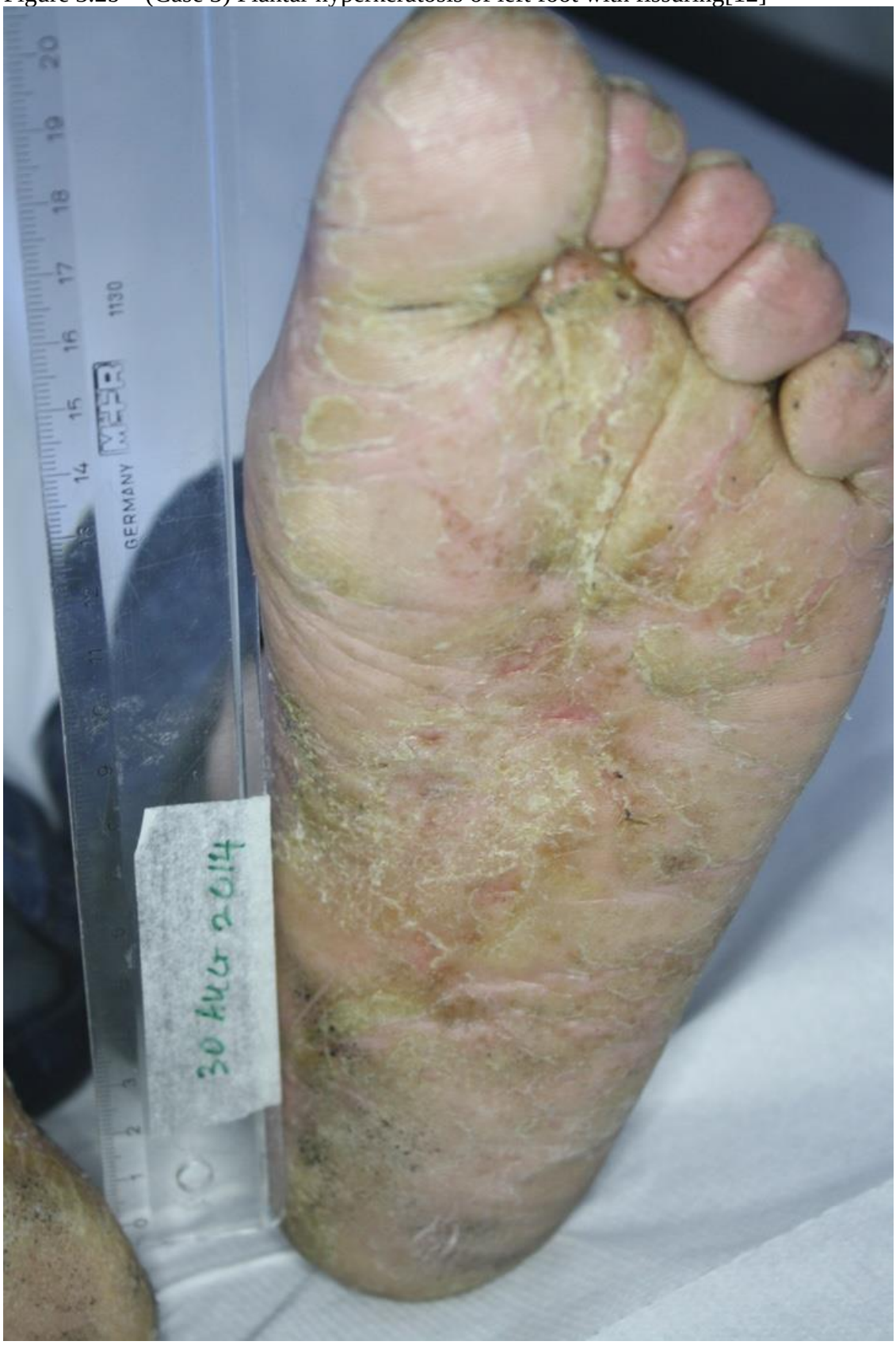


Figure 3.2c – (Case 3)Plantar hyperkeratosis of right foot with fissuring[12]

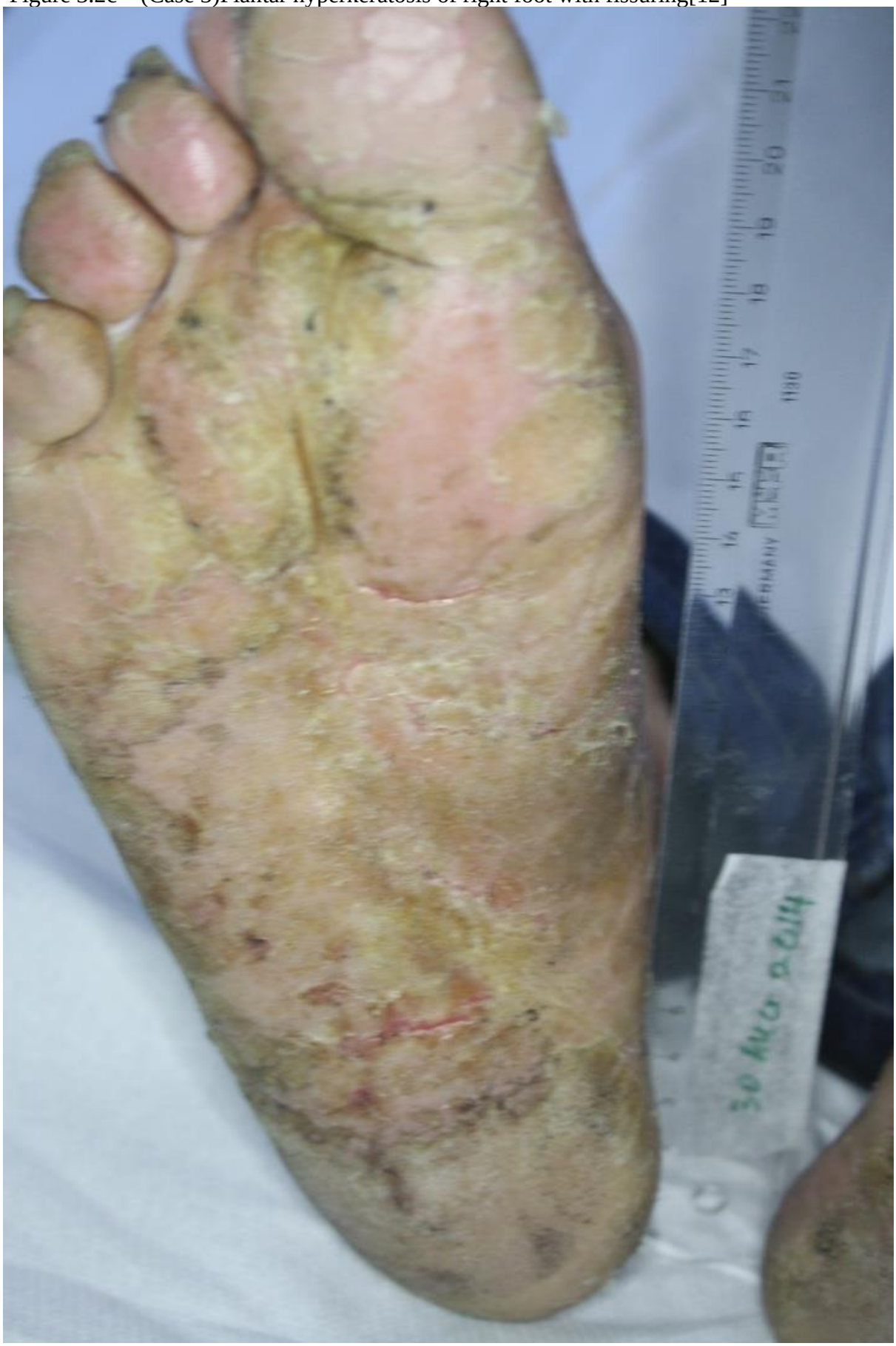


Figure 3.2d – (Case 3)palmar lesions in remission[12]

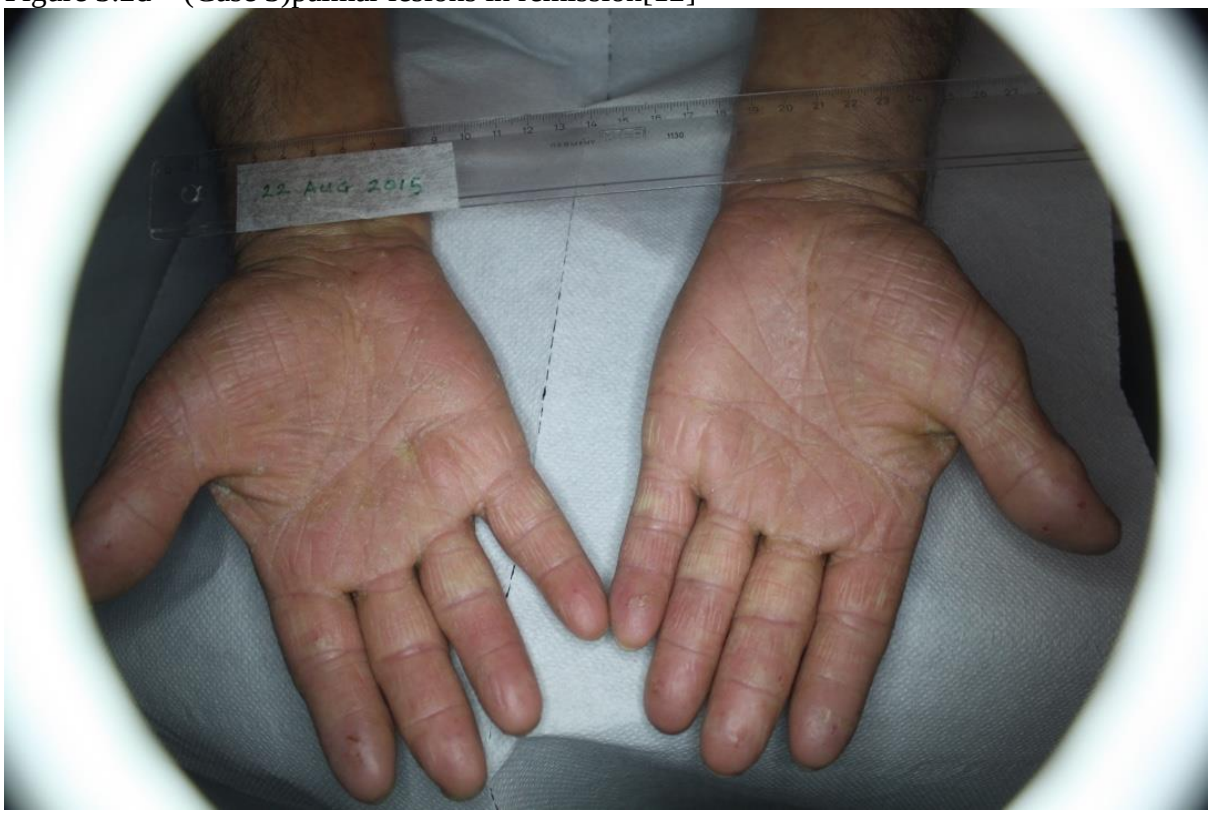
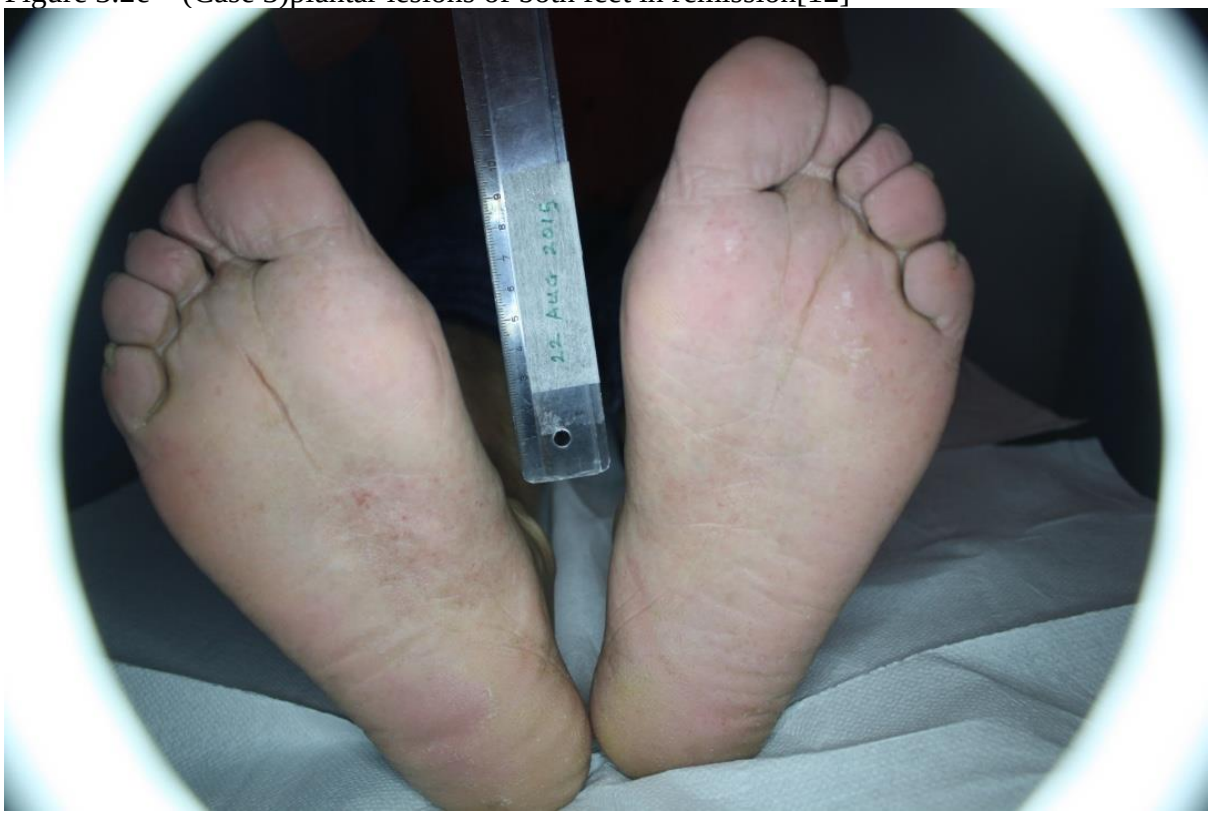


Figure 3.2e – (Case 3)plantar lesions of both feet in remission[12]



3.3. Homeopathic Treatment of Long-Standing Psoriasis –Two Case Reports and Discussion [14]

Introduction:

Long-standing psoriasis can pose problems for patients. The aesthetic aspect of the disease, as well as the complications of treatment may reduce the patients' quality of life. I presented two cases of long-standing psoriasis – stable classic form and erythrodermic form – detailing the patients' progress in order to show homeopathic physicians what to expect during a successful homeopathic treatment for psoriasis.

Case 1 - A 56-year-old male presented with a 17-year history of skin eruption all over his body. It had begun as a small lesion on his right leg, which then spread to involve his entire skin surface. Approximately 1 month prior to presentation, he developed a pustular eruption. He had been treated with topical and systemic steroids (the latter was prescribed for his pustular rash), as well as emollients and antipruritic creams. No preceding history of stressful trigger could be elicited. His medical history was significant for an episode of tachycardia (arrhythmia) and poor sleep. The patient had smoked over 20 cigarettes daily for 30 years and drank alcohol, with occasional episodes of excess. Physical examination revealed erythematosquamous papules and irregular erythematous patches with a background of erythema on the trunk and limbs. Thickening with whitish discolouration of the toenails, intense erythema affecting both lower limbs and oedema of the feet, features which are all suggestive of erythroderma, could also be seen. The patient was prescribed the homeopathic medicine *Sulphur* at 1MK potency, one dose weekly, and returned for follow-up six weeks later. At six weeks after the commencement of treatment, the patient returned feeling better and reported a worsening of his psoriasis on the 4th or 5th day after commencement of treatment. This had manifested as the appearance of new lesions, with associated itching, as well as with intensification of some old lesions, manifesting as increased redness and enlargement. At this week six follow-up there were now new, more stable rashes on his neck and trunk, but his old trunk lesions were no longer visible. There were still lesions on his limbs, but the background erythema and pedal oedema were diminished and there an improvement in appearance of his toenails. The patient reported better sleep though it was still unrefreshing. He was asked to continue *Sulphur*, MK, potency weekly for a further 8 weeks, together with emollients. He returned 12 weeks later (with 18 weeks of total treatment) and reported that he was feeling much better with no new lesions and the disappearance of the old lesions. He was having improved sleep and awakening more refreshed. He had experienced some weight loss, partly due to a change in diet. Only a few

plaques on the arms and the forearms were visible on physical examination. Also, the lower limbs were better and his toenails showed improvement. Another 8 weeks of *Sulphur* MK potency was recommended weekly. He returned at 6 weeks (24 weeks of treatment) reporting that he was feeling much better, although he had developed some new lesions on his upper limbs. Sleep remained good and he had lost 7-8 kg since the onset of treatment. Skin examination revealed a few limb lesions, no background erythema with improvement of toenail lesions. The patient was lost to follow-up after this.

Case 2 - A 32-year-old female presented with an 8-year history of psoriasis. Her lesions had first appeared on the elbows and spread to her scalp, knees, legs and inguinal areas. No family history of psoriasis or other illness could be elicited and the patient smoked about 20 cigarettes daily for the past 20 years. Also, the patient had restless sleep, and awakened unrefreshed. She was also chilly, i.e. intolerant of cold. Physical examination revealed erythematosquamous plaques on her elbows, knees, right leg and dorsum of her left foot. The diagnosis of psoriasis vulgaris was made. She was prescribed homeopathic *Lycopodium clavatum* at MK potency, one dose every week and bland emollients. She returned at 9 weeks after the commencement of treatment and reported an increase in the size of her skin lesions. Although her sleep was still restless, she reported awakening refreshed. Clinical examination showed larger, though less erythematous plaques, which were covered by thinner squames. The patient was recommended a continuation of the homeopathic *Lycopodium clavatum,* MK potency, weekly dose, along with the emollients. She returned 8 weeks later for a follow-up (at about 17 weeks of treatment). At this visit she reported a pregnancy of approximately 12 weeks gestation and mild nausea. Sleep was considerably improved and was refreshing. She felt her skin lesions were better. Physical examination showed increase in the size of her plaques, but with thinner, fewer squames and central clearing of the psoriatic plaques. The patient was recommended a continuation of the *Lycopodium clavatum,* MK potency, weekly dose, and homeopathic *Tabacum*, C15 or C30, potency as needed, for nausea and to continue using the emollients. She was seen in the clinic 8 weeks later at about 25 weeks of treatment and about 20 weeks gestation. At this visit she reported experiencing further improvement of the rash, with occasional, short-lived new eruptions and mild nausea, which did not require the use of *Tabacum*. Physical examination showed a thinning of all plaques, with minimal erythema and large areas of healed skin within the plaques. The patient was asked to continue *Lycopodium clavatum,* MK, one dose weekly, together with the emollients. After a further 8 weeks (about 33 weeks of treatment) and 28 weeks gestation she was seen once more for a follow-up visit. At this visit she reported no

new lesions. Skin examination revealed almost total remission of lesions, with only residual post-inflammatory hypopigmentation. Fifteen weeks later (48 weeks of treatment), having had a safe and uneventful delivery, with an aggravation of lesions post-partum, which lasted about and was followed by amelioration of lesions. Physical examination revealed few islands of psoriatic papules in the areas of the old plaques. She was recommended *Lycopodium clavatum,* MK, weekly dose, with emollients. She was seen 12 weeks later (60 weeks of treatment) and reported no new lesions, with skin clearance and some mild hair loss. Physical examination revealed clearing of lesions over all affected areas, with some postinflammatory leucoderma. She was recommended *Lycopodium clavatum,* MK, one dose every fortnight for 12 weeks. The patient was seen 12 weeks later (72 weeks of total treatment) and presented with small, very thin plaques on her elbows. She was enjoying caring for her baby and reported no stress, but also admitted to frequently leaning on her elbows while carrying the baby. The lesions were considered either a possible Koebner phenomenon or a possible pressure-related hyperkeratosis of the elbows. She was recommended *Lycopodium clavatum*, MK, one dose weekly for another 12 weeks. The patient became lost to follow-up, but we encountered each other about a year later while she was walking her baby in the neighbourhood. She had had no new lesions and was quite satisfied with the results of the treatment, though hoped to come in for a follow-up nevertheless. This case was illustrative of the homeopathic principle of direction of cure, i.e. from central to peripheral areas. Thus, the plaques of this female patient began to heal from the centre to the periphery, while at the same time, the erythema diminished, the thickness of the skin decreased and the squames were smaller and less coarse. This direction of gradual improvement can also be observed in other skin diseases during the course of successful classical (individualised) homeopathic therapy. Such may sometimes be seen in cases of spontaneous remission of psoriatic plaques.

Figure 3.3a – Erythematous plaques on right upper limb (Case 1)[14].

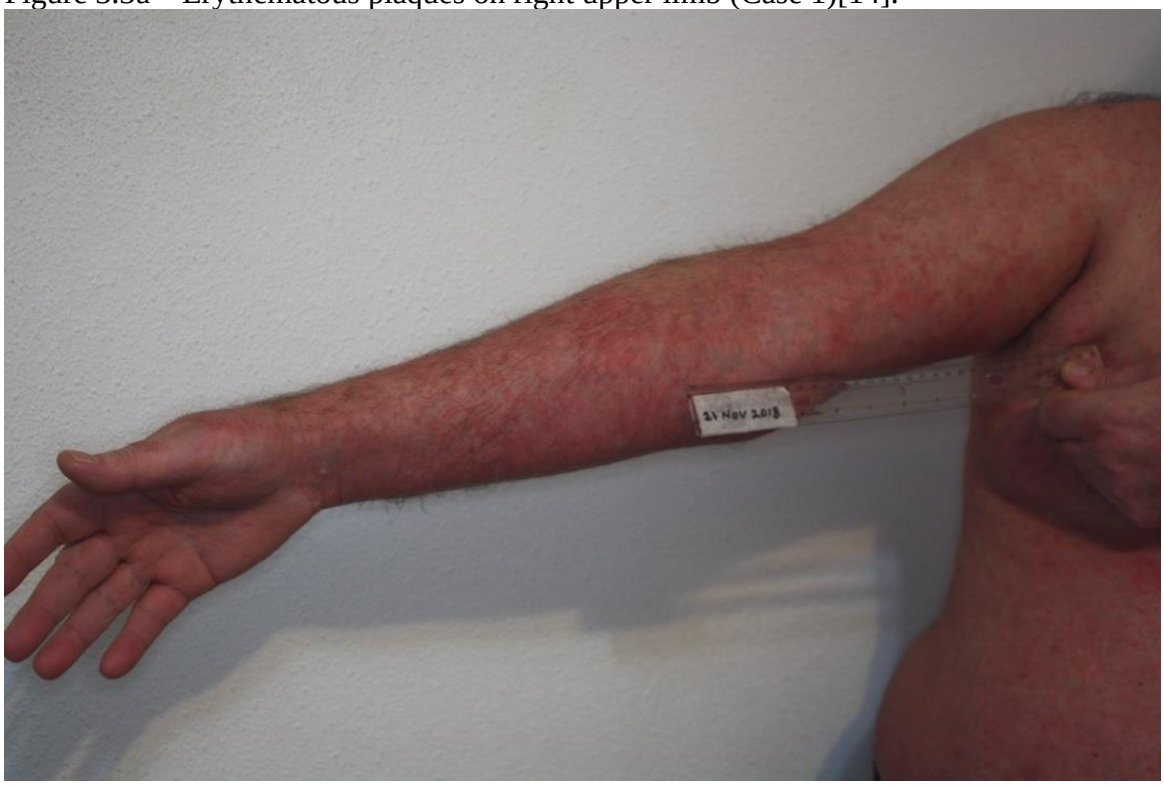


Figure 3.3b – Erythematous plaques with background erythema on lower limbs (Case 1) [14]

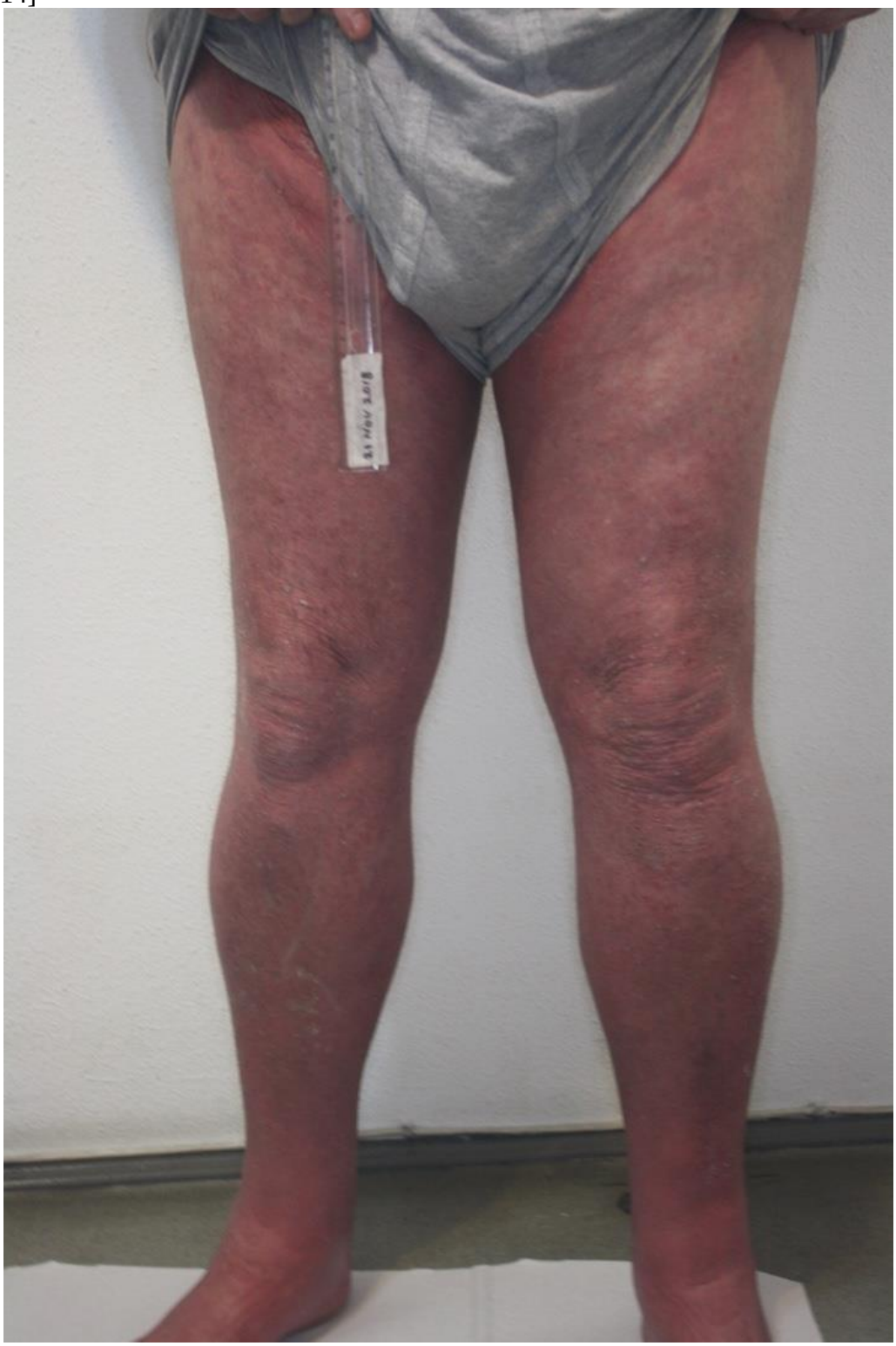


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Figure 3.3c – Oedema and erythroderma of feet, with onychodystrophy (Case 1)[14].

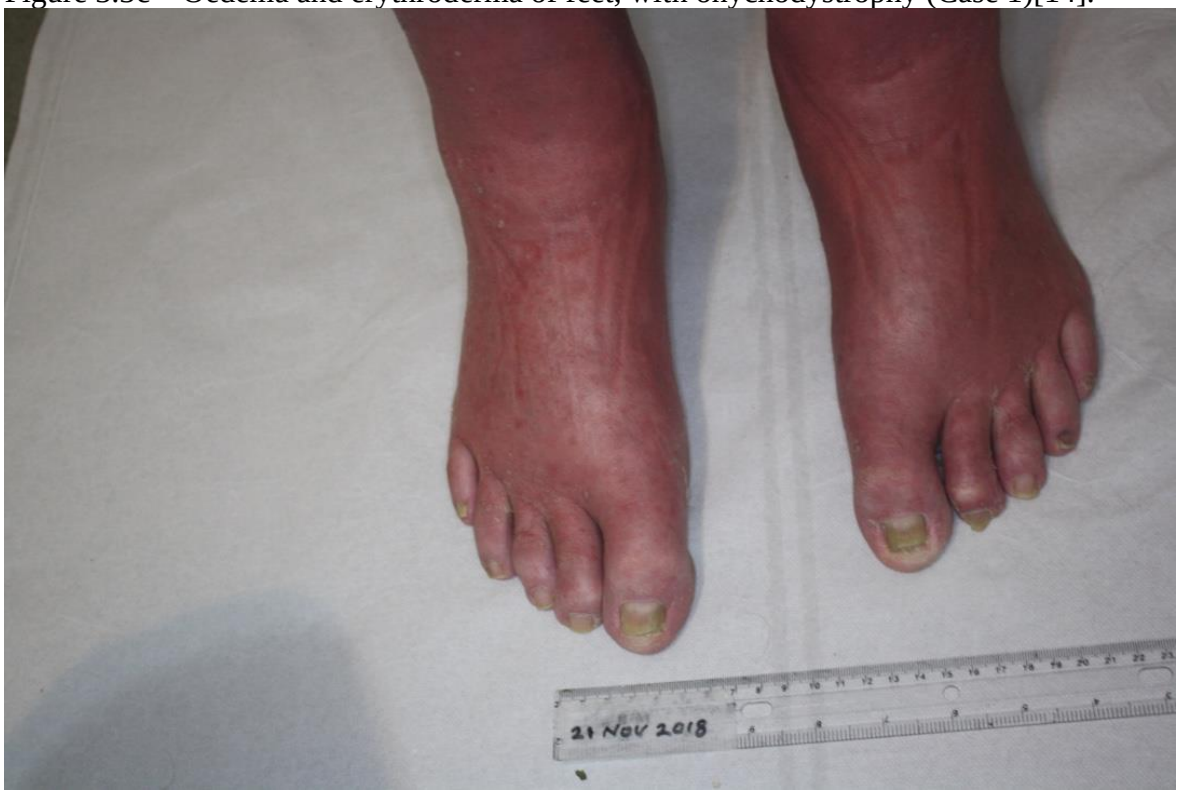


Figure 3.3d – Clearance of lesions of right upper limb (Case 1)[14].

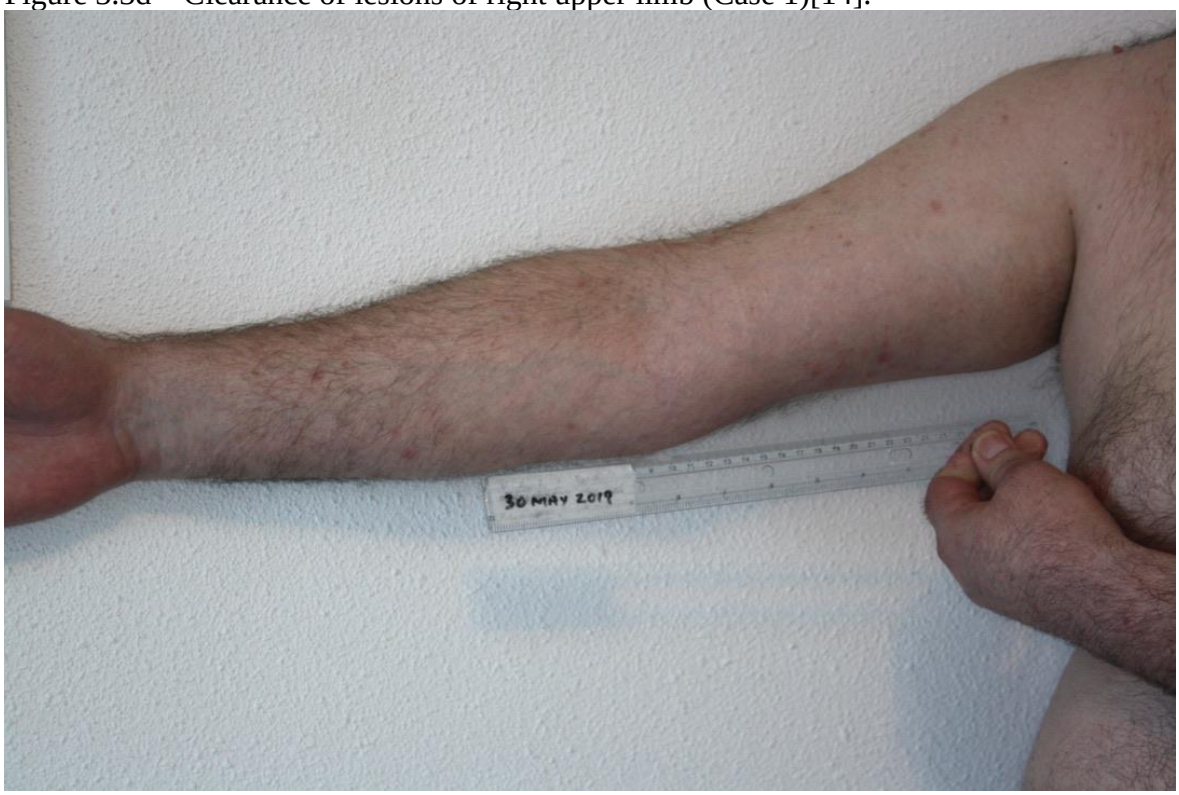


Figure 3.3e – Clearance of lesions and of erythroderma of lower limbs (Case 1)[14].

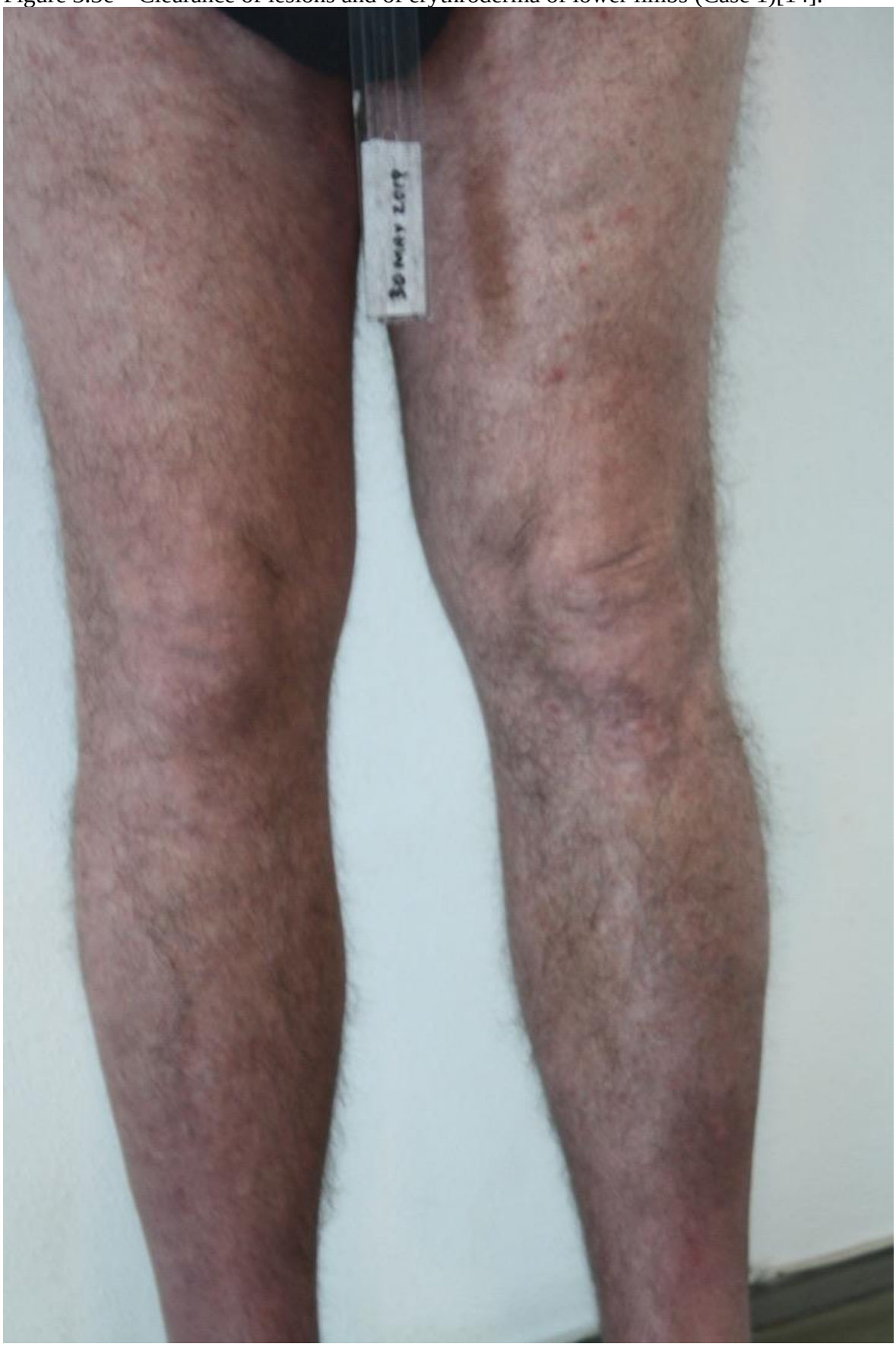


Figure 3.3f – Resolution of erythroderma, oedema and improvement of onychodystrophy (Case 1)[14].

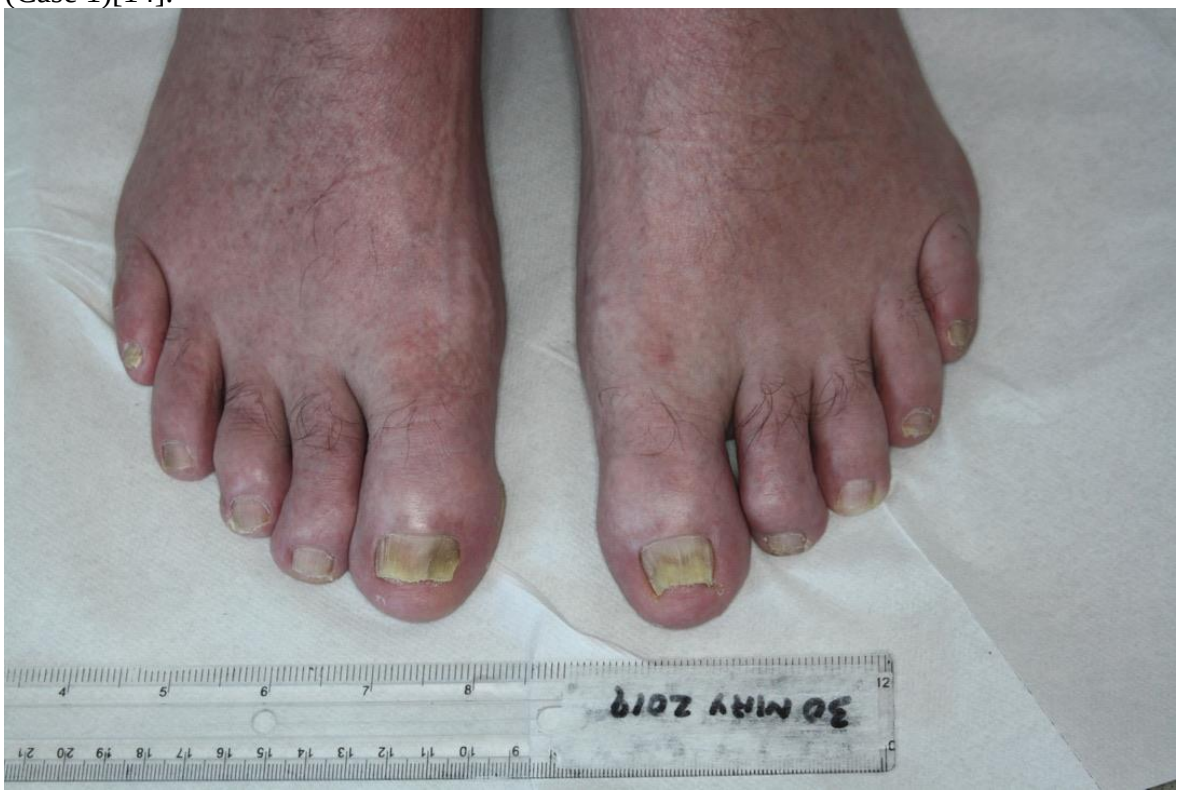


Figure 3.3g – Erythematosquamous plaques on left elbow (Case 2)[14]

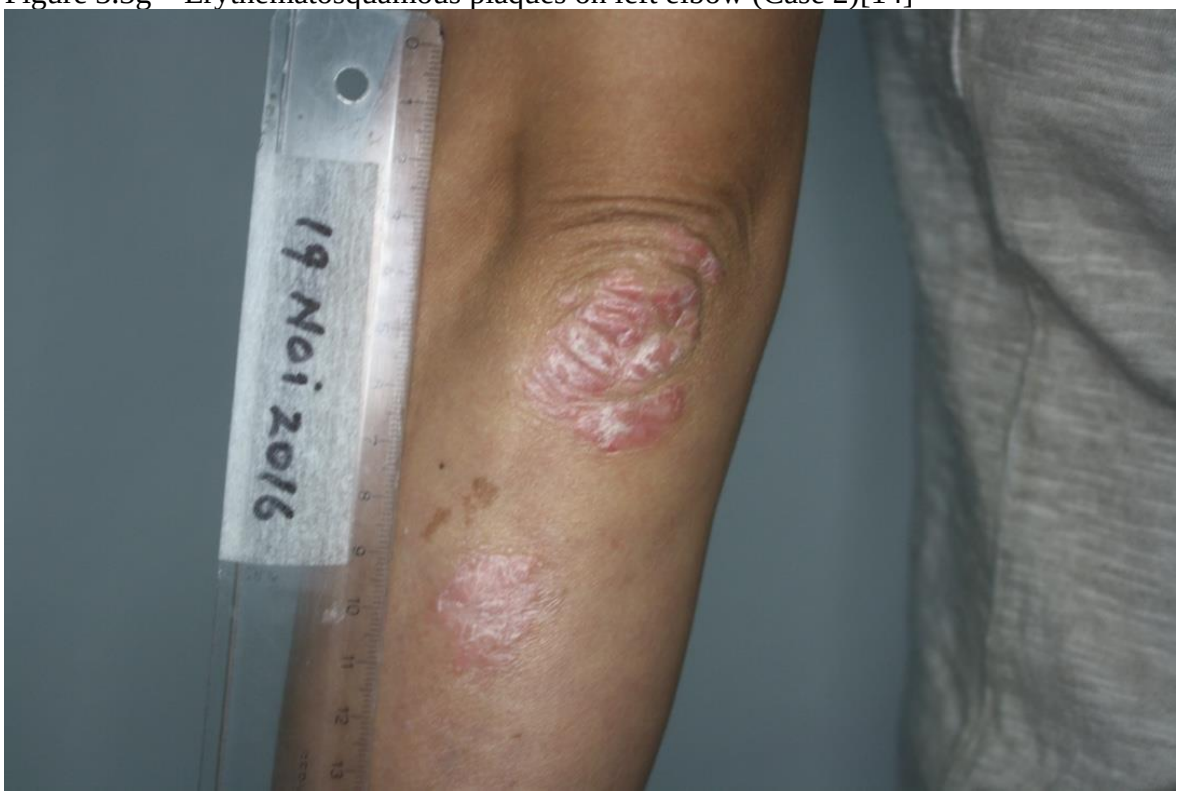


Figure 3.3h – Enlargement of erythematosquamous plaques on left elbow (Case 2)[14]

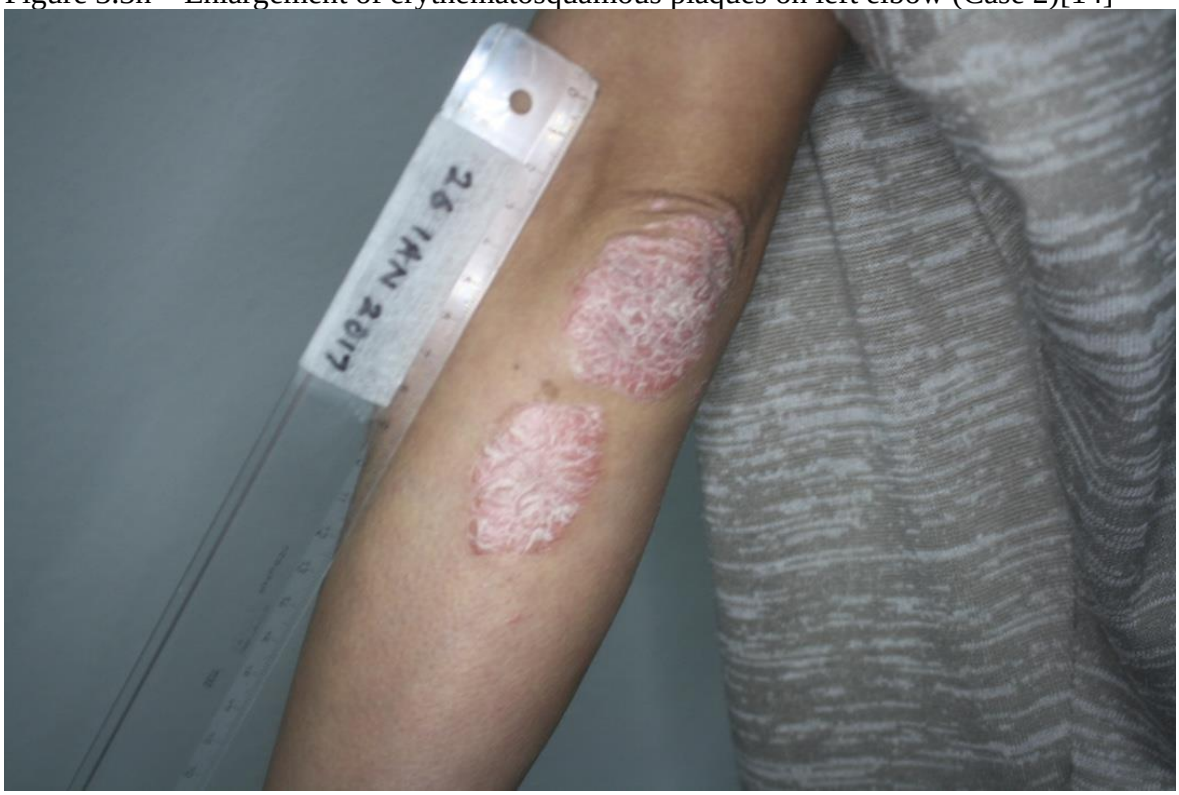


Figure 3.3i – Central clearing with confluence of plaques on left elbow (Case 2)[14]

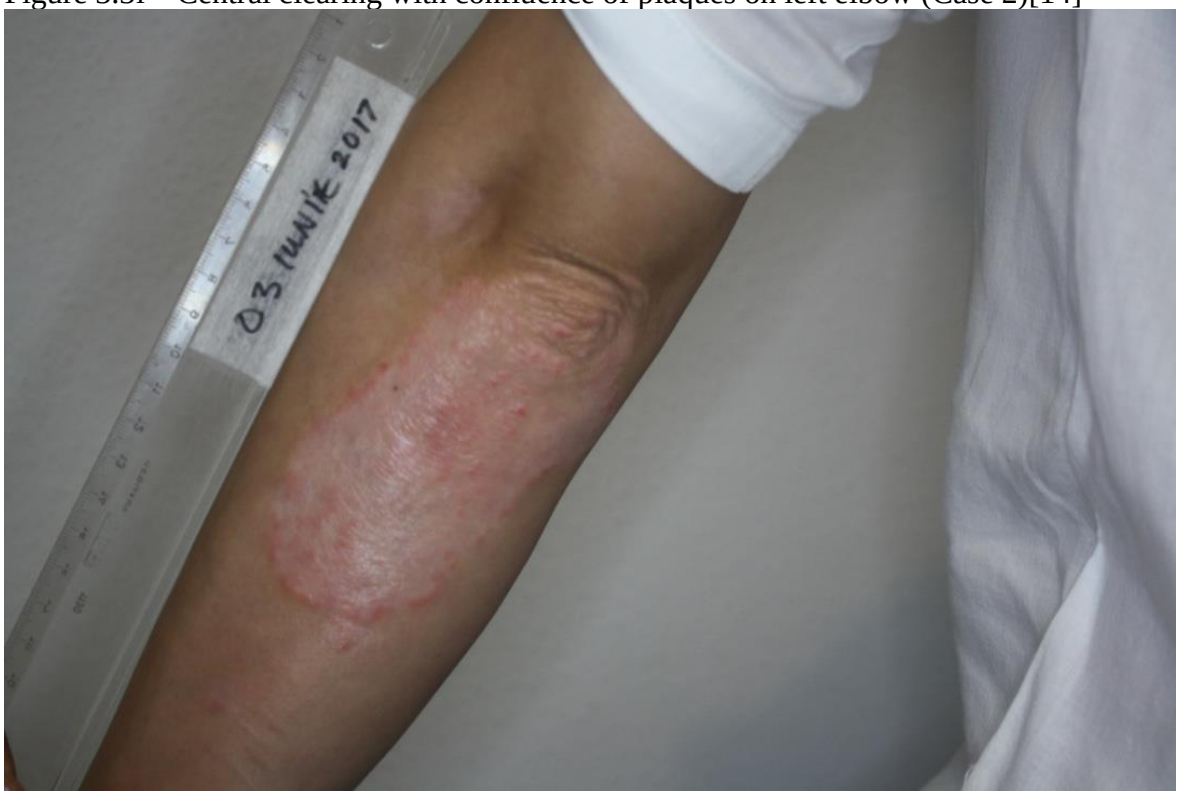
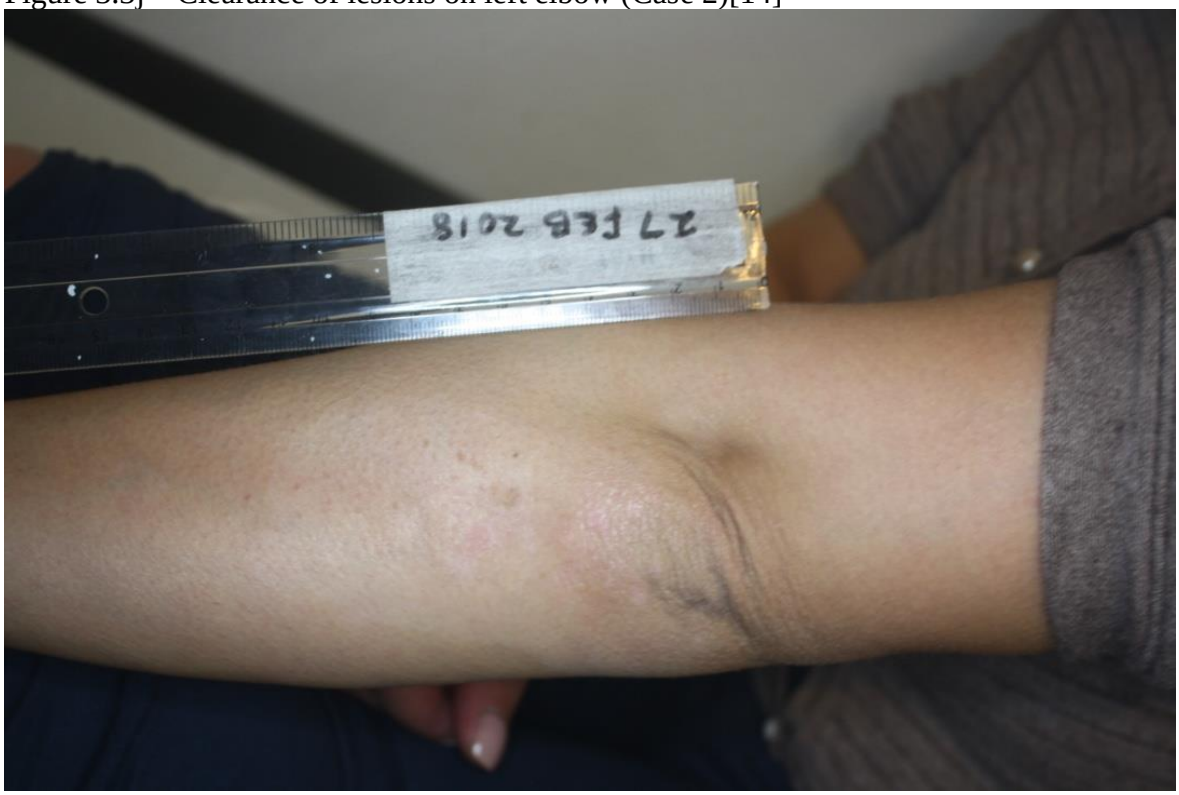


Figure 3.3j – Clearance of lesions on left elbow (Case 2)[14]



Discussion:

Psoriasis is a chronic inflammatory disorder, which can take many forms. It relapses and remits spontaneously. Topical and systemic therapies that are recommended currently are aimed at suppressing the disease and maintaining this suppression. These therapies pose risks of side-effects, including the potential for severe co-morbidities associated with immunosuppression.

My case studies suggest that it may be possible to obtain long-standing remission using individualised homeopathic therapy. These positive results of homeopathy were also obtained in difficult to treat cases, such as the case of erythroderma discussed in section 3.3. Pregnancy is not a contraindication to psoriatic treatment, as seen in the cases presented in sections 3.1 and 3.3. By virtue of the fact that, at ultrahigh dilutions, such as those I used, they do not contain molecules of the original substance, homeopathic medicines have no probability of causing teratogenic effects. Generalised psoriasis responds quite well to homeopathic treatment and a pattern of response was described in section 3.3. There were no side-effects seen with this treatment. Homeopathy provides a cheap and efficacious therapeutic option for long-term treatment of patients with psoriasis, providing long-lasting remissions, without the risk of side-effects associated with conventional treatments.

4 Homeopathy in the therapy of lichen planus

4.1 "Case series of an alternative therapy for generalised lichen planus: Four case studies"[15]

Introduction:

Lichen planus is an idiopathic, cell-mediated autoimmune disorder, manifesting as itchy skin rash and mucosal lesions in most cases. There are other, less common variants or subtypes of this disease. The clinical features of lichen planus have been described as the 'Six Ps' of this disease and they are: Pruritic, purple, polygonal, planar, papules and plaques. These key features encompass the main manifestations of this disorder. Different subtypes of lichen planus are more prevalent in certain populations and subgroups, for example, actinic, hypertrophic, pigmentosus and childhood variants are more common in African American and darker-skinned populations. It is of note that childhood lichen planus has a greater male prevalence.

It is thought that there is a potential for malignant change in association with mucosal lesions. Spontaneous remission of lichen planus often occurs. Topical and systemic therapies are utilized including potent topical steroids, topical calcineurin inhibitors, psoralen and ultraviolet A (PUVA), narrow band UVB, oral corticosteroids and acitretin.

I published a case series (n=4) of generalised, recalcitrant lichen planus treated with individualised homeopathic medicine[15].

Case 1 - A 48-year-old female presented with a 7-month history of generalized lichen planus. She had failed to respond to topical corticosteroids therapy and to the removal of her dental fillings. Examination revealed violaceous papules on her upper and lower limbs, oral mucosal lesions and poorly defined, erythematous, blanching, macular rash on the decolletage. She was prescribed homeopathic *Ignatia amara* at MK potency, weekly. She went into remission at 3 months after the commencement of therapy. About 2.5 years after her last visit, she presented with a relapse of the oral lesions, following work-related stress and dental work. These lesions also responded to *Ignatia amara* MK potency.

Case 2 - A 65-year-old female presented with a 27-year history of generalized lichen planus that had been unresponsive to topical steroids. Examination showed generalized, violaceous papules, with no mucosal involvement. She was prescribed homeopathic *Aurum metallicum,* MK potency, weekly and went into remission. She relapsed at 8 months after onset of therapy, following a stressful event and remitted again with repetition of *Aurum*

metallicum after 1 month of therapy. She remained in remission for 3 years until the death of her mother, which triggered a relapse for which she received *Aurum metallicum* again and she went into remission once more.

Case 3 - A 38-year-old male presented with a 21-year history of generalized lichen planus. Medical history was positive for hepatitis B and asthma. Topical clobetasol produced only limited success. Examination revealed generalized, violaceous papules, with oral and genital involvement. He was prescribed homeopathic *Lycopodium clavatum* at MK potency, weekly dosage, and remitted by 2 months after the onset of therapy. He remains in remission but became lost to followup.

Case 4 - A 41-year-old male presented with a 12-year history of itchy rash, which had limited response to topical steroids and UVA therapy. Medical history was significant for reduced sense of smell. Examination revealed violaceous, hypertrophic papules, with a generalised distribution and dystrophic nails. He also had palmar and plantar hyperkeratosis. No mucosal lesions were observed. He was prescribed the homeopathic medicine *Carcinosinum* at MK potency and remitted by 6 months of treatment. He also had an improved sense of smell. He presented about 2 years later, with his son for a homeopathic treatment of the latter's acne and was still in remission.

Discussion:

The therapy of lichen planus is aimed at controlling and suppressing the disorder and curative treatment is not documented in the literature. Such therapies include topical and oral steroids, topical and oral calcineurin inhibitors, PUVA, metronidazole, itraconazole, griseofulvin, hydroxychloroquine, dapsone and thalidomide. These options are fraught with side effects, some of which are potentially severe.

Complementary and alternative therapies have been tried for lichen planus. These include traditional Chinese medicine and herbs. Some studies have shown the herb *Aloe vera* to be more effective than triamcinolide for oral lichen planus. The effect of homeopathy on lichen planus was investigated in a randomized controlled trial using homeopathic *Ignatia amara*. The study group comprised 30 individuals with histopathologically confirmed erosive and/or atrophic lichen planus. The follow-up period was 4 months. The patients were randomized to either placebo or *Ignatia amara*, 30c potency. Mean lesion size and pain scores were significantly in favour of homeopathic treatment. Of note is the fact that one of the patients in my case series was also treated with *Ignatia amara*, although at MK potency, and she went into long lasting remission. Although my case series was small (n=4), these

presentations were of generalized, recalcitrant lichen planus and some also had mucosal involvement. Dermatologists are aware that these are typically difficult to treat in daily clinical practice. Therefore, therapies that could potentially place the patient in long term/permanent remission, without the risk of serious adverse effects, would always be welcome.

Figure 4.1a – 38-year old male with dystrophic toenails(Case 4) [15]

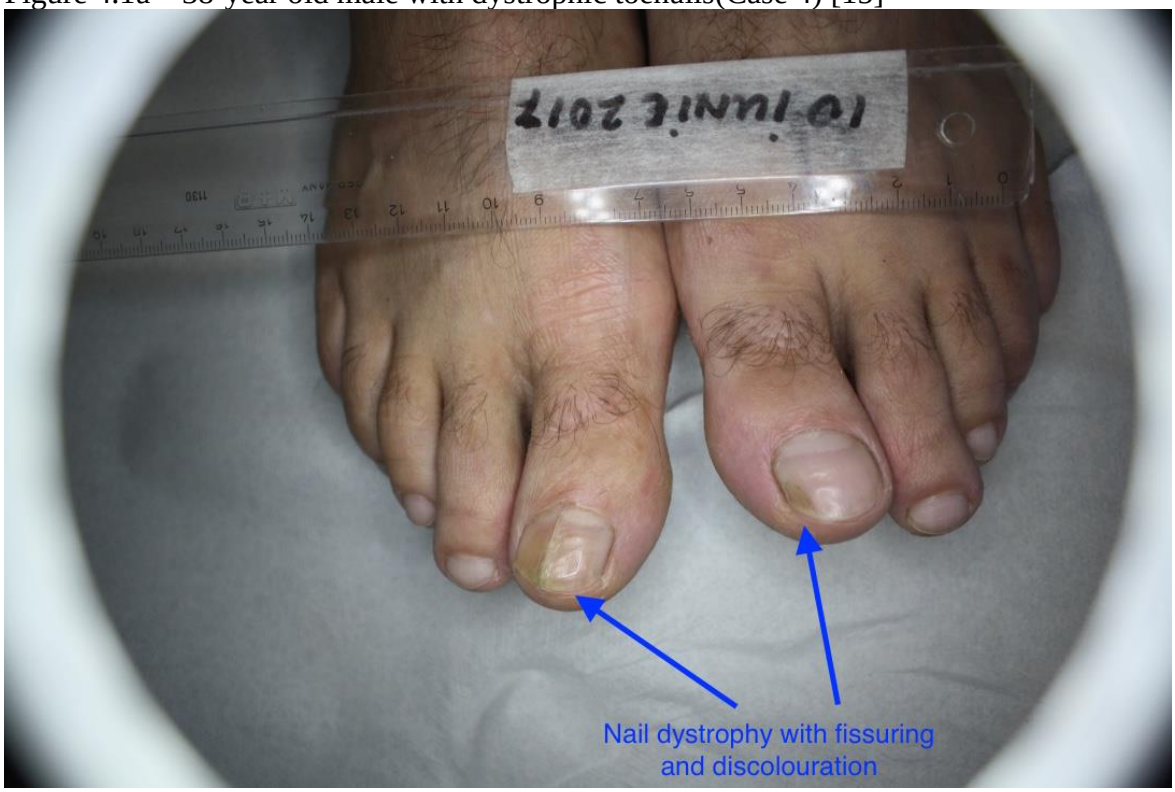


Figure 4.1b – 38-year old male with hypertrophic, violaceous papules on anterior legs(Case 4) [15]

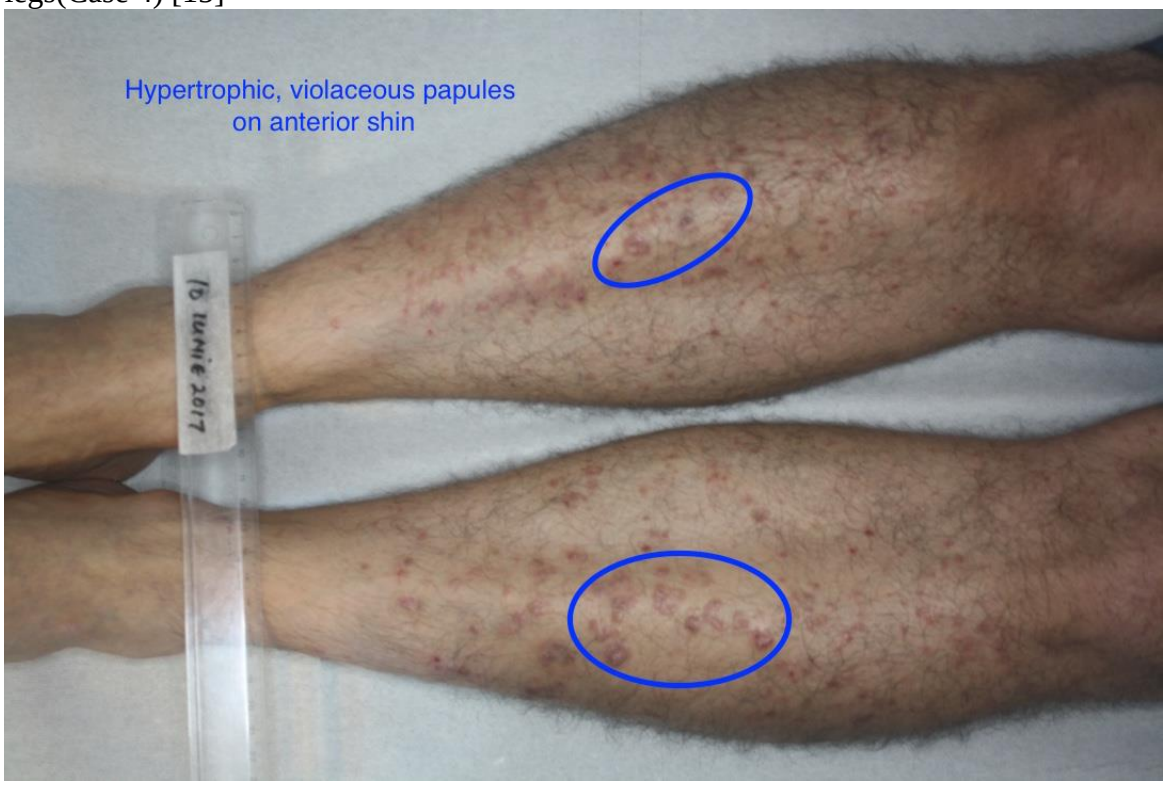


Figure 4.1c Healed dystrophic nails(Case 4) [15]

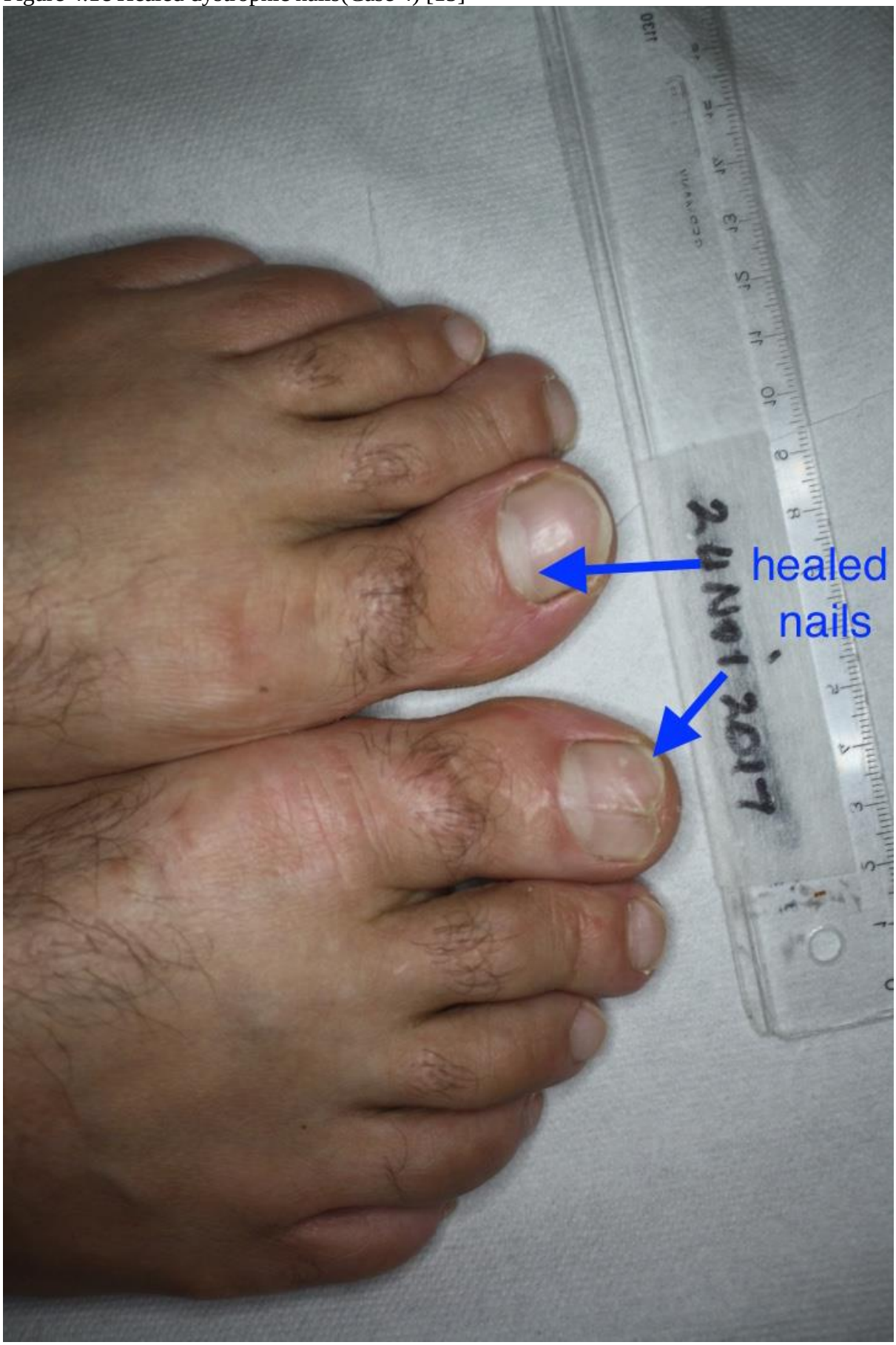
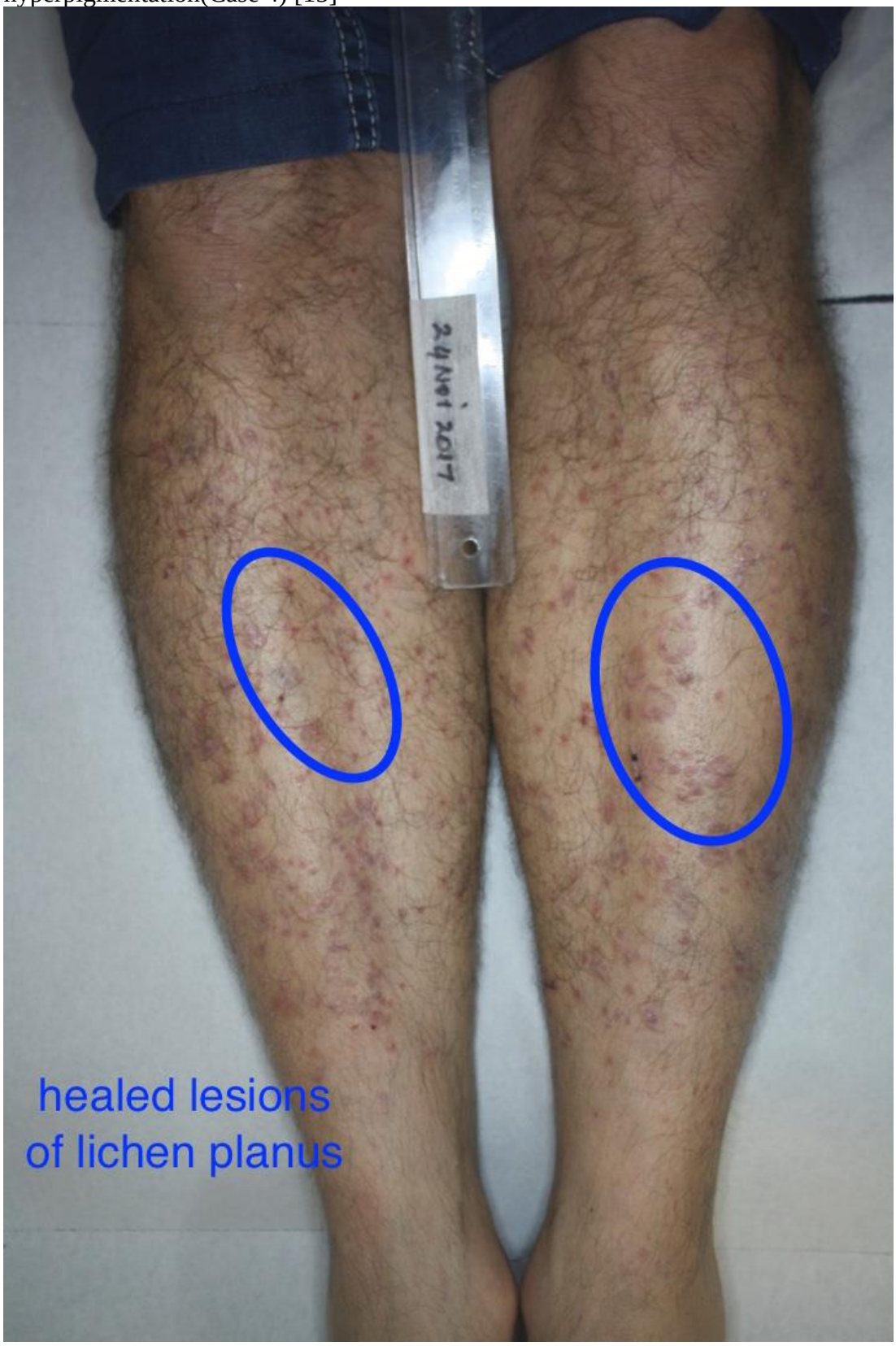
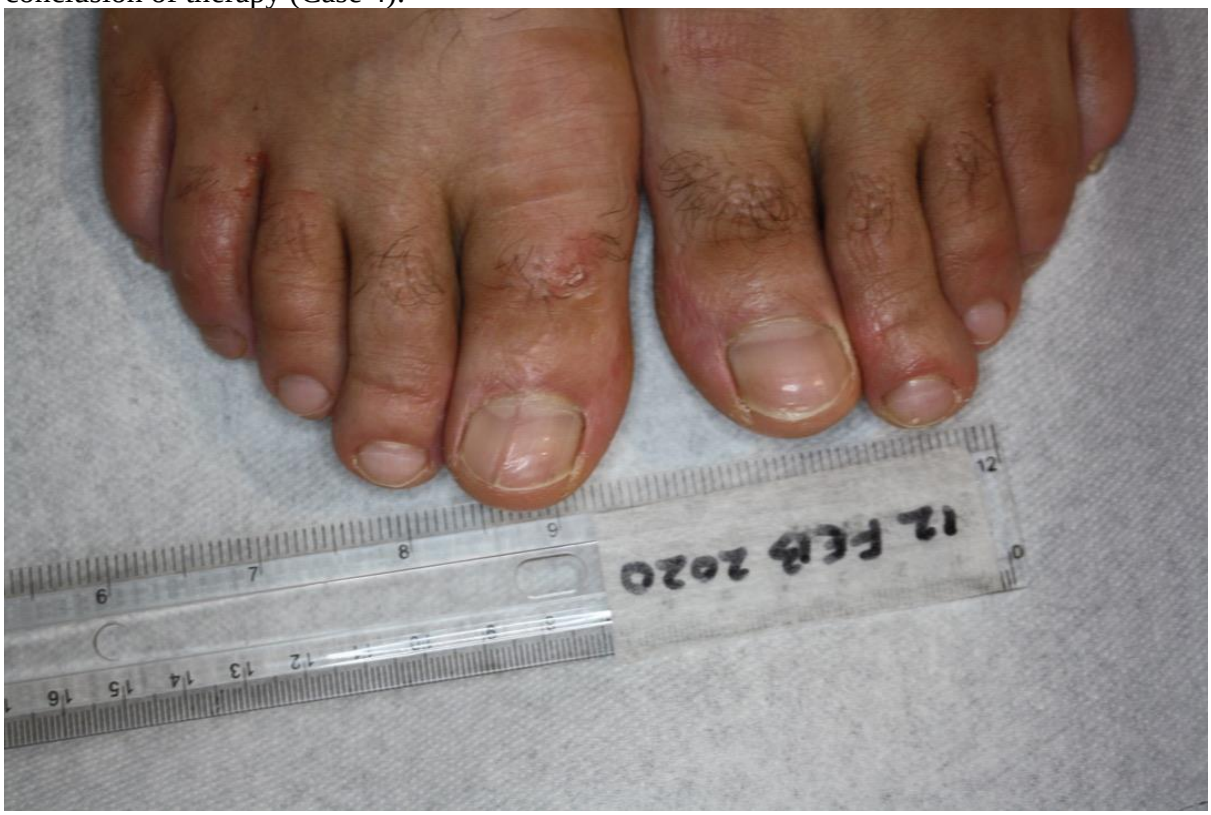


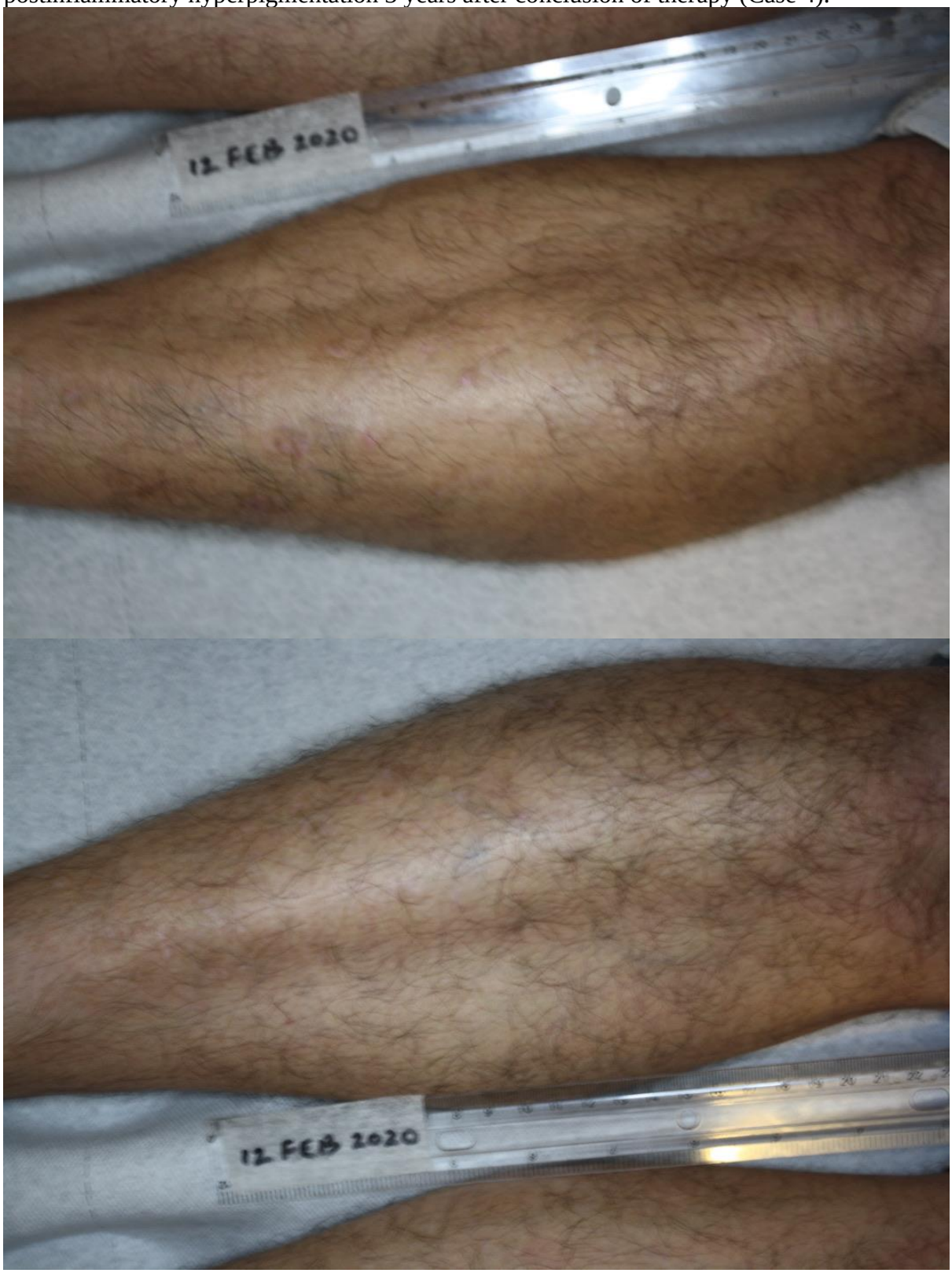
Figure 4.1d – Healed anterior leg lesions, with residual postinflammatory hyperpigmentation(Case 4) [15]



Figures 4.1e – Patient's nail lesions are still in remission, the nails are smooth, 3 years after conclusion of therapy (Case 4).



Figures 4.1f and 4.1g – Patient's skin lesions are still in remission, with disappearance of postinflammatory hyperpigmentation 3 years after conclusion of therapy (Case 4).



5 Homeopathy in the therapy of mycosis fungoides [16,17]

5.1 "Homeopathy as therapy for mycosis fungoides: Case reports of three patients."[17]

Introduction:

Mycosis fungoides is a form of cutaneous T-cell lymphoma and it is an infrequently encountered neoplastic disorder affecting T lymphocytes. Based on the WHO–EORTC (World Health Organization–European Organization for Research and Treatment of Cancer) criteria, cutaneous T-cell lymphoma can be classified into two main groups — aggressive and indolent. Mycosis fungoides is classified as an indolent variety. Mycosis fungoides is not known for spontaneous remission and therapy includes topical or systemic corticosteroids, retinoids, interferon-α-2b and biologics. These medications are fraught with the potential for risk of severe adverse effects. As a result, therapeutic modalities, which hold the promise of efficacy with good safety profiles will always be welcome additions.
I published a case series (n=3) of mycosis fungoides treated with homeopathic medicine. These cases illustrate the potential that homeopathy might have in the treatment of this neoplastic disorder.

Case 1 - An 84-year-old female presented with a 5-year history of mildly itchy skin rash. It began gradually on her forearms and then spread to her back. Her medical history was significant for osteoarthritis, duodenal ulcer, hypertension and insomnia. The latter was an ongoing source of distress for the patient. Examination revealed multiple, poorly-defined, small brown patches on forearms and trunk, with minimal squames. There was no lymphadenopathy. Histopathology suggested parakeratosis variegata and immunohistochemistry confirmed patch mycosis fungoides. Based on the degree of skin involvement, she was classified as stage T1b. The patient rejected advice to have an oncology consultation. She was prescribed homeopathic *Lycopodium clavatum* at MK potency, to be administered weekly and bland hydrating creams. She was in remission by 10 weeks after the onset of treatment, with improved sleep and was lesion-free by 20 weeks. The patient had rejected an oncology consultation, being lesion-free by the time of the immunohistochemistry (of note, immunohistochemistry was done at 28weeks of treatment, as the patient had to foot the bill) and she preferred to continue her homeopathy treatment instead. She was reached by telephone 2 years after the onset of treatment (the patient no longer felt the need to come for follow-ups as she felt well) and she confirmed that she was

still in remission, though she continued to take *Lycopodium clavatum* as she felt it would keep her from relapsing.

Case 2 - A 79-year old male presented with a 1-year history of psoriasis. His lesions were associated with burning sensations. His history was significant for chronic lymphocytic leukemia, which was on observation with no medication. On examination there were thin, erythematous, irregular, poorly defined patches, with minimal squames on both lower limbs. Histopathology and immunohistochemistry confirmed patch stage mycosis fungoides. He was classified as stage T1a or T1b, as the total body surface area that was affected could not be accurately calculated. He was prescribed homeopathic *Sulphur* at MK potency, weekly dose. Initially, he became lost to follow-up as he had to care for his wife, who fell ill and later passed on. He returned 3 years later, presenting with larger lesions of similar morphology and with similar locations. Treatment was reinstituted with *Sulphur* MK, daily. The patient went into remission at 4 months. There was no improvement or aggravation of his leukaemia. About 4 months after the onset of remission, the patient developed generalized herpes zoster and was admitted and treated with intravenous acyclovir. It was complicated by post-zoster neuralgia and foot drop for which he was treated with gabapentin orally. He reported the development of lesions, which were similar in morphology and location to his original mycosis fungoides after gabapentin therapy. The lesions remitted again with homeopathic *Sulphur*, MK potency, weekly treatment while his neuralgia and foot drop improved with acupuncture therapy.

Case 3 - A 22-year-old male presented with a 6-month history of generalized itchy rash. There was no history of medication intake and no family history of similar lesions was obtained. Physical examination showed well-defined, erythematous plaques with thin squames, on upper and lower limbs as well as on the trunk. There was no nail involvement and no adenopathy. Histopathology and immunohistochemistry confirmed the diagnosis of mycosis fungoides. The patient was prescribed homeopathic *Sulphur* at MK potency, weekly dose. He went into remission at 4 weeks of treatment. At 5 months, he reported that there was a deterioration of his skin lesions, but he was also under stress from forthcoming exams. He was switched to *Aurum metallicum* MK potency, weekly, and he continued to improve. Seven months later, the patient became lost to follow-up and returned 10 months afterwards reporting a period of violent aggravation of his lesions, which coincided with a period of deep, emotional upset. He had been prescribed homeopathic *Staphysagria* by another homeopath, who was a relative, and appeared to have improved. He continued *Staphysagria*, by mutual agreement for another 3 months but reported bloating (associated with high soft-

drink consumption). On examination, new lesions were observed on his anterior legs. *Sulphur* MK was recommenced, the patient improved and continued to improve until he was lost to follow-up again. The patient remained in remission over 1 year after his last visit (based on telephone conversations).

Discussion:

Mycosis fungoides is an indolent form of cutaneous lymphoma. It is staged according to the WHO and ISCL/EORTC criteria. The literature suggests that the incidence of mycosis fungoides may be increasing, but this may be an artefact resulting from improved diagnostic techniques. Nevertheless, it is still an infrequently encountered disorder, with a figure of approximately 0.18/100,000 person-years for Norway, for example. A wide range of therapeutic modalities is available. These are often chosen to fit the individual patient's disease stage and particular circumstances. Nevertheless the prognosis of mycosis fungoides is often promising, with a 27.2% morbidity and mortality over a 27-year period of study. Mycosis fungoides still warrants treatment because it is not known for spontaneous remission and it may progress. Current treatments for mycosis fungoides have potentially hazardous side effects. In this study, I presented three cases of immunohistochemically confirmed mycosis fungoides that were treated with classical homeopathy. This means that the homeopathic medicine considered to best fit the patient was prescribed. No side-effects were observed in this patient group.

Figure 5.1a – erythematosquamous plaques on anterior thighs (Case 3, date of photograph 24 Aug 2012)

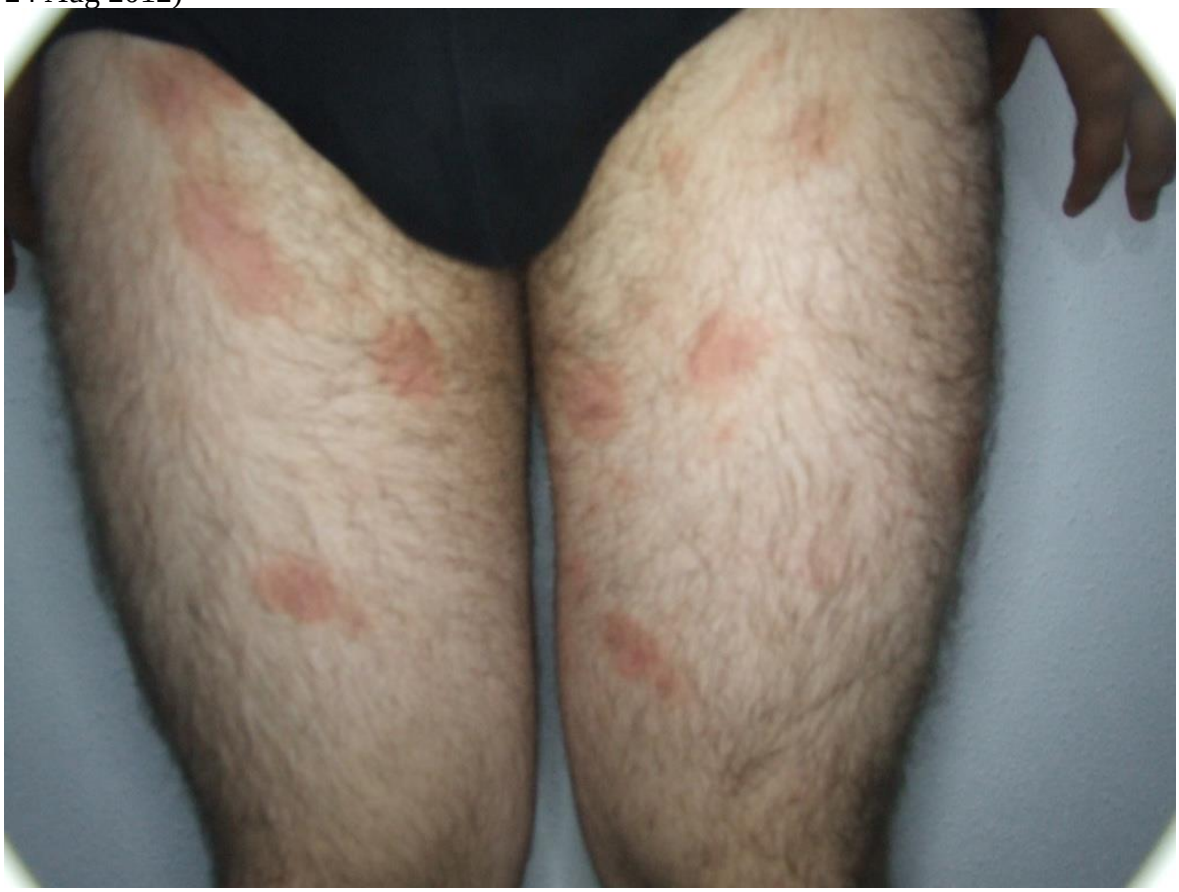
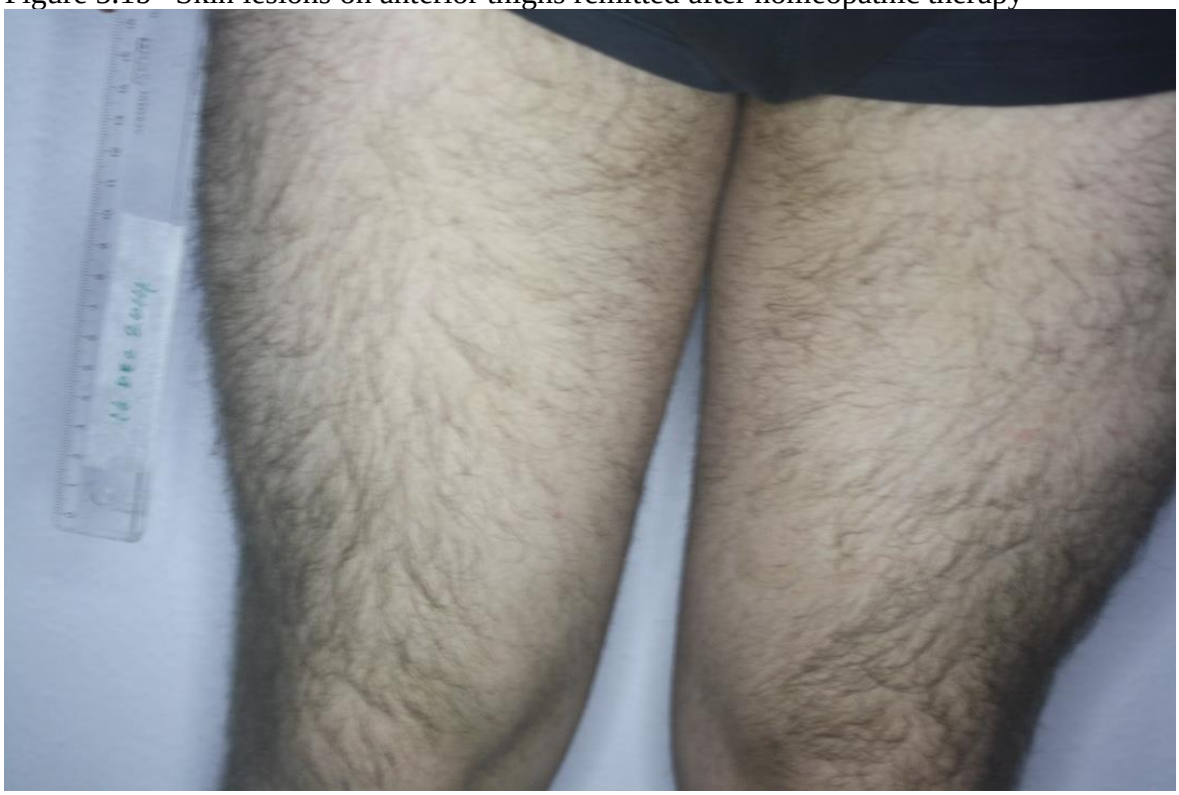


Figure 5.1b –Skin lesions on anterior thighs remitted after homeopathic therapy



6 Homeopathy in the therapy of urinary tract infections

6.1 "Classical homeopathy and bacterial urinary tract infections" [18]

Introduction:

Recurrent urinary tract infections are a frequently encountered disorder in medical practice. Antibiotics tailored to the sensitivity of the organism are usually the recommended therapeutic approach. However, there are situations in which other treatment methods may be desirable. Amongst such situations are pregnancy and recurrent infections resistant to antibiotic therapy. Also, patients may prefer not to have antibiotic treatment, out of a fear of the potential adverse effects. Increasingly antibiotic resistance is also raising the spectre that urinary tract infections may no longer be amenable to antibiotic treatment. As a result, there may be a future need for alternative methods of caring for people with this disorder.

Urinary tract infection is a global problem. Over 1.9 million children were treated for urinary tract infections in 2007 with 4.7% of these patients requiring hospital admission. Over 90% of these visits were by female patients[19]. In the United states in 2011 approximately 400,000 hospital admissions were attributed to urinary tract infections with a cost of over US$2.8billion, which comprised a 52% increase in incidence over 1998 and 2011[20]. Antibiotic resistance appeared to contribute to this increase in the number of hospital admissions[20]. This increased antibiotic resistance, together with the reduced investment in new antibiotic research opens the avenue for other therapeutic options.

I published a case series (n=3) of recurrent urinary tract infections treated with homeopathic medicines[18]. The homeopathic approach used was the classical one, i.e. individualised homeopathic medicines were prescribed. However, symptomatic homeopathic medicines were also used as adjuvant therapy.

Case 1 - A 1-year old female was brought for consultation by her parents for a 4-month history of *Escherichia coli* recurrent urinary tract infection and fever. She had already had 3 episodes during this 4-month period. Although the patient responded to antibiotics each time, she relapsed following their withdrawal. Echography of the genitourinary tract showed no abnormalities. Pregnancy, birth and developmental history were not significant. All recommended vaccines had been administered. The patient was treated with homeopathic *Phosphorus* CH30, weekly and improved, with clearing of the urinary tract infection as shown by negative urine culture and no recurrence over a 3-month observation period.

Case 2 - A 36-year old female presented with a 4-year history of glossodynia and dysuria. Mycology and bacteriology yielded positive cultures for *Candida albicans* on the

tongue and for *Escherichia coli* in the urine. Repeated courses of antibiotic therapy had failed to produce lasting remissions. Her medical history was significant for a thyroid nodule, dyspareunia, erythematous rosacea and melasma. The patient had no history of diabetes. She was prescribed the homeopathic medicine *Platinum metallicum*, at MK potency, weekly dose, as well as homeopathic *Candida albicans*, and *Collibacillinum* (homeopathic *Escherichia coli*), both at CH15 or CH30 potency, depending on what was available. She improved and further mycology and bacteriology yielded negative tongue and urine cultures. Her melasma and rosacea improved and her thyroid function remained stable over a 10-month follow up period.

Case 3 - A 54-year old female presented with a 3-year history of recurrent urinary tract infection. Urine cultures repeatedly grew *Klebsiella spp*. and she had failed to respond to repeated courses of antibiotic therapy. Medical history was significant for a cerebrovascular accident with neurologic complications, which had been treated by this physician also. She was prescribed the homeopathic medicines *Causticum*, *Cantharis vesicatoria* and *Eupatorium purpureum* for her symptoms. The first medicine was considered her constitutional medicine, while the latter two were given as adjuvant symptomatic medicines. The patient improved and developed negative urine cultures over a 3-month observation period.

Discussion:

Urinary tract infections are a significant source of morbidity with up to 4.7% of children being hospitalized for this disorder[19]. In the US, over 7 million office visits per year are due to urinary tract infections and 15% of all community-prescribed antibiotics are attributable to this[20]. Half of all women are expected to experience at least one episode of urinary tract infection over the course of their lifetime and one third them will experience it by the age of 24 years, whereas only a smaller proportion of men will suffer from urinary tract infections[21]. Recurrent urinary tract infections therefore constitute a significant problem for public health. The results of a case series (n = 5) suggested that there is a potential place for homeopathy in the treatment of recurrent urinary tract infections in patients with spinal cord injury. In this study, the authors reported that three of the patients treated with homeopathy remitted and did not relapse[22].

My case series comprised 3 patients, all with positive urine cultures, who had failed to respond adequately to repeated antibiotic therapy. These patients all responded to homeopathy and did not remit following cessation of treatment, over a varied follow up

period. This suggests that classical homeopathic treatment and homeopathy in general, could be useful in the treatment of recurrent urinary tract infections.

7 Homeopathy in the treatment of Rosacea

7.1 "Rosacea and homeopathy" [23]

Introduction:

Rosacea is a frequently encountered cutaneous disorder most often affecting the face. It is characterized by central facial erythema. Other features like telangiectasia and papulopustular eruptions occur, but they are not essential for a diagnosis. Presently, it is classified as erythematotelangiectatic (characterized by transient or persistent erythema and telangiectasia), papulopustular rosacea (characterized by persistent facial erythema, transient papules and pustules), phymatous rosacea (skin thickening, irregular nodules that may affect the nose, cheeks, forehead, chin or ears) and ocular (foreign body sensation in the eyes, itching, stinging, dryness as well as telangiectasis of the sclera). An atypical variant, with distribution outside the usual areas; a granulomatous variant comprised of noninflammatory, hard, yellow, brown or red papules or nodules of uniform size and a fulminant variant have also been described. These are not considered subtypes, but rather are variants of rosacea. Rosacea more recently has been classified into phenotypes – the diagnostic phenotype, the major phenotype (in the absence of the diagnostic), the secondary phenotype and the ocular phenotype[24].

I published a case study (n=3) of rosacea treated with individualised homeopathic medicines.

Case 1 - A 53 year-old male presented with a 1-year history of facial eruption. The eruption began on the skin between the eyebrows and spread to the cheeks. It was associated with itching and stinging sensations and worsened by shaving. His medical history was significant for a lumbar disc disease and loss of vision in the right eye as a result of an accident. He had smoked for thirty-four years and smoked an average of 20-60/day, but had stopped 4 years prior to presentation. He drank unspecified quantities of home-made wine regularly. Physical examination showed a middle-aged male in good general health, with central facial erythema, papules and telangiectasia, mostly involving the "butterfly area" of the face. The eruption was slightly worse on the left. He was prescribed the homeopathic medicine *Lachesis*, at MK potency, weekly for 6 weeks as well as an *Aloe vera* cream to be used topically, as often as needed. At 3 months after the commencement of treatment the symptoms were no longer present and the lesions much improved. He had also stopped using the homeopathic medicine without consulting me. At 6 months after cessation of the homeopathic medicine, the patient remained in remission.

Case 2 - A 32-year-old female presented with a 10-year history of facial rash. It had been previously diagnosed as seborrheic dermatitis. It was worsened by sun exposure, cold weather, dust and emotions, especially anger. She had been treated with a topical steroid cream for this rash, with only temporary improvement. Her medical history was significant for a hand dermatitis that had been unsuccessfully treated with conventional and homeopathic medications. She smoked about 10 cigarettes/day for the past 11 years. On examination, she was in good general health, with erythematous plaques and pustules in the butterfly and zygomatic areas more pronounced on the right side. She had no visible hand lesions. She was prescribed homeopathic *Lycopodium*, at MK potency, weekly and *Aloe vera* cream as needed. At her 6-week follow-up visit, the lesions were healed. She continued to remain in remission and reported improvement in her hand dermatitis.

Case 3 - A 34-year old woman presented with a sudden-onset facial eruption, associated with occasional itching. She also reported stinging and redness with sun exposure. She had been prescribed courses of systemic antihistamines and hydroxychloroquine tablets. Her medical history was insignificant. On examination, she was found to have a papular, erythematous eruption, with mild underlying oedema. She was prescribed homeopathic Causticum, at MK potency, weekly. At 6 weeks, she showed improvement with almost complete clearing of the lesions and 8 months after cessation of treatment, remission was sustained.

A 35-year-old female came to clinic presenting with a facial rash of 3-years duration. It manifested as dryness, redness, and pimple-like lesions. There was no ocular symptomatology, and no aggravating or ameliorating factors. Her medical history included anemia, H. pylori infection with gastritis and appendicectomy, as well as abundant menses. Clinically, erythema, papules with occasional pustules, as well as underlying oedema, especially of the central area of the face could be observed. A diagnosis of rosacea was made and the patient placed on the homeopathic medicine Platinum metallicum, at 1 MK potency, weekly. At the 6-week follow-up visit, she showed improvement of her facial lesions, with just facial erythema present and a few papules. Her improvement had been preceded by aggravation of her lesions, after commencement of treatment, with amelioration followed by aggravation, then by sustained amelioration. Her sleep improved, becoming refreshing. The anaemia was better, with regularisation of menses, without abundant flow. She felt more “harmony” within and her gastritis symptoms improved. She continued to show improvement and was almost completely lesion-free at 5 months after onset of treatment. She remained in remission, with occasional lesions (when under stress) at 15 months after

commencing therapy. This was reported the chapter written by me *Homeopathy in the Therapy of Acne and Rosacea.* In: Rupani R.N., Lio P.A. (eds) *Integrative Dermatology*. **Springer, Cham**., 2021

Discussion:

Rosacea is a chronic disease of varying severity. There are several phenotypes of this disorder as well as unusual variants[24]. The therapy of rosacea can be challenging. This includes topical agents like benzoyl peroxide, clindamycin and metronidazole, as well as systemic medicines like retinoids, metronidazole and doxycycline. Laser therapy and electrosurgery may also be useful in some cases. Lifestyle changes, which may help include the avoidance of trigger factors such as stress, spices and sun exposure. My cases suggest that homeopathy has the potential to provide cheap, gentle and lasting therapy for papular and erythematotelangiectatic rosacea, without the risk of side-effects.

Figure 7.1a (case 2) – erythematous papules on cheeks and lateral face (before treatment, date of photograph – 22 June 2011) [24]

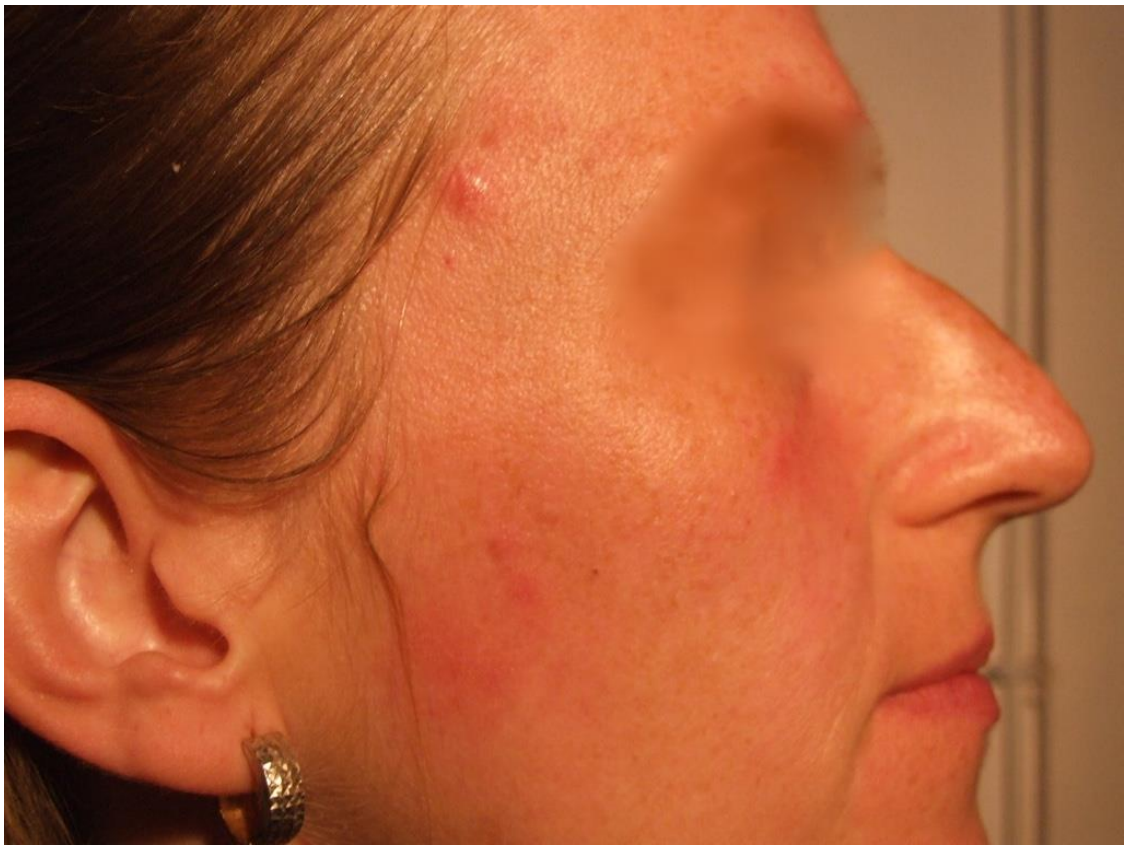
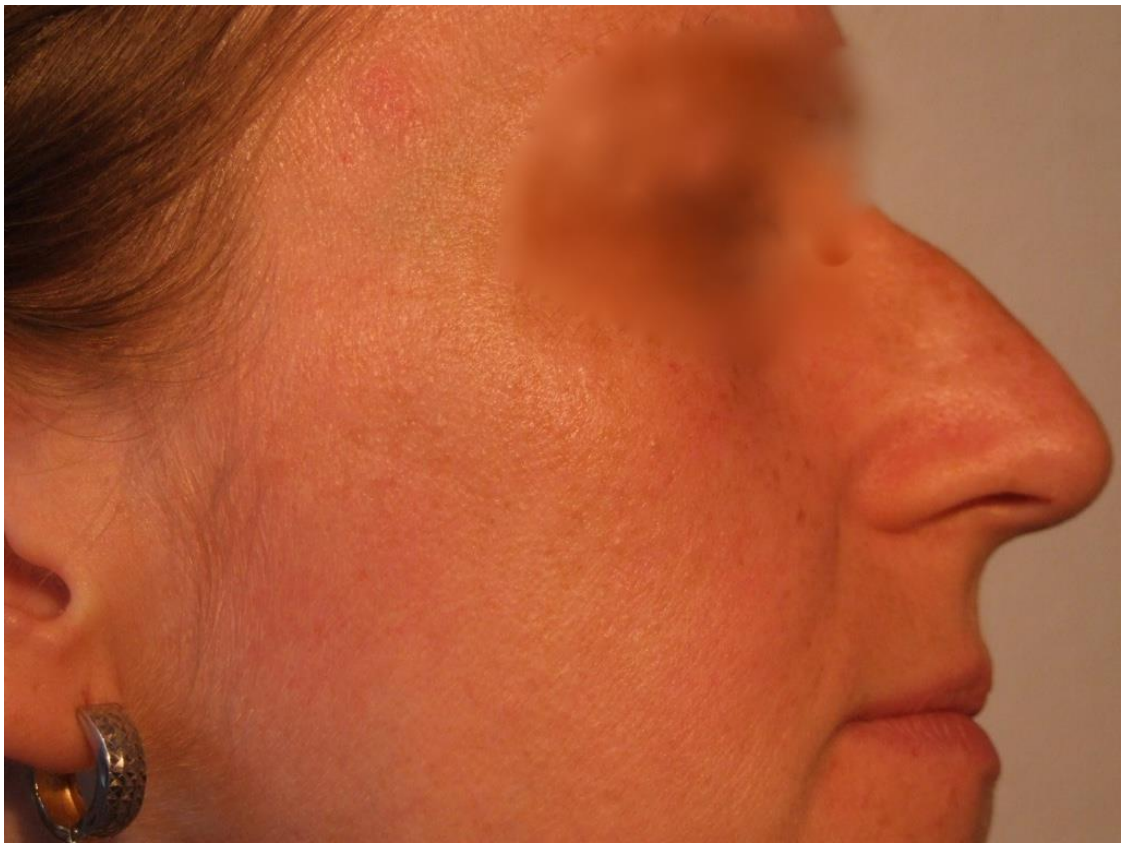


Figure 7.1b (case 2) – patient in remission[24] (date of photograph 02 Aug 2011)



8 Homeopathy in the therapy of atopic dermatitis

8.1 "Atopic dermatitis and homeopathy". [25]

Introduction:

Atopic dermatitis is a chronic disorder of immunity predominaantly affecting the skin, associated with allergen sensitization and impaired barrier function. There is frequently a family history of pruritic skin disease or asthma. It appears to be more prevalent in urban than in rural areas and in industrialised countries. In India, the prevalence was 2.4-6% of 37000 children [26] and was 8.5% in south-eastern Nigerian[27]. The exact cause or causes of atopic dermatitis are unknown. However, breastfeeding for at least 3 months appears to reduce the risk in infants of atopic dermatitis[28]. Genetic factors may play a role, as monozygotic twins have a higher rate (77%) of atopic dermatitis than dizygotic twins (15%) [28]. Several loci on genes have been linked to atopic dermatitis[29].

Various therapeutic strategies may be used for managing atopic dermatitis, including emollients, topical and systemic steroids, calcineurin inhibitors, UVB therapy, as well as biologics and probiotics.

I published a case series (n=3) of patients with severe atopic dermatitis treated with individualised homeopathic therapy[25].

Case 1 - A 22-year old female presented with an erythematous rash on her upper lip, associated with itching. Her medical history at this visit was not significant, but a later visit was significant for a history of itchy rash since early childhood and migraine headaches.

After several visits, in which she received homeopathic treatments, the symptoms appeared to worsen with increased rashes, which only showed transitory improvement. Finally, she received an individualised homeopathic treatment in the form of *Aurum metallicum* at MK potency. The rash disappeared and her migraine diminished. After 1 year following inception of this treatment, she only had residual mild dry skin around the neck area. The migraines had diminished greatly in intensity and frequency.

Case 2 - A 10-month old baby girl was brought by her mother for a generalized, itchy rash, which had been present for several months. The itch was aggravated by heat and by bathing with very warm water, as the mother had read somewhere that bathing with very warm water was healthy. The patient frequently woke at night and had restless sleep, probably due to itch. Medical history revealed dry skin in the mother and parapsoriasis in the maternal grandfather. All developmental milestones had been met so far and vaccinations

received on schedule. On examination, there were erythematous, squamous patches, with some weeping lesions that also affected the flexural and extensor areas of the limbs, the face and neck.

She received the homeopathic medicine *Lachesis* at C30 potency, weekly dose. The patient improved continuously with this treatment and, 6 months after cessation of treatment, continued to remain almost completely lesion-free and symptom-free. The patient has also returned to normal sleep patterns. I had the opportunity to see this patient over the course of several years, while consulting her and other family members for various disorders and she continued to remain well.

Case 3 - An 11-month old baby boy was brought by his parents for a 3-month history of generalized itchy rash. There was no family history of itchy rash and his medical history was insignificant. All developmental milestones were normal and vaccinations had been done on time. On examination there were generalized, erythematous, squamous plaques, localised mostly to the upper chest, neck and abdominal areas. There was relative facial sparing. The patient was prescribed the homeopathic medicine *Lachesis* at C30 potency, weekly dose and he improved. He was lesion-free by one month and, 3 months later, remained free of lesions. He has been lesion-free for years, according to his parents, who consult me occasionally for other unrelated medical issues.

Discussion:

Atopic dermatitis is a common skin disorder, with a higher prevalence in industrialised nations, but its prevalence in non-industrialised countries is on the rise. Pruritus and cutaneous dysimmunity are the most important features of atopic dermatitis. There are major and minor criteria for diagnosis. The major criteria are pruritus (itch), rash with typical morphology and personal or family history of atopy. Minor criteria include xerosis (dry skin), increased serum IgE, pruritic rash in skin creases. Nipple eczema, cheilitis, Dennie-Morgan infraorbital fold and itch while sweating, amongst others. Various treatment strategies are used for atopic dermatitis, including emollients, topical and systemic steroids, calcineurin inhibitors, UVB therapy, biologics and probiotics. Itamura and Hosoya[30] showed that individualised homeopathic medicine could be helpful in the therapy of atopic dermatitis. Their case series involved 17 patients (13F and 10M) with long-standing atopic dermatitis that had been treated with various conventional medical methods. Individual homeopathic medicine was added onto their conventional therapy. The results showed over 50% improvement in their skin condition in 15 of 17 patients; in sleep in 10 of

13 patients; in satisfaction in daily life by 9 of 12; in fulfilment at work by 7 of 11 and in human relations by 10 of 14. Therefore, individual homeopathic medicines could be considered a useful therapy in atopic dermatitis. My cases responded positively to individualised homeopathic medicine and continued to remain in remission long after the cessation of treatment. No side-effects were seen. I could conclude that homeopathy is an option that should be considered for the therapy of atopic dermatitis.

Figure 8.1a (case 2) – 10-month old girl with generalised itchy rash [25] (date of photograph 07 June 2011)

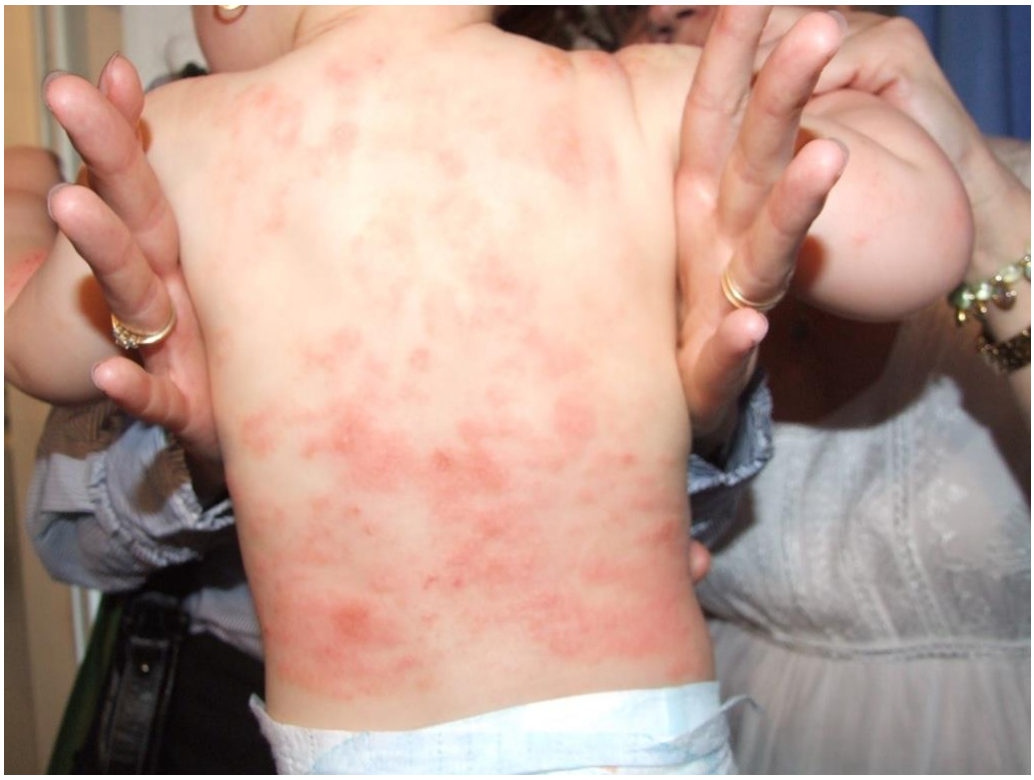
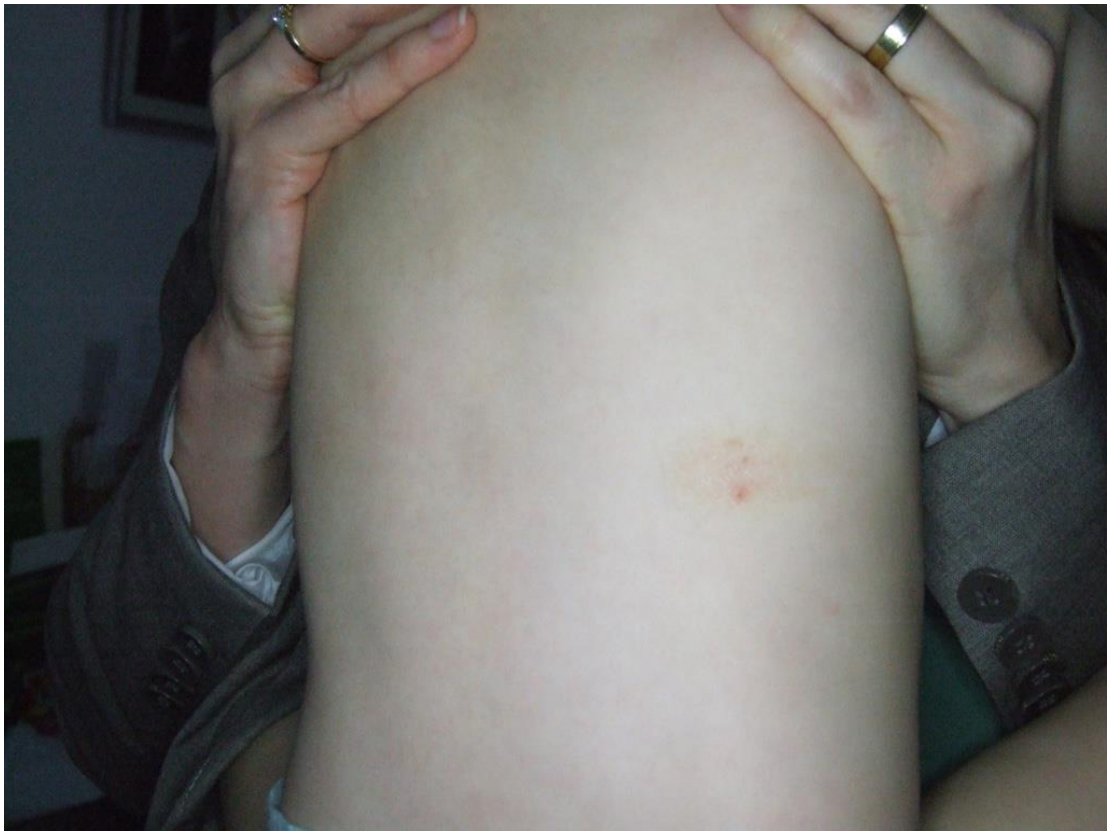


Figure 8.1b (Case 2) – patient in remission[25] (date of photograph 02 Feb 2012)



9 Homeopathy in the therapy of seborrheic dermatitis

9.1 "Seborrheic dermatitis and homeopathy" [31]

Seborrheic dermatitis is a frequently encountered, usually mild, skin disorder. Infants as well as adults may be afflicted, although onset is usually around puberty. Seborrheic dermatitis is found frequently in HIV infected patients. Various treatment modalities exist, including antifungal agents, antiparasitic agents, mild topical steroids and selenium sulphide. They are all aimed at control and not cure of the disease.

I published a case study (n=2) of patients with long-standing seborrheic dermatitis, who responded to individualised homeopathic treatment and remained in remission long after the cessation of treatment.

Case 1 - A 25 year-old female, with a facial rash that had been relapsing and remitting for years, presented with a severe flare that had been on for one month. She had been treated with methylprednisolone cream, with limited effect. She felt that stress was a major contributing factor to her flares. She had been a non-smoker for 8 years.

Her medical history was significant for mild hepatomegaly with raised enzyme levels, gastritis, appendicectomy and suspected pelvic inflammatory disease. On examination, she had a scaling, erythematous rash, with poorly defined borders and a predominantly central facial distribution. There were no truncal lesions. She was prescribed the homeopathic medicine *Ignatia amara*, MK potency, once and was asked to stop using methylprednisolone and sulphur creams and in their stead to use an *Aloe vera*-containing cream as an adjuvant to the homeopathic treatment. She also received acupuncture treatment for her abdominal pains. Her rash worsened following cessation of the steroid creams but one month later, the lesions had remitted and she remained in remission 2 years after the onset of treatment.

Case 2 - A 42-year old female presented with an asymptomatic facial and scalp eruption, which had been treated for years with methylprednisolone and sulphur creams. The eruption was worse during periods of emotional stress. Her medical history was significant for bilateral benign mammary dysplasia, which had been treated with hormonal and anti-inflammatory creams, as well as mild lumbar intervertebral disc disease. On examination, she was found to have a slightly brown rash that was covered with thin squames, with extension beyond the borders of the hairy scalp and circinate margins. She was prescribed homeopathic *Magnesia carbonica* at CH200 potency, weekly, as the higher MK potency was unavailable. At two months, the lesions remitted. She has occasional slight exacerbations during periods of great stress, but remains otherwise in remission.

Discussion:

Seborrheic dermatitis is a chronic inflammatory disorder affecting the scalp, face and chest. Although various therapeutic modalities exist, they do not bring about disease cure and can be fraught with side-effects, including cutaneous atrophy from topical steroid overdependence.

My cases suggest that long-standing, treatment-resistant cases of seborrheic dermatitis may respond to individualised homeopathic therapy and should be considered as an option in the management of seborrheic dermatitis that is resistant to conventional therapy.

Figure 9.1a (Case 1) – Erythematous plaques with irregular margins on central face with squames and some vesicles. [31] (date of photograph 28 Jan 2009)

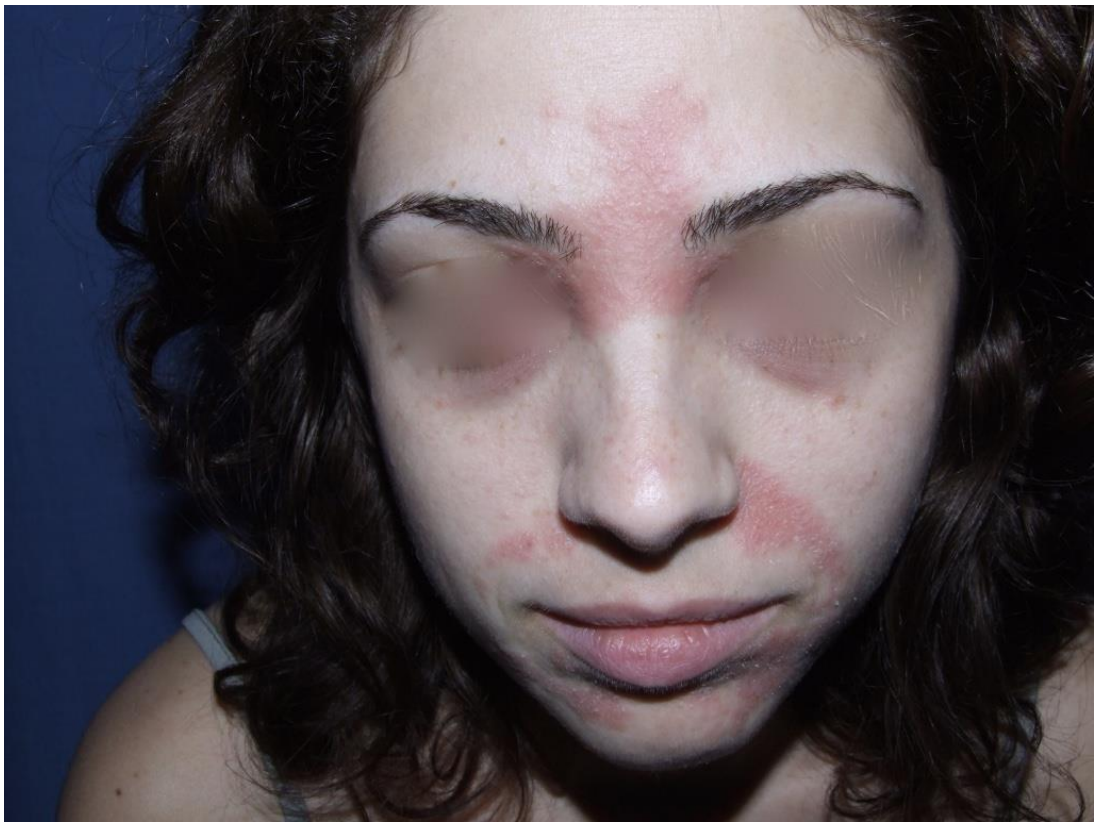
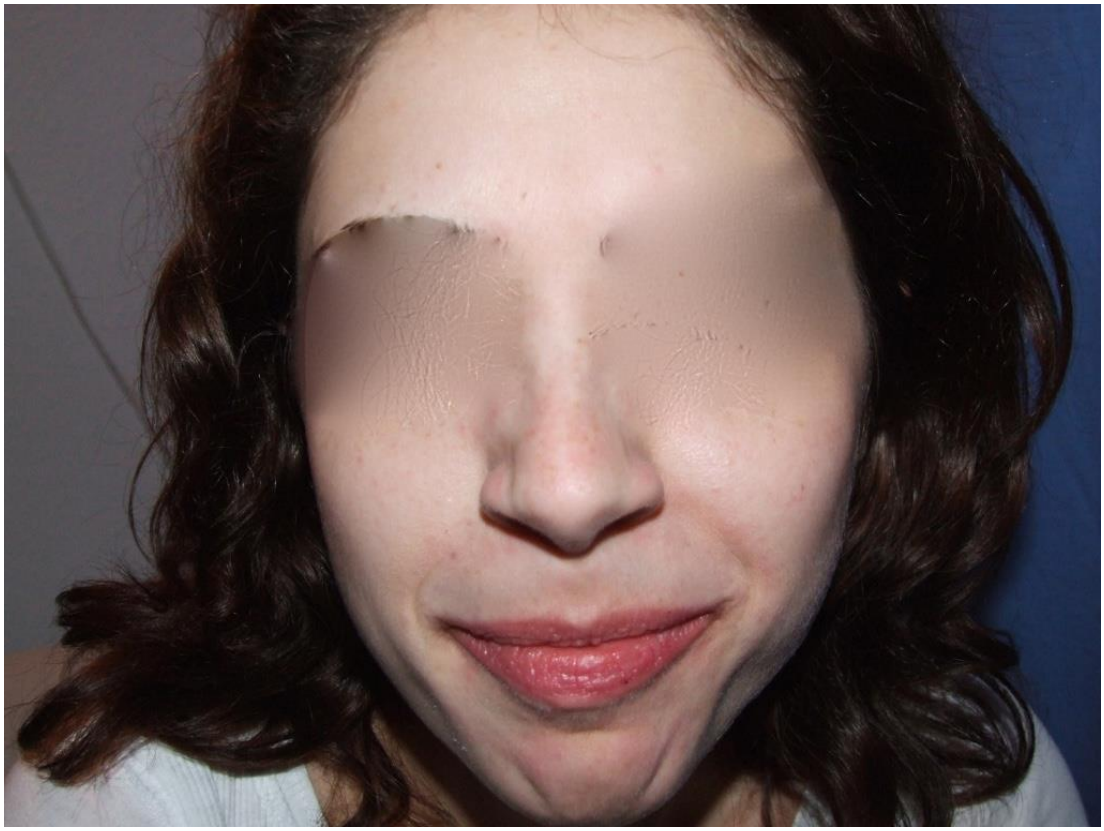


Figure 9.1b – patient in remission, lesion-free [31] (27 Feb 2009)



10 Homeopathy in the therapy of dermatitis herpetiformis

10.1 "Homeopathy in the treatment of dermatitis herpetiformis – a case presentation" [32]

Introduction:

Duhring disease or dermatitis herpetiformis was first described by Dr. Louis A. Duhring of Philadelphia in 1884[33]. He was also the first to use the designation dermatitis herpetiformis in his paper. Duhring disease is a bullous dermatosis characterised by grouped bullae/vesicles, papules, plaques and excoriations, located on the extensor surfaces of the elbows, knees, back and buttocks. Duhring disease appears to be slightly more common in males and tends to affect northern European populations. It is rare in Asian and African populations. The onset of the disease is usually in the second to fourth decades. It is an immunologic reaction resulting in the deposition of immunoglobulin A (IgA) in the papillary dermis. Histopathologic features include dermal papillary collections of neutrophils at the papillary tips (microabscesses) and fibrin deposition. Granular deposition of IgA at the dermoepidermal junction of clinically uninvolved skin is the gold standard for diagnosis. Dermatitis herpetiformis is associated with gluten-sensitive enteropathy. Also, serum levels of IgA anti-epidermal transglutaminase autoantibodies may aid in distinguishing untreated dermatitis herpetiformis from other pruriginous vesiculobullous dermatoses[34].

I published a case report of a patient with dermatitis herpetiformis treated with individualised homeopathic medicine and followed up over several years.

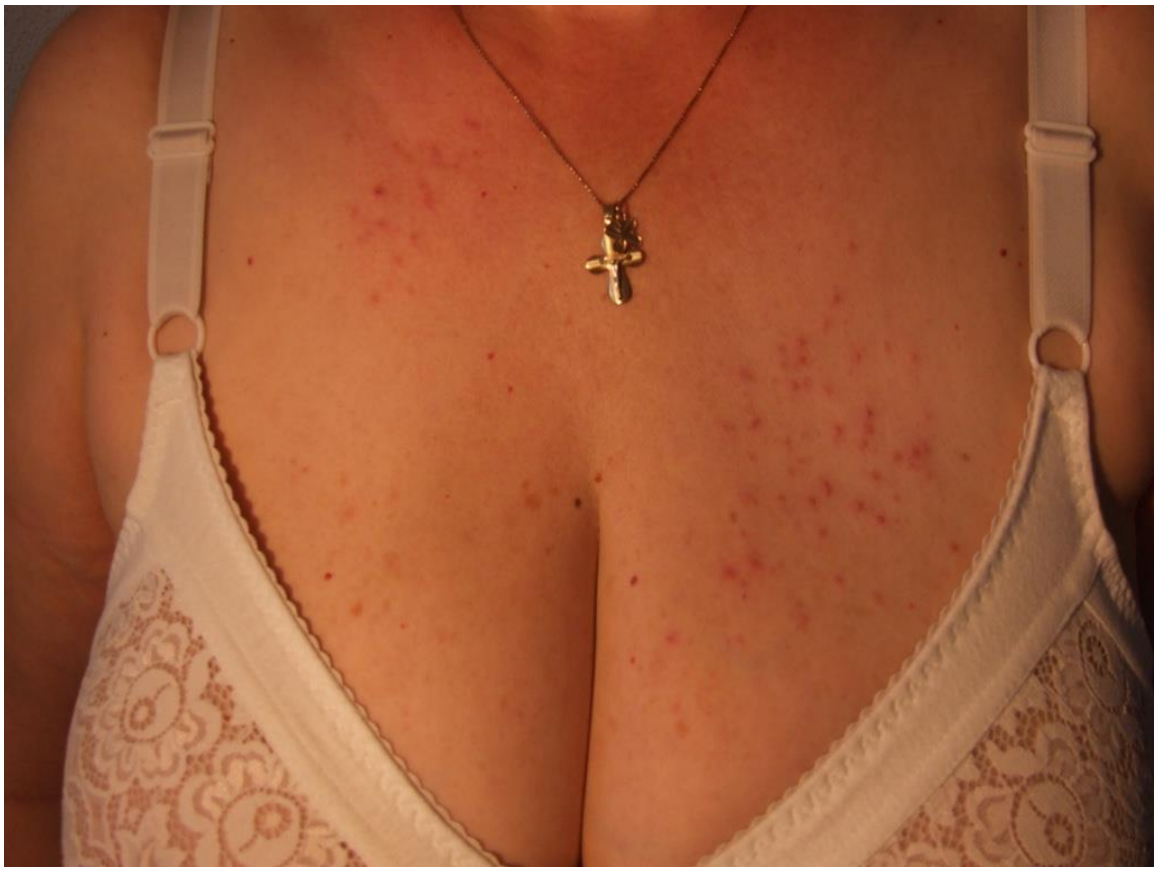
Case report - A 57-year-old female presented with a 35-year history of pruritus and occasional rash. The itch was worsened by heat, by unspecified foods in the evenings and at night. She also suffered from poor sleep and constipation. No lesions were noted on initial examination. The patient received the homeopathic medicine *Aurum metallicum* MK potency, weekly. She returned 10 days later, presenting 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. At this visit, she admitted to having been treated with dapsone for a presumed diagnosis of dermatitis herpetiformis and was on a gluten-free diet. The motives for initially withholding this information were not clarified by the patient and undue effort was not made to obtain this information because this might have made the patient uncooperative. A biopsy was recommended and the patient consented to this after she was reassured about the benign and potentially beneficial nature of the aggravation that followed the homeopathic treatment (which had already been explained to

her at the first visit). The treatment with homeopathic *Aurum metallicum* was continued and Calamine lotion and homeopathic *Rhus toxicodendron* C30 potency, both *prn*, were recommended additionally for the itching. Histopathology was indicative of dermatitis herpetiformis. Direct immunofluorescence could not be done, as the patient could not afford it. By 8 weeks after the onset of treatment, the patient was much better. There were few new lesions and the pruritus was very much reduced in intensity. Her sleep was much better. Examination showed few active lesions and some residual lesions. The patient became lost to follow-up until she was invited by me for a consultation 15 months later. At this visit, she stated that she had been symptom-free for over 1 year, but due to financial constraints she could not come for consultations. She stated that she was also able to consume gluten-containing foods with no adverse reactions. She was invited for a follow-up visit 14 months later and she expressed her satisfaction with her treatment. She had developed no new lesions in spite of eating an unrestricted diet, which included lots of wheat bread. Not only had the patient been in remission for over 2 years, but she had also been able to consume gluten-containing foods without relapse of her dermatitis herpetiformis.

Discussion:

Dermatitis herpetiformis is a chronic bullous disease associated with gluten-sensitive enteropathy. The differential diagnosis of this disease includes eczema, atopic dermatitis, urticaria, bullous pemphigoid, linear IgA disease, pemphigoid gestationis, neurotic excoriation and scabies. A history suggestive of gluten-sensitive enteropathy, as well as the characteristic histopathologic features and direct immunofluorescence will help distinguish dermatitis herpetiformis from the other pruritic disorders named earlier. Management of this disease includes elimination of gluten-containing foods from the diet and suppression with medication, which includes dapsone, considered first line treatment, sulfasalazine and sulphamethoxypyridazine, corticosteroids, azathioprine and antihistamines. The case presented was diagnosed without recourse to direct immunofluorescence (the gold standard). Histopathology of involved skin can be characteristic and, together with the clinical picture, sufficed in this case for a proper diagnosis. The patient was able to return to a gluten-containing diet without harmful side effects or relapse of her disorder. This suggests that individualised homeopathic treatment may not only lead to the remission of the cutaneous lesions of dermatitis herpetiformis but also be potentially useful in the treatment of the accompanying gastrointestinal disorder.

Figure 10.1a and Figure 10.1b – Erythematous vesicules and small papules, with some grouped together on the anterior chest and posterior thighs[32]. (date of photographs 30 Jun 2011)



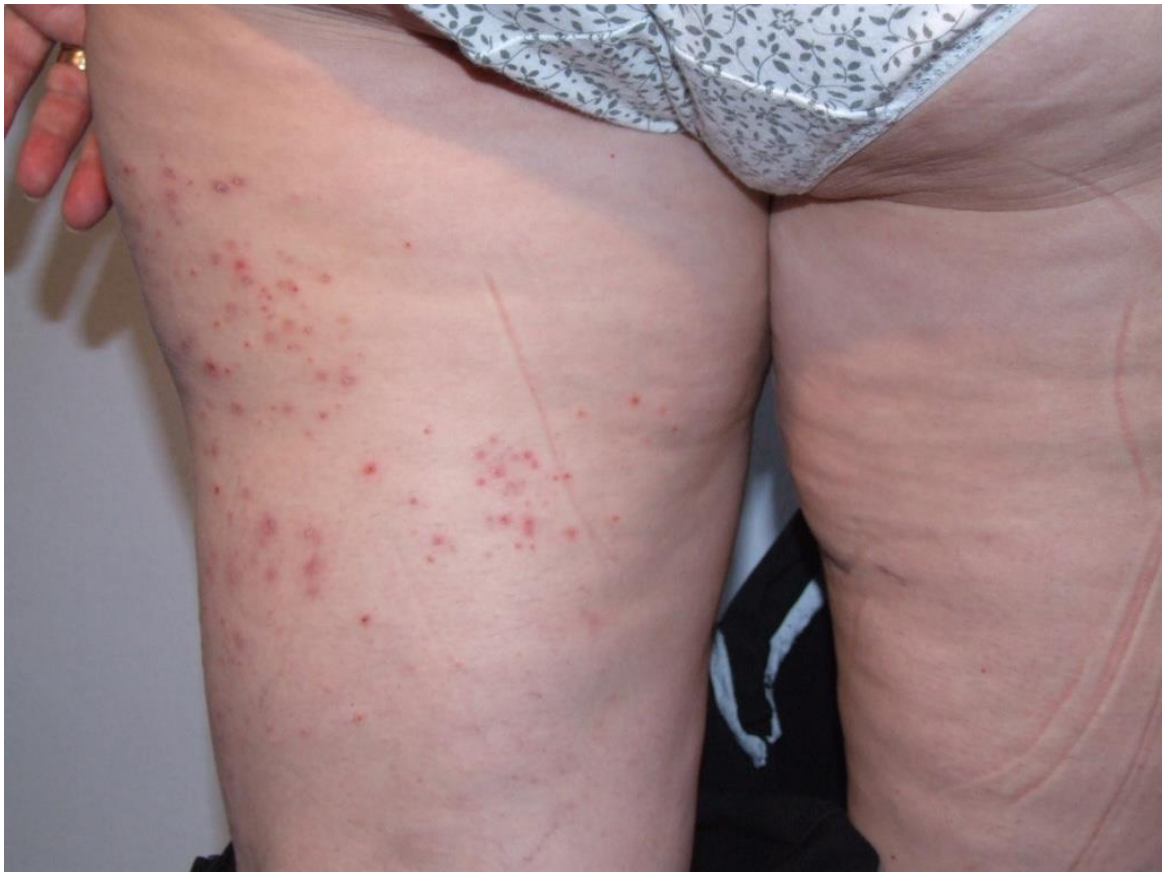
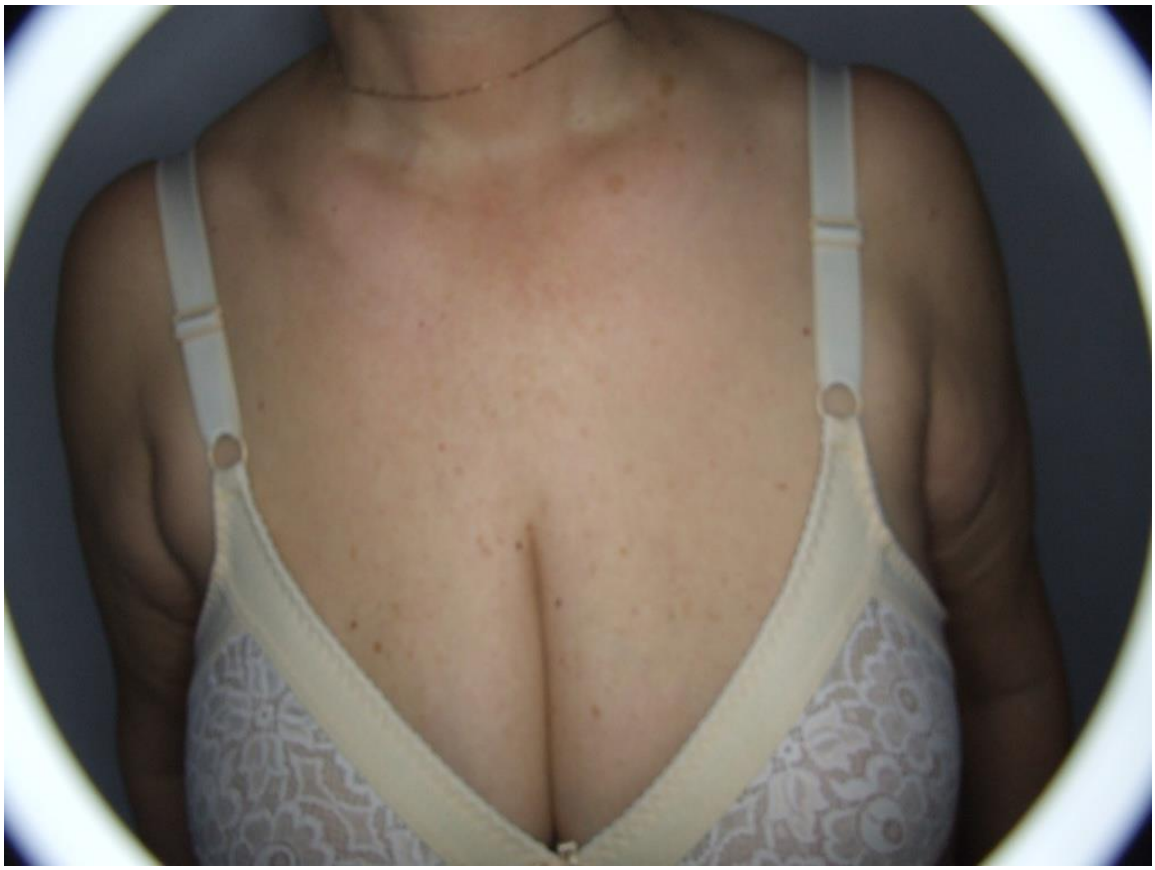
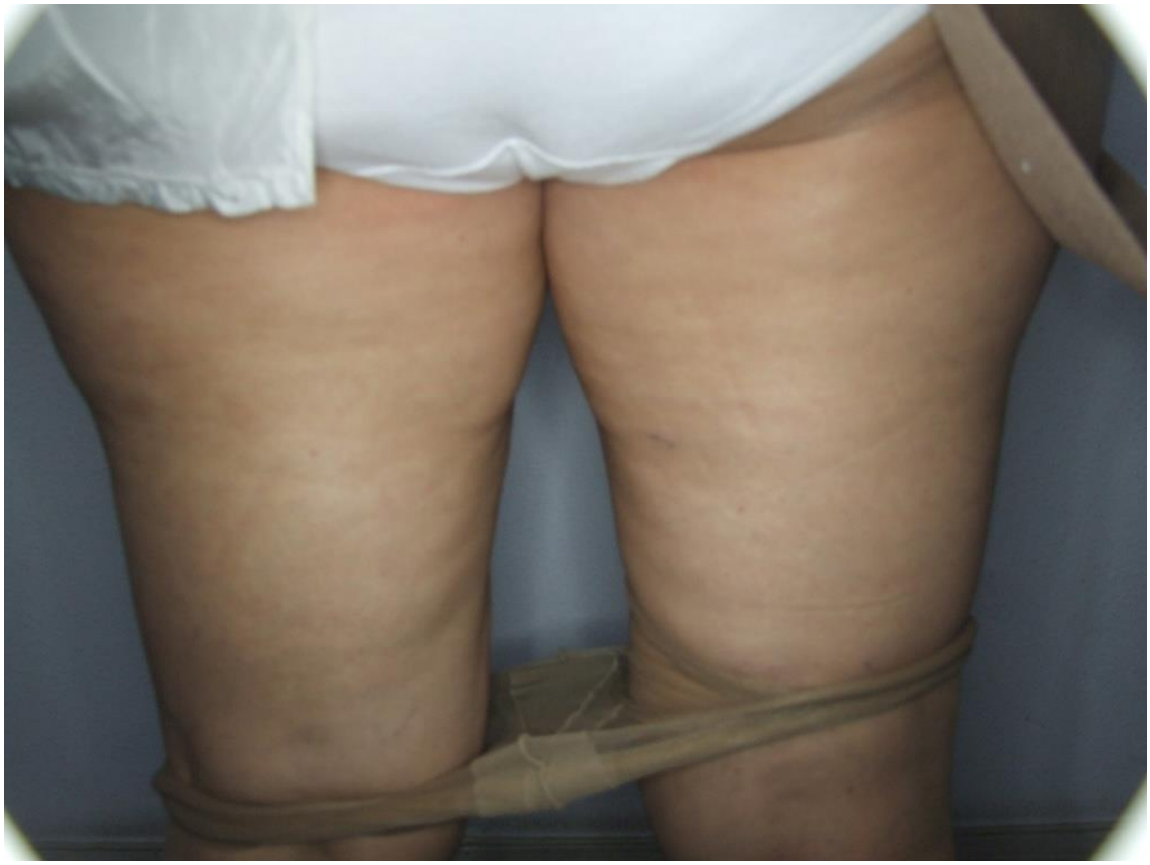


Figure 10.1a and Figure 10.1b – lesions in remission [32] (date of photographs 28 Nov 2012)





11 Homeopathy in the therapy of melasma

11.1 "Homeopathy and melasma – a case presentation" [35]

Introduction:

Melasma is a commonly encountered disorder of pigmentation, which affects the face in the majority of cases. It is much more common in females and the exact etiology is unknown, although various factors such as sunlight (ultraviolet light) exposure and hormonal factors have been implicated. While not life-threatening, it is a potential source of distress and diminished quality of life, bearing in mind the cosmetic effects it can have. Various therapeutic methods are used, including laser and intense pulsed light, hydroxyquinone or combination therapy with a steroid or a retinoid and 4% hydroxyquinone may produce the excellent results with improvement in quality of life scores [36,37].

I published a case report of homeopathy in the treatment of a patient with melasma, with one year post-treatment follow up [35].

Case 1 - A 34-year old female presented with a 1-year history of facial rash. She had been treated with topical methylprednisone acetonate 0.1% cream and a triple combination nystatin, neomycin and triamcinolone cream with unsatisfactory results. She was not currently on any medication and her last pregnancy was 12 years prior to presentation and she had only one child. No history of joint or muscle pain could be elicited. The eruption worsened with sun exposure and also with emotional stress following her son's hospital admission. She had symptoms of itching and stinging as well as hypersensitivity to touch. On physical examination there was a female patient in good general health, with diffuse, irregular, poorly defined hyperpigmented macules involving the nasal bridge and the malar areas, with slightly greater intensity on the right side. There was mild infiltration noted visually and on palpation of the affected areas. Physical examination of other systems was normal and routine blood tests done for work purposes were reportedly normal. Melasma, photosensitivity reaction and lupus erythematosus were the potential differential diagnosis. A biopsy was offered, which she refused. She was asked to stop using the creams and was recommended homeopathic *Lycopodium* MK potency, weekly, as well as homeopathic *Apis mellifica* C30, as needed, for the stinging, slightly edematous facial rash. The patient showed improvement with almost complete clearance of the rash at the follow-up visit six weeks later. The homeopathic medicine was stopped and the patient placed under observation. She continued to improve and remained lesion-free more than one year after treatment.

Discussion:

A case of melasma, which had failed to respond to standard therapy (topical steroids), but had remitted with homeopathic treatment, has been presented. The patient was treated with homeopathic *Lycopodium clavatum* and improved. The improvement remained 1 year after the cessation of treatment, in spite of not using sunscreens.

Figure 11.1a – Patient with irregular, hyperpigmented macules on the malar areas and nose[35] (date of photograph 10 May 2010)

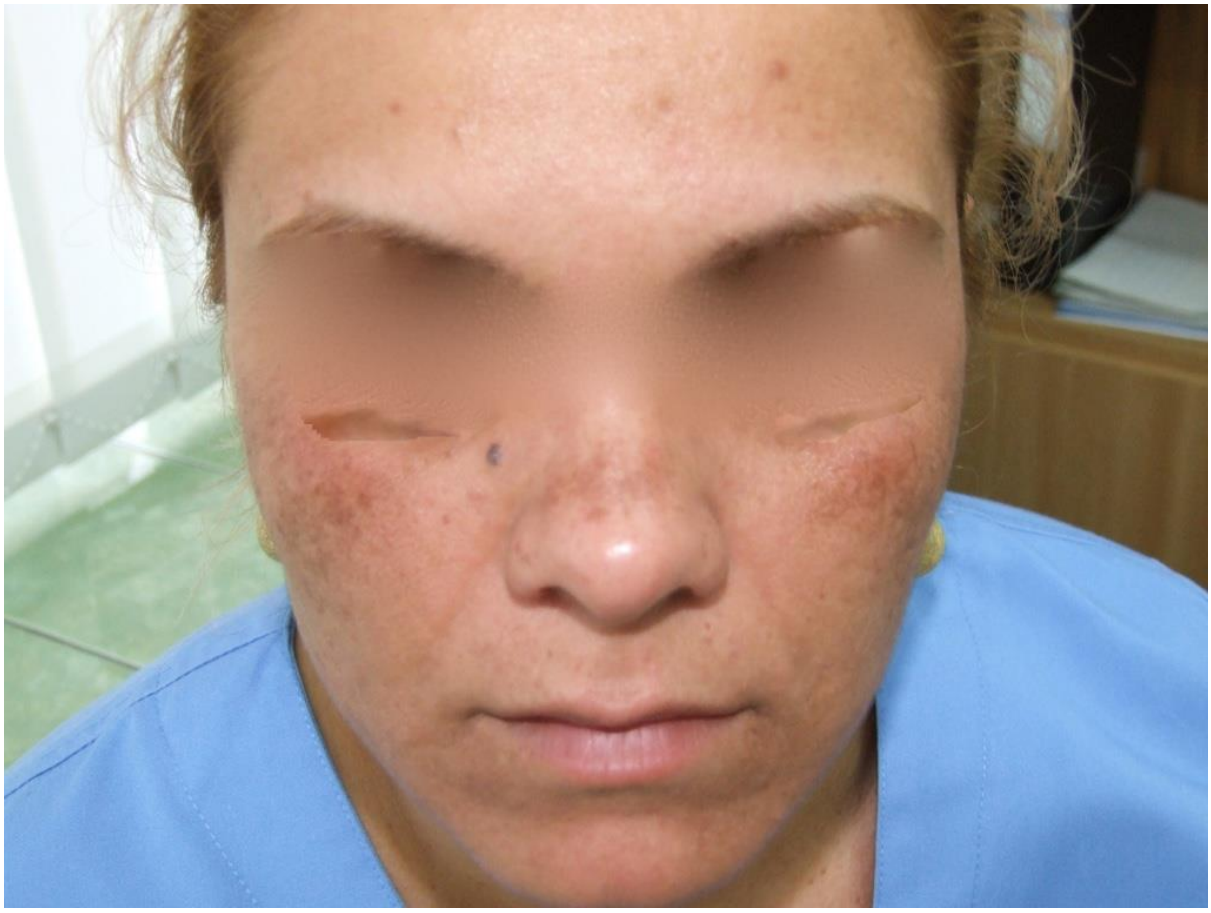


Figure 11.1b - Patient in remission, at six weeks after treatment [35]
(date of photograph – 18 June 2010)

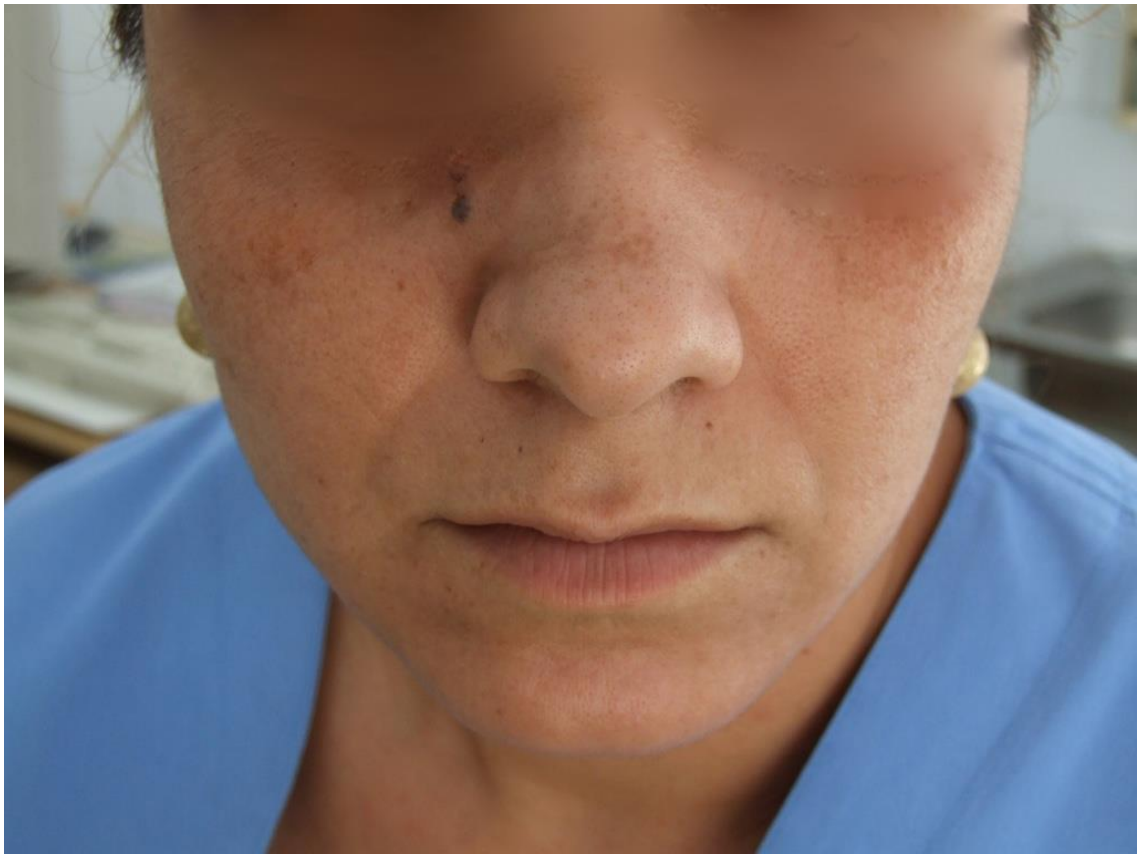
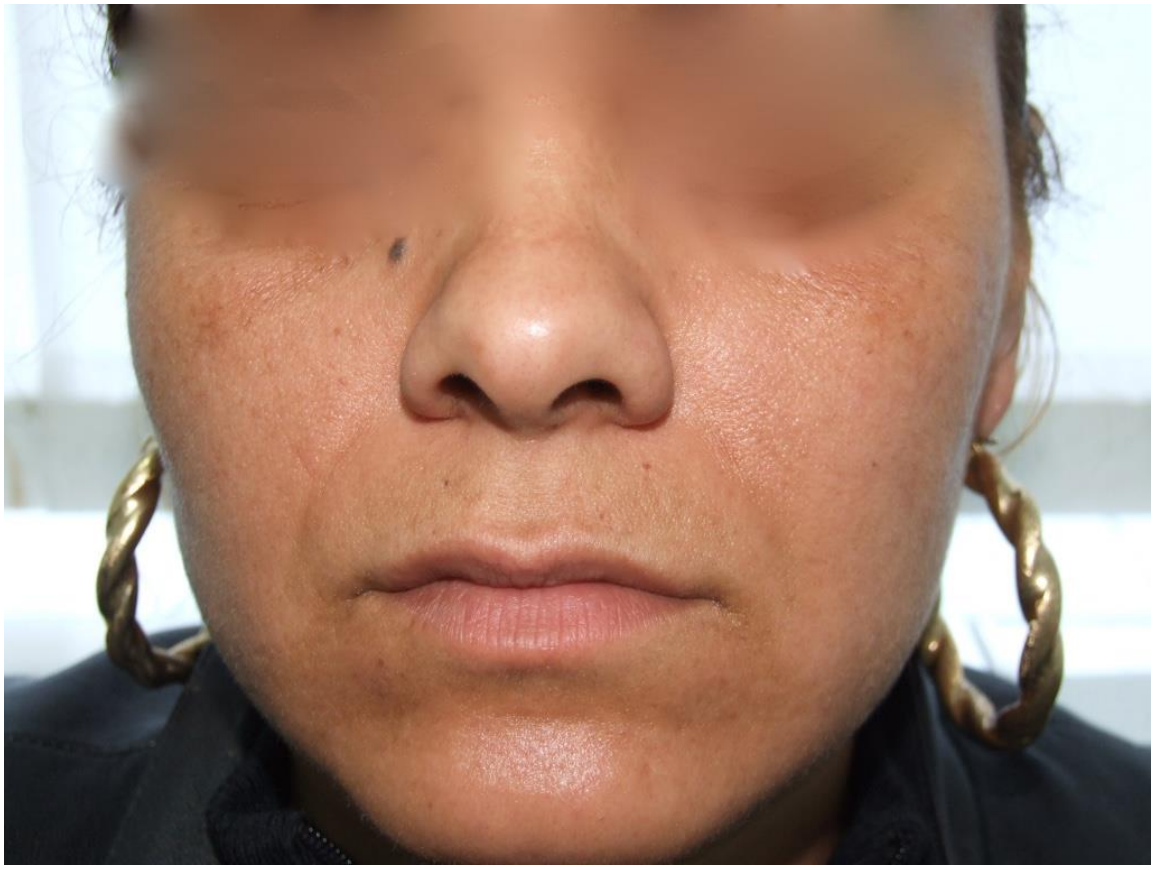


Figure 11.1c – patient at 1 year after cessation of treatment and still in remission [35] (Date of photograph 20 April 2011)



12 Homeopathy in the therapy of Elephantiasis nostras

12.1 "An integrative therapeutic approach to elephantiasis nostras verrucosa: A case report" [12.1]

Introduction:

Elephantiasis nostras is severe lymphedema, which is frequently associated with characteristic skin changes, including ulcers, deep skin folds, hyperkeratosis and a cobblestone appearance. The latter is probably the reason for the designation 'verrucosa' occasionally used in the designation of this disease. Elephantiasis nostras is difficult to treat. A variety of methods, including compressive stockings, surgery, manual lymph drainage, pressure appliances and medications have been attempted. Diuretics have been of little value as lymphedema is due to accumulation of protein-rich fluid, as opposed to the simple fluid accumulation of edema. *Apocynum cannabinum*, popularly known as dogbane or indian hemp, is a poisonous plant, which was used by indigenous tribes for a variety of purposes. It is also used in homeopathy for the treatment of oedema.

I published, together with my colleagues, a study of a case of elephantiasis nostras of 3-4 years duration that was treated successfully with combined furosemide and homeopathic *Apocynum cannabinum.*

The case: A 72-year old female presented with a 3 to 4-year history of massive leg edema, which began on the right leg and progressed to involve the left leg. No history of infections, cardiac, renal, thyroid or hepatic disease was elicited. However, tests revealed mild anaemia and renal impairment (hypoalbuminemia and raised creatinine). The patient was housebound and therefore more comprehensive tests could not be done. She had been on therapy with furosemide 80 mg/day, without alleviation of her condition. Clinical examination showed elephantiasis with limb diameters of 68/46 cm (right mid-calf/ankle) and 67/43 cm (left mid-calf/ankle). She also had erythema, oozing and excoriation of the legs with deep folds and creases. A recommendation of 120 mg of furosemide daily and the homeopathic medicine *Apocynum cannabinum* at CH30 potency, *t.d.s.,* together with daily povidone iodine dressing for her legs was made. Compressive stockings could not be used by the patient due to unavailability of an adequate size. The oozing and erythema diminished gradually and her leg diameters decreased. In Table 12.1 the gradual decrease in limb size at approximately 8-week intervals is documented. At 12 months after onset of treatment, limb diameters were 63/42 cm for right mid-calf/ankle and 65/41 cm for left mid-calf/ankle with minimal oozing. At 18 months after onset of treatment, leg diameters were 46/35 cm

for right and 48/36 cm for left mid-calf/ankle areas, with improvement in skin appearance. The patient was consequently able to be mobile and therefore to take short walks around her apartment block or up and down the communal stairs, as the weather permitted. An increase in limb diameters was noticed at the 23-month visit. This followed the death of her sister who was her primary care giver. At this visit the patient had been accompanied by her nephew. She became lost to follow up after this consultation and was later reported as deceased.

Discussion:

Elephantiasis nostras is not known for spontaneous remission. The combination of furosemide 120 mg/day and *Apocynum cannabinum* at CH200, *t.d.s.* proved very valuable in the treatment of our patient. Patient's improvement was slow and the reduction in limb size over time was gradual and incremental (Table 12.1), each centimetre dimunition in size meant a large reduction in oedema, which could be observed clinically as significant improvement over the entire limb. The improvement in the limb appearance in the form of disappearance of the cobblestone appearance and the deep folds, as well as the healing of the excoriations and oozing, led to improvement in the quality of life of the patient. Elephantiasis nostras is a chronic disorder characterized by massive lymphedema and it has numerous possible causes. Many modalities of treatment have been tried, including benzopyrones, retinoids, selenium, surgery, laser therapy, manual therapy, and compressive therapy, with varying effects. Stem cell treatment has also shown promising results, but diuretics are not considered effective. Therapy of this disease is aimed at reducing disability, thereby alleviating the psychological distress associated with the condition, and to manage comorbidities. Elephantiasis nostras is not usually responsive to diuretic therapy as lymphedema, unlike simple oedema, is characterized by a high proportion of proteins in the extracellular space, due to impairment of lymphatic function. The patient in this study was already on furosemide therapy and it was felt that no benefit would be gained from its removal, but rather that there might be some gain from an slightly increased dosage (taking into consideration the patient's underlying renal insufficiency), together with the use of homeopathic *Appocynum cannabinum.* Homeopathic medicines consist of highly diluted substances, which are thought to work by stimulating the body's innate capacity for regeneration. The patient from the present study responded well to a combination of a homeopathic medicine and high-dose furosemide. It is unlikely that any placebo effect played a significant role in this case, given the non-spontaneously remitting nature of this

disorder. The findings from this case report may provide impetus for further research into the role of integrative therapeutic approaches (high-dose furosemide and homeopathy) in the therapy of lymphedema.

Table 12.1 Change in leg diameters during period of treatment

Dates	Left mid-leg	Left ankle	Right mid-leg	Right ankle
10 May 2014	67.0 cm	43.0 cm	68.0 cm	46.0 cm
13 June 2014	66.0 cm	46.0 cm	67.0 cm	46.0 cm
26 July 2014	67.5 cm	45.0 cm	70.0 cm	47.0 cm
13 September 2014	64.5 cm	46.0 cm	67.0 cm	46.0 cm
04 October 2014	65.0 cm	43.0 cm	65.5 cm	45.5 cm
29 November 2014	64.0 cm	43.0 cm	64.5 cm	45.0 cm
07 February 2015	63.5 cm	38.5 cm	63.0 cm	42.0 cm
04 April 2015	62.0 cm	41.0 cm	62.0 cm	42.0 cm
16 May 2015	65.0 cm	41.0 cm	63.0 cm	42.0 cm
17 July 2015	-	-	-	-
12 September 2015	50.0 cm	38.0 cm	48.0 cm	38.0 cm
07 November 2015	48.0 cm	36.0 cm	46.0 cm	35.0 cm
08 January 2016	48.0 cm	36.0 cm	47.5 cm	39.0 cm
12 April 2016	52.0 cm	41.0 cm	47.0 cm	39.0 cm

Figure 12.1a Erythema, crusting, cobblestone appearance of the leg at onset of therapy [38]

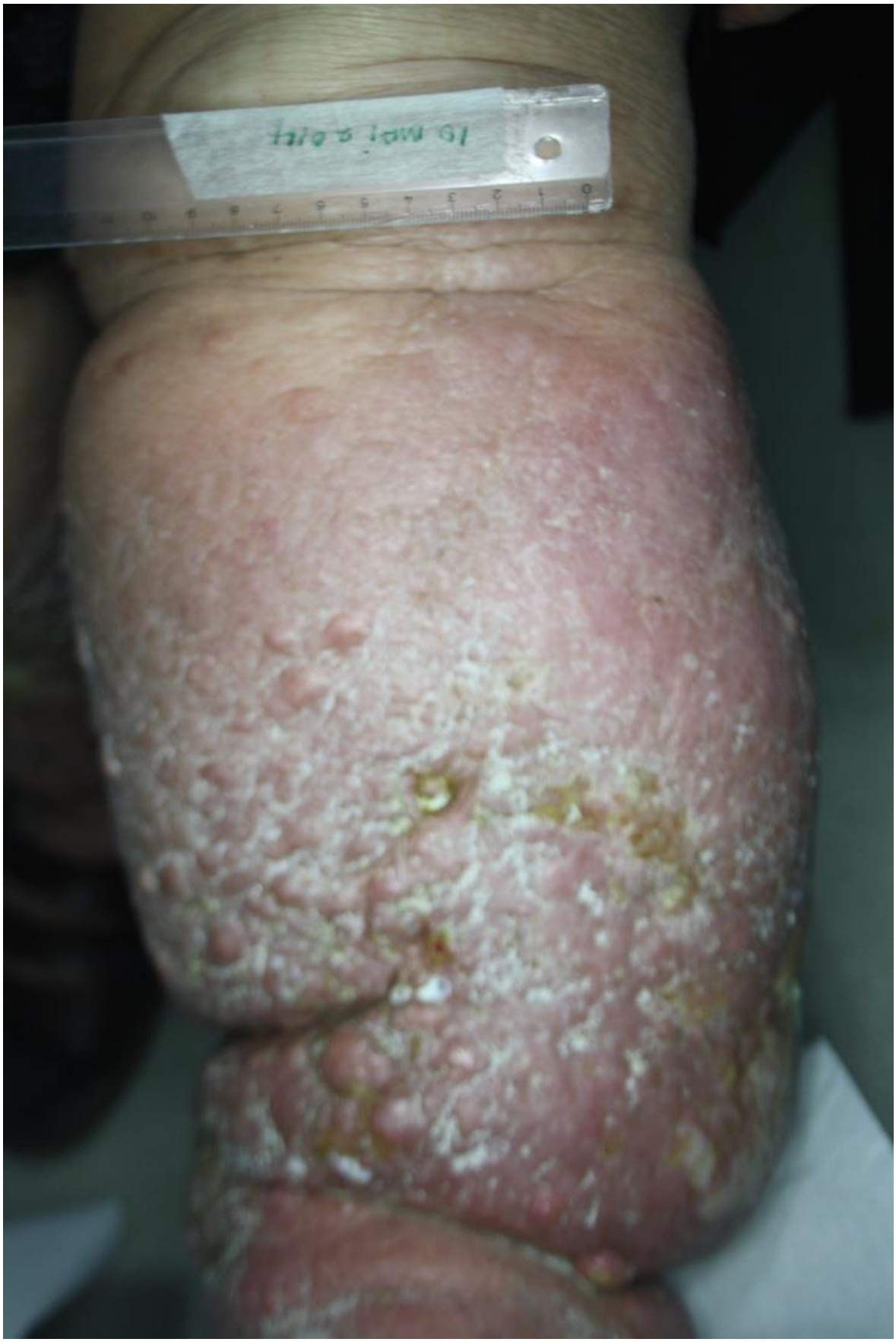


Figure 12.1b Erythema, crusting, cobblestone appearance of the leg at onset of therapy[38]

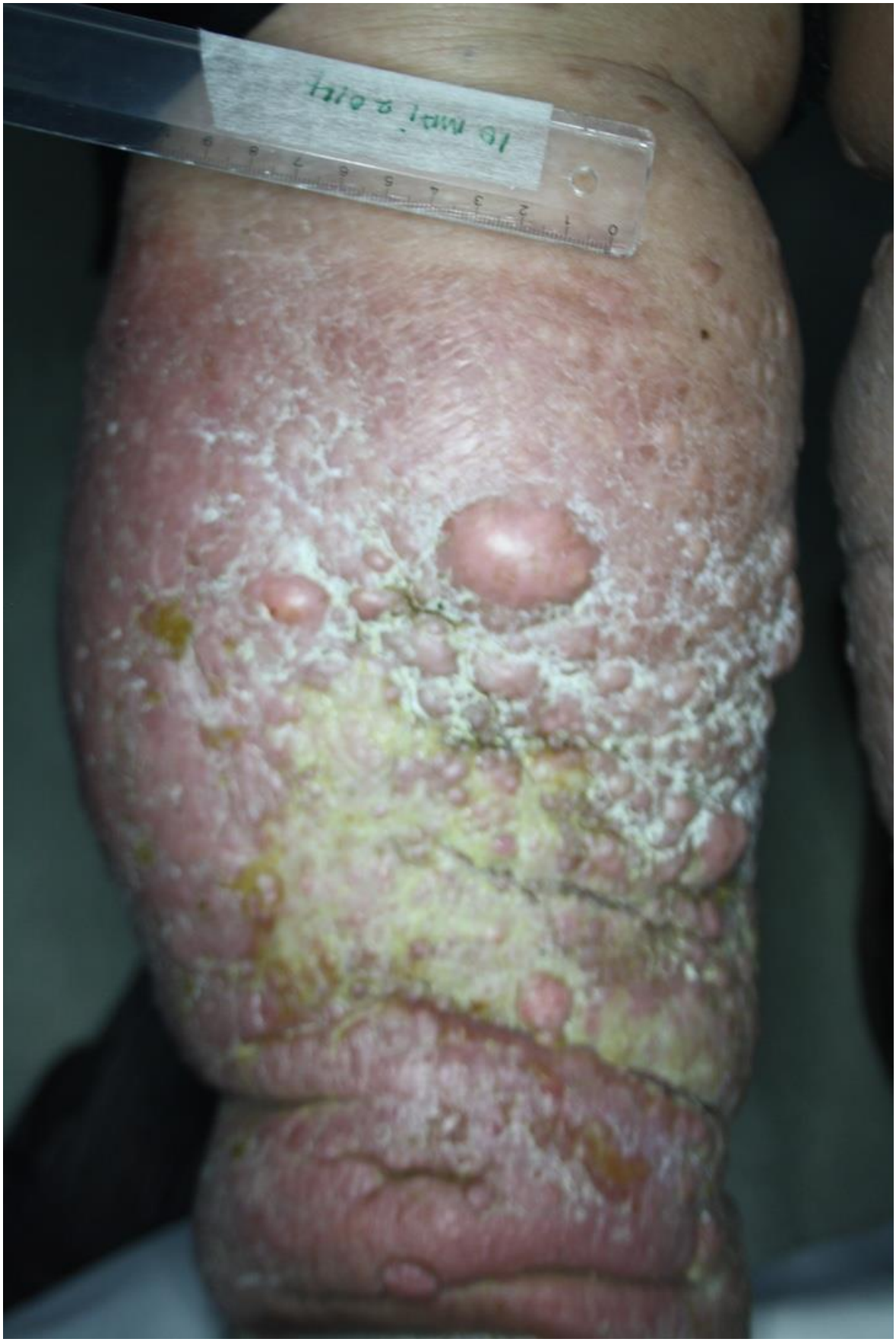


Figure 12.1c Diminished limb size and erythema, after one year of therapy[38]

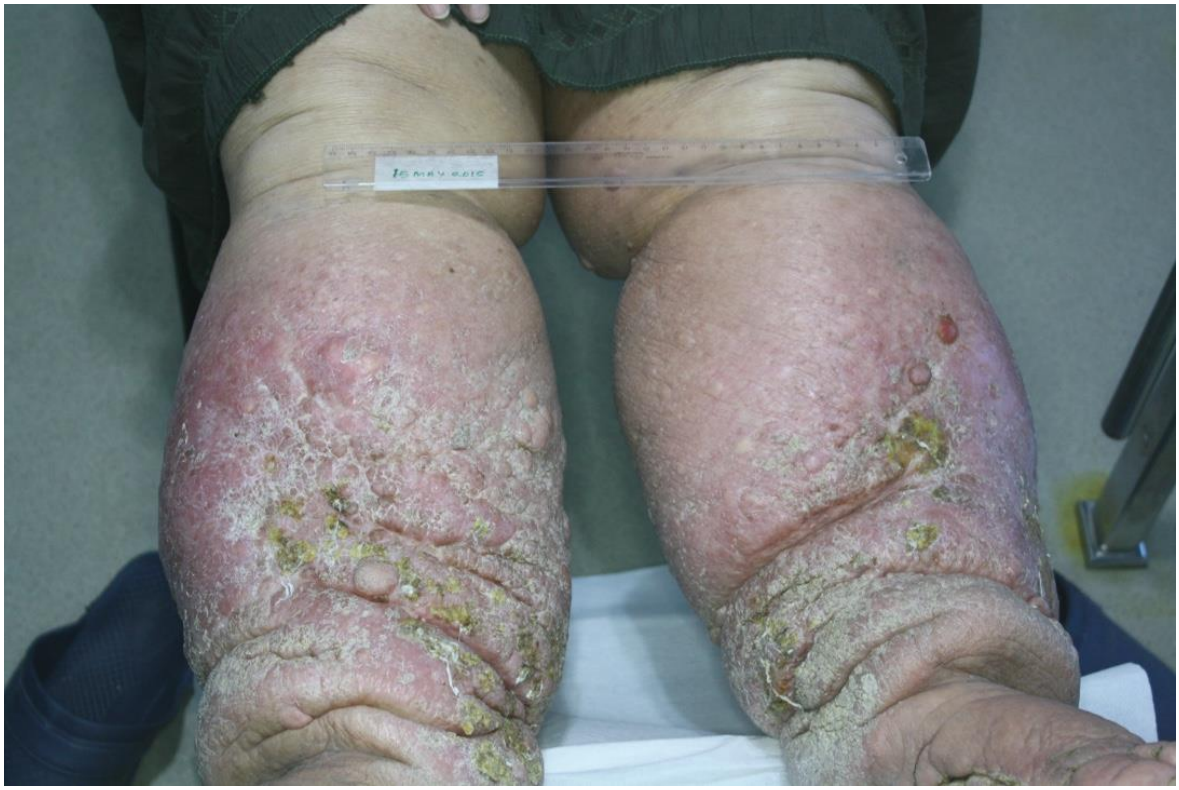
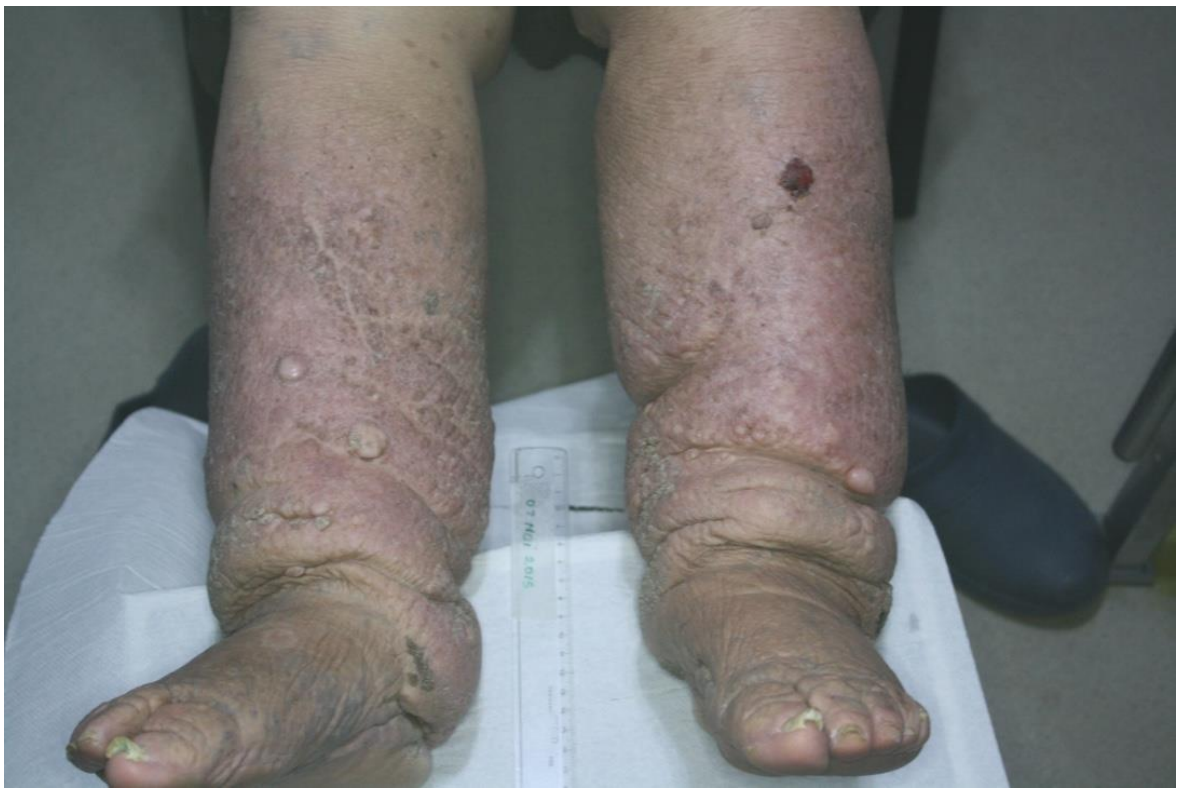


Figure 12.1d Much minimal erythema, no crusting, folds or cobblestone appearance at 18 months of therapy[38]



13 Cutaneous ulcers

Introduction:

Cutaneous ulcers are a significant area of dermatology. They are a commonly encountered disorder and the list of differential diagnoses of these disorders is very large. This includes diabetes, vasculitis, trauma, infection, malignancy, neuropathy, vasculopathy and varicose veins, amongst others. They are a significant cause of diminished quality of life. Their treatment can be very expensive and time-consuming, thereby placing a burden on healthcare services and on patients and their families.

I present several cases of cutaneous ulcers treated using natural products and published in the international literature. Malignant ulcers in patients with diabetes mellitus are also presented, demonstrating the potential for misdiagnosis and, in consequence, delayed or inadequate therapy. These cases of malignant ulcers further underline the need for multidisciplinary approaches to foot ulcers therapy.

13.1 "Magistral prescription with silver nitrate and Peru balsam in difficult-to-treat diabetic foot ulcers" [39]

A 50-year-old male with a history of long-standing type 2 diabetes mellitus presented with a 6-month history of nonhealing, painful foot ulcer. He smoked an unspecified amount of tobacco daily. Examination revealed an ulcer on the dorsal surface of the right foot, with partially granulated base, in which some exposed tendons could be seen. The ulcer margin was well-circumscribed and had a punched-out appearance. There was associated pedal oedema and onychodystrophy with onycholysis. Pulses could not be palpated and a previous arteriography had suggested a diagnosis of severe arteriopathy, which was not amenable to surgical therapy. The patient claimed he had been offered amputation by the surgical department of a regional hospital, which he had refused. I recommended a magistral preparation (1% silver nitrate, 10% Peru balsam in a cream base), known as Miculicz ointment, to be applied to the ulcer daily; sulodexide tablets and povidone iodine solution for the areas of onycholysis. Paracetamol and, occasionally, tramadol, were recommended for pain relief. The patient's ulcer healed in 6 months and, despite the unresolved arteriopathy, remained healed at more than 1 year after initial presentation.

Figure 13.1a – Ulcer on dorsum of right foot, with some granulation tissue and visible tendons with onycholysis[39].

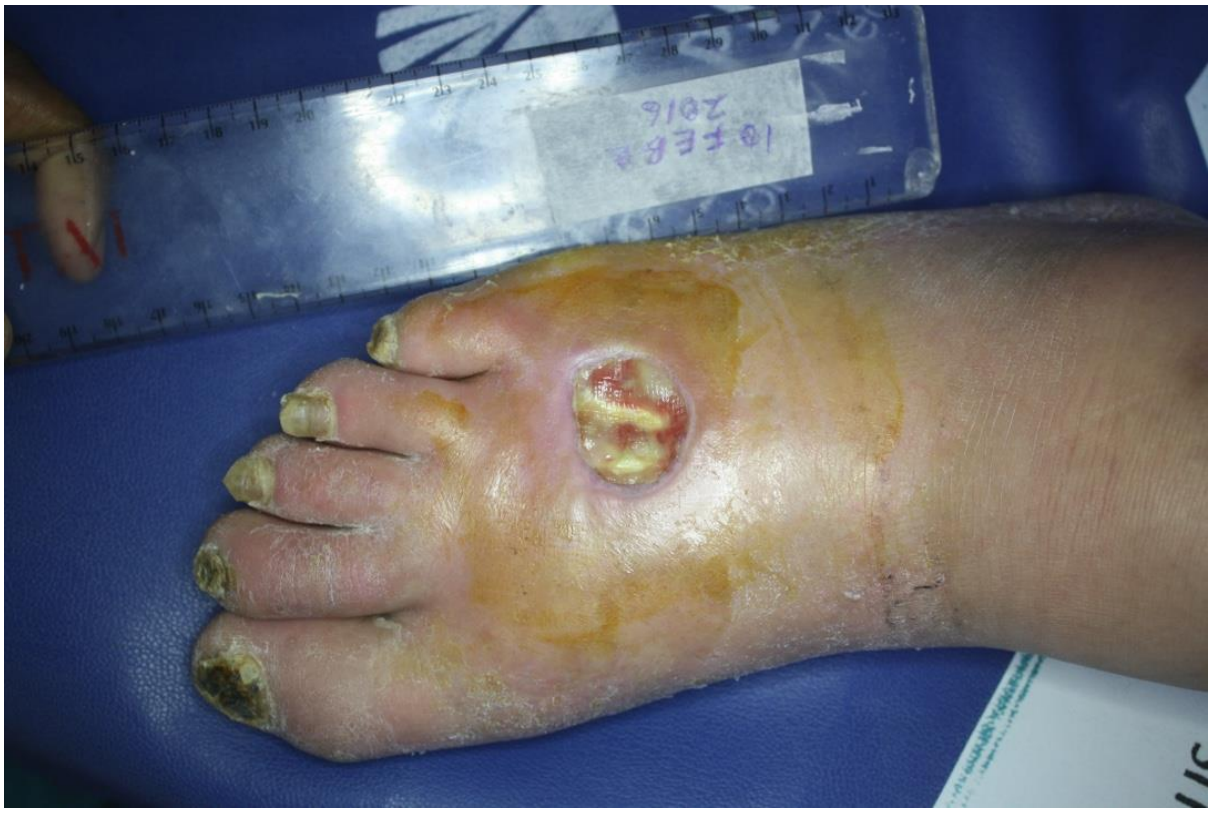
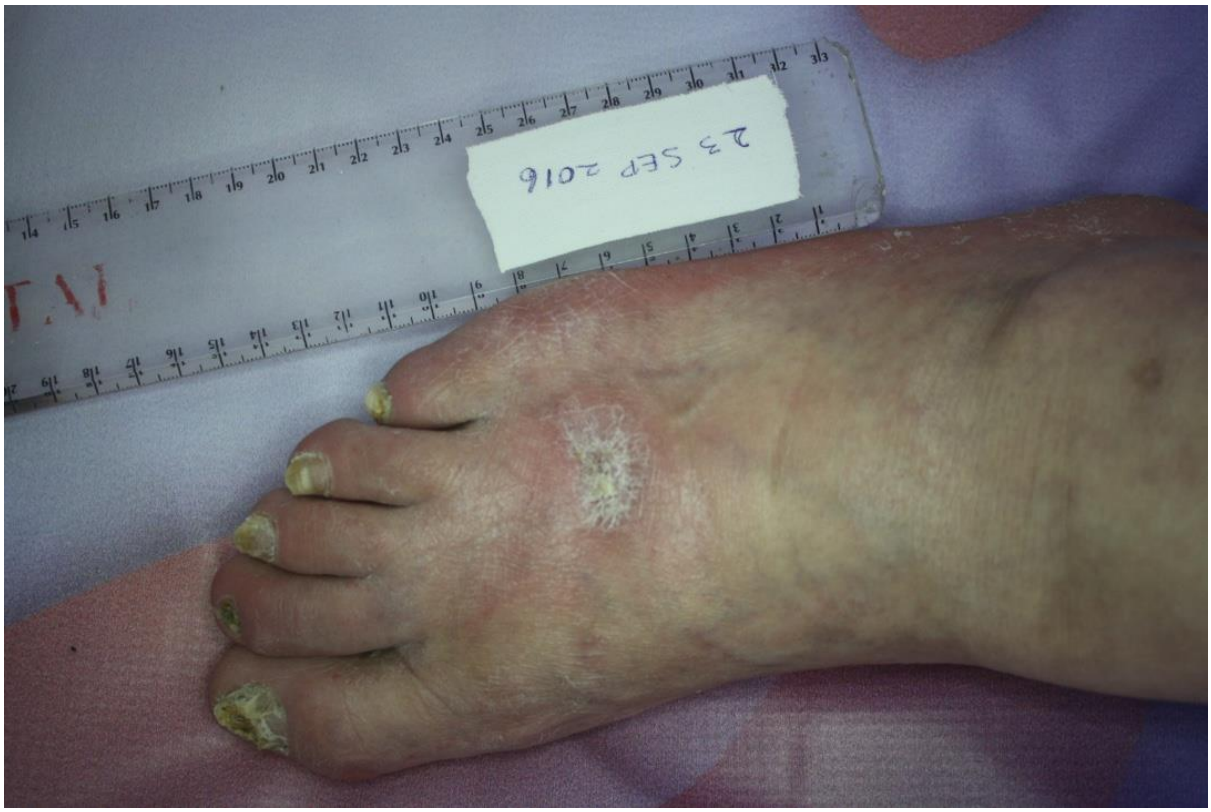


Figure 13.1b – healed ulcer with improvement in nail appearance. [39]



13.2 “Patient education, self-care and medical grade honey — managing a diabetic ulcer” [40]

An 85-year-old male presented with a 2-week history of right leg ulceration. The ulcer was the consequence of having tripped and fallen at his home. His medical history was significant for long-standing type 2 diabetes mellitus, renal impairment and ischaemic cardiopathy. His HbA1c was 5.6%. On examination, there was a large (approximately 20 x 12 cm), L-shaped ulcer, with irregular margins on his lower right anterior and lateral leg. It had a granulating base, which was partially covered by slough. The wound produced a copious, clear exudate, which had no significant odour. The patient was treated with a honey gel preparation composed of gamma-sterilised honey and other healing factors, including antioxidants. The product was initially applied by me, as the consulting physician and the patient was instructed on home use. The dressing was recommended to be changed daily. By one week of treatment, the secretion had stopped and healing had begun with epithelialisation at the margins and islands of granulation tissue within the ulcer. Weekly follow-up visits were carried out, while the patient continued home care in between those visits. Full skin epithelialisation was achieved at about 24 days after the onset of treatment and the patient was discharged from the outpatient clinic.

Figure 13.2a – L-shaped ulcer with irregular margins and a partially granulated base[40].

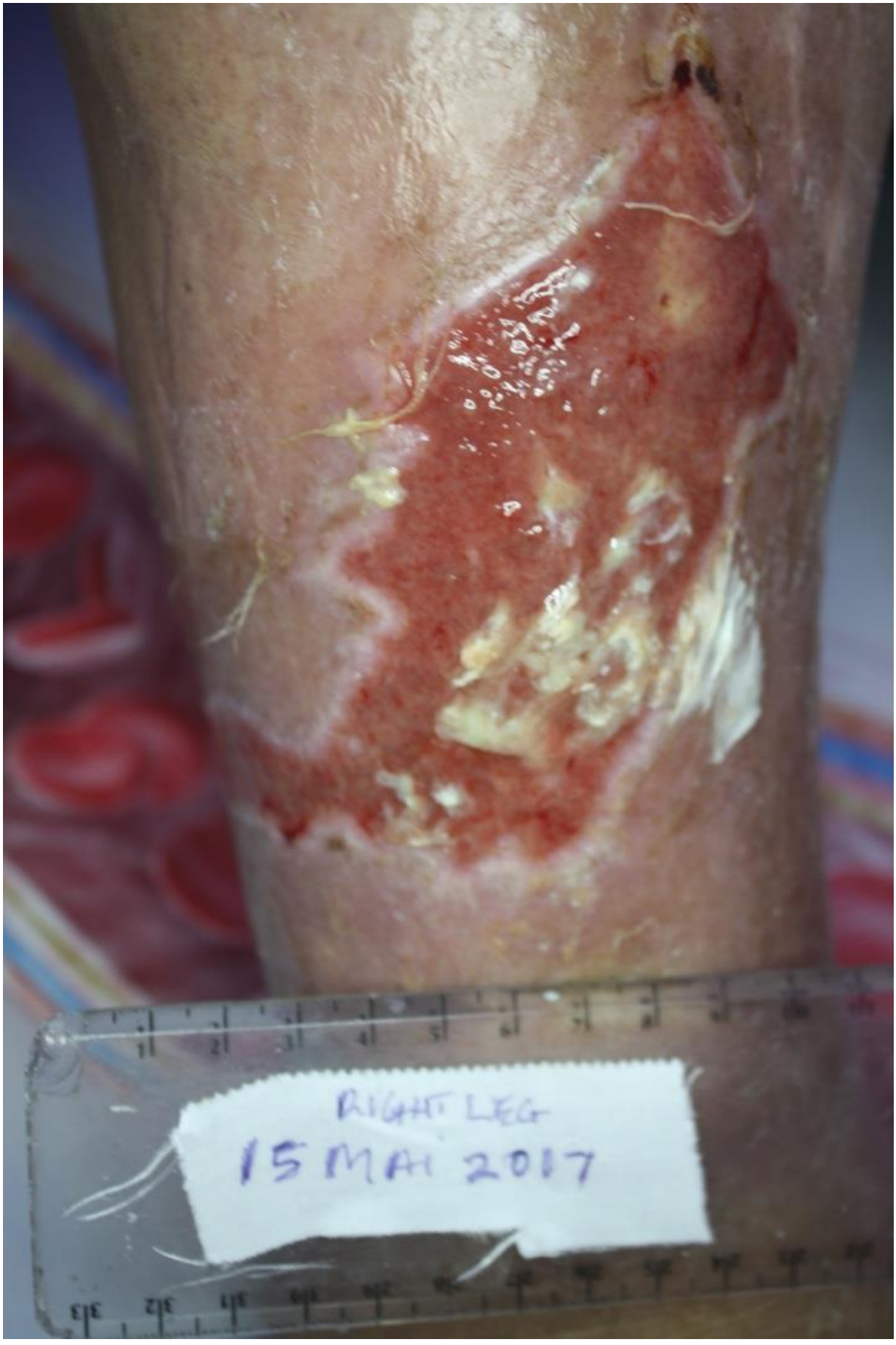


Figure 13.2 b – Healing ulcer, with central islands of granulation tissue and an advancing edge[40]

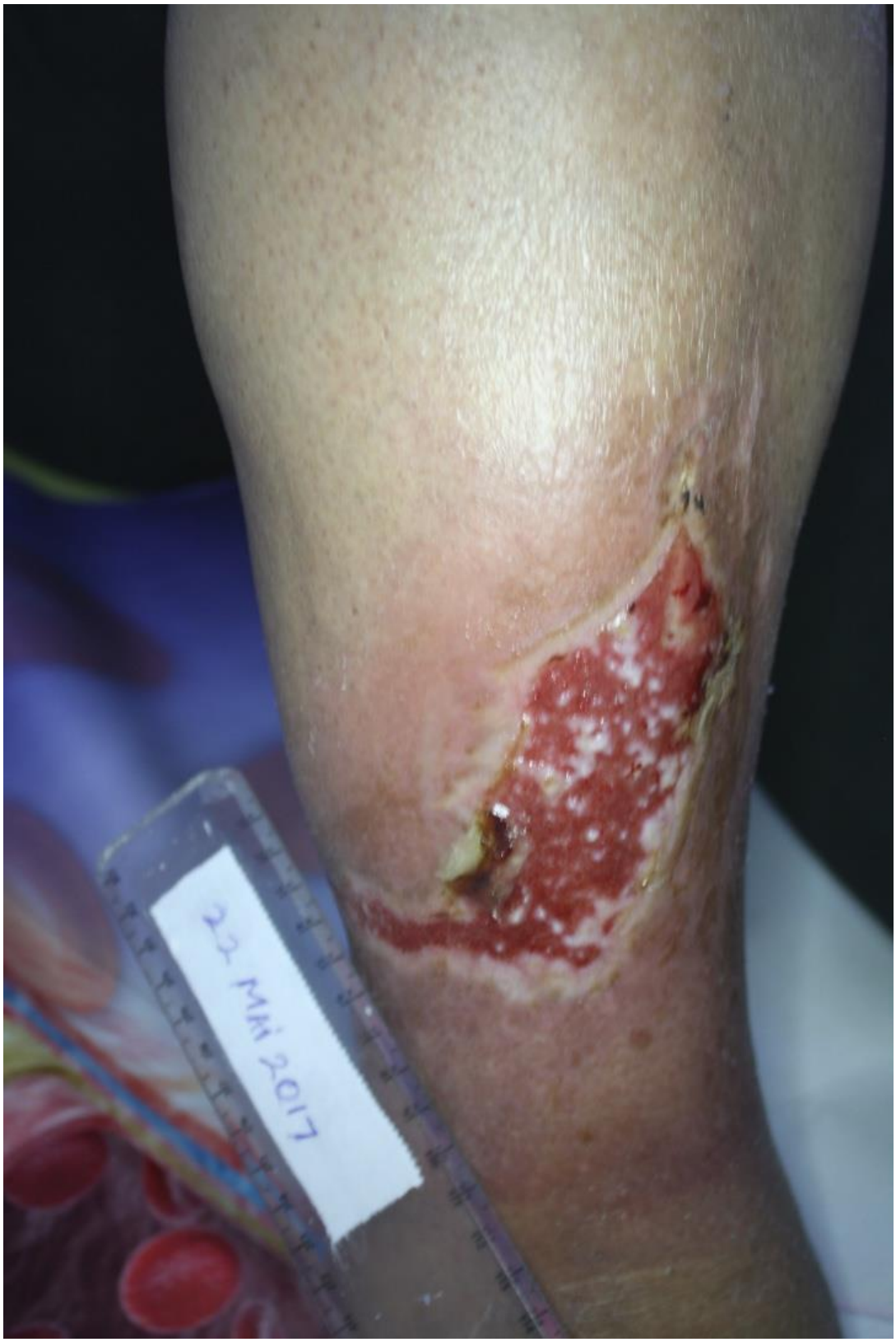
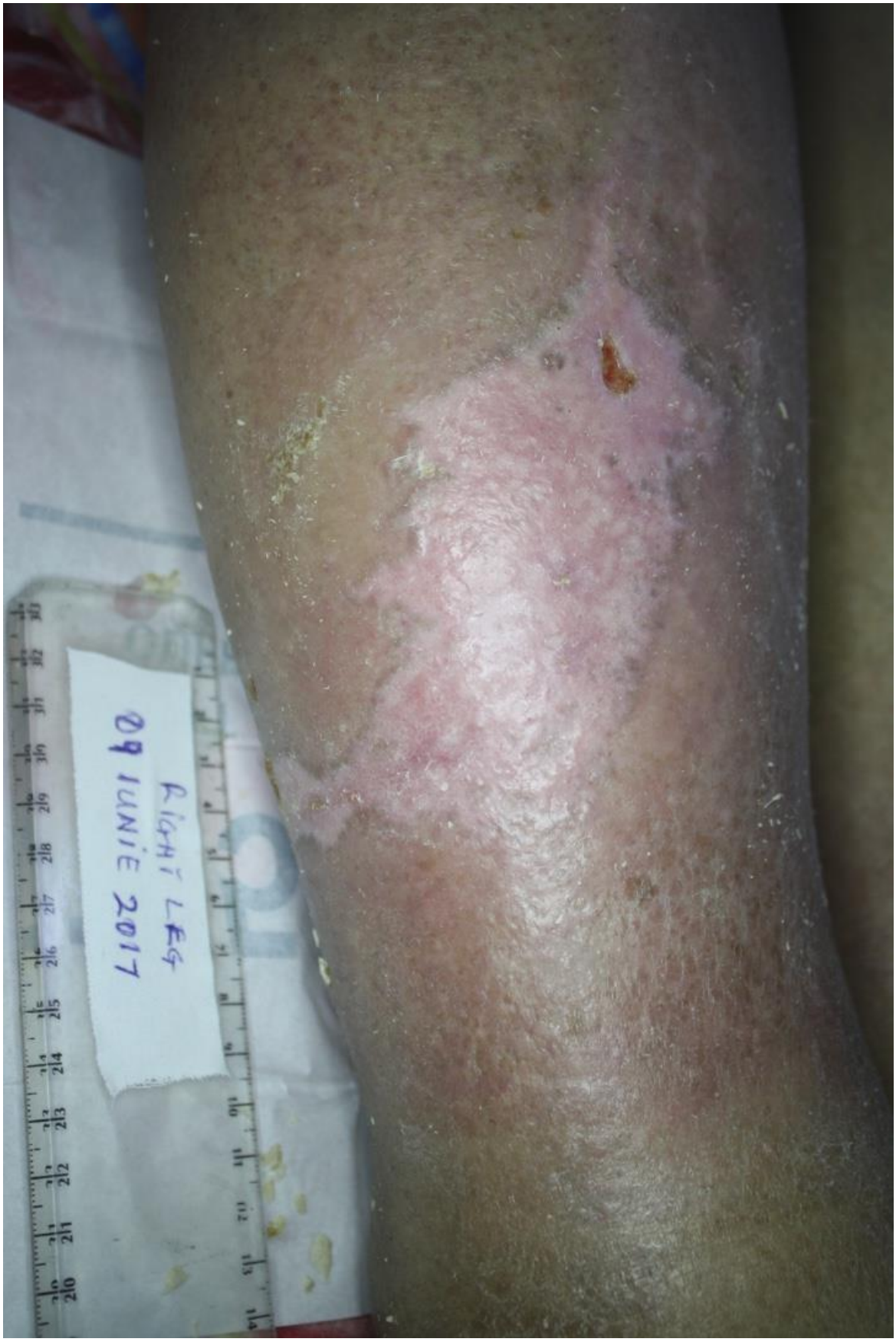


Figure 13.2 c- Ulcer fully healed[40].



13.3 Medical grade honey in a customised approach to limb salvage in a non-compliant patient [41]

A 63-year old male with a 20-year history of type 2 diabetes presented with a foot ulcer of one month duration. He was poorly compliant, having rejected the prescriptions of standard antidiabetic medication given to him, choosing herbal medicines instead and he declined to do a HbA1c test. Initial recommendation for amputation was rejected by the patient. In an effort at limb salvage, oral antibiotics, topical povidone iodine solution and homeopathic *Belladonna* C30 were prescribed. Fresh green cabbage leaves were recommended for the inflamed periulcer skin. The necrotic area became delineated from the remaining healthy tissue in the first week of treatment. The patient returned one month later, after my vacation, with a neglected ulcer following surgical toe amputation. Daily dressings were applied in my office using medical grade honey dressings, with ulcer healing in 2 weeks.

Wound dressings with medical grade honey can be a useful therapy for post-surgical ulcers, even in patients with diabetes who are non-compliant to therapy.

Figure 13.3a Ischemic toe ulcer with underlying incipient gangrene[41]

Figure 13.3b Gangrene with limitation of the affected toe from the rest of the foot [41]

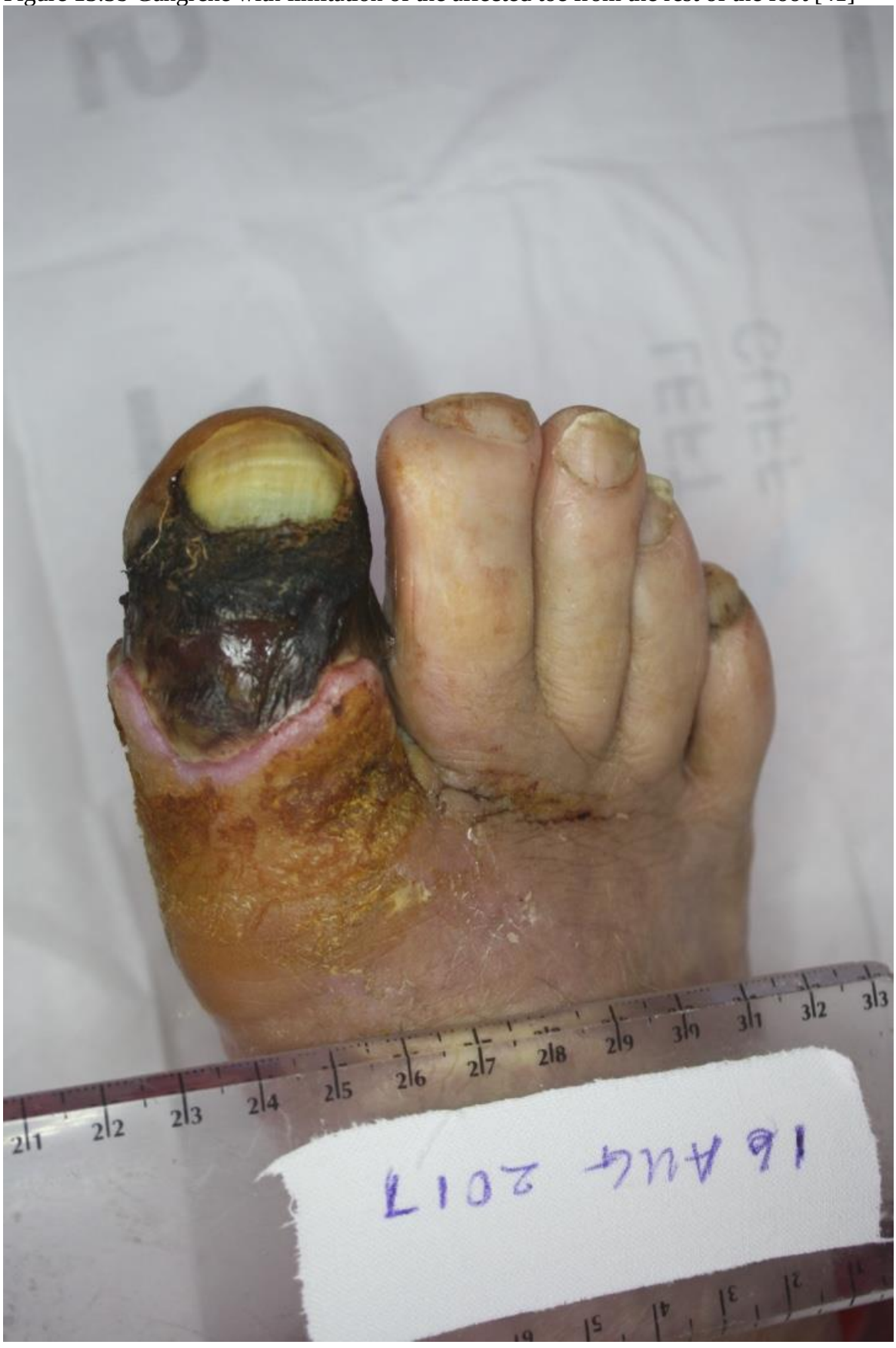


Figure 13.3c Ulcer of forefoot following amputation [41]

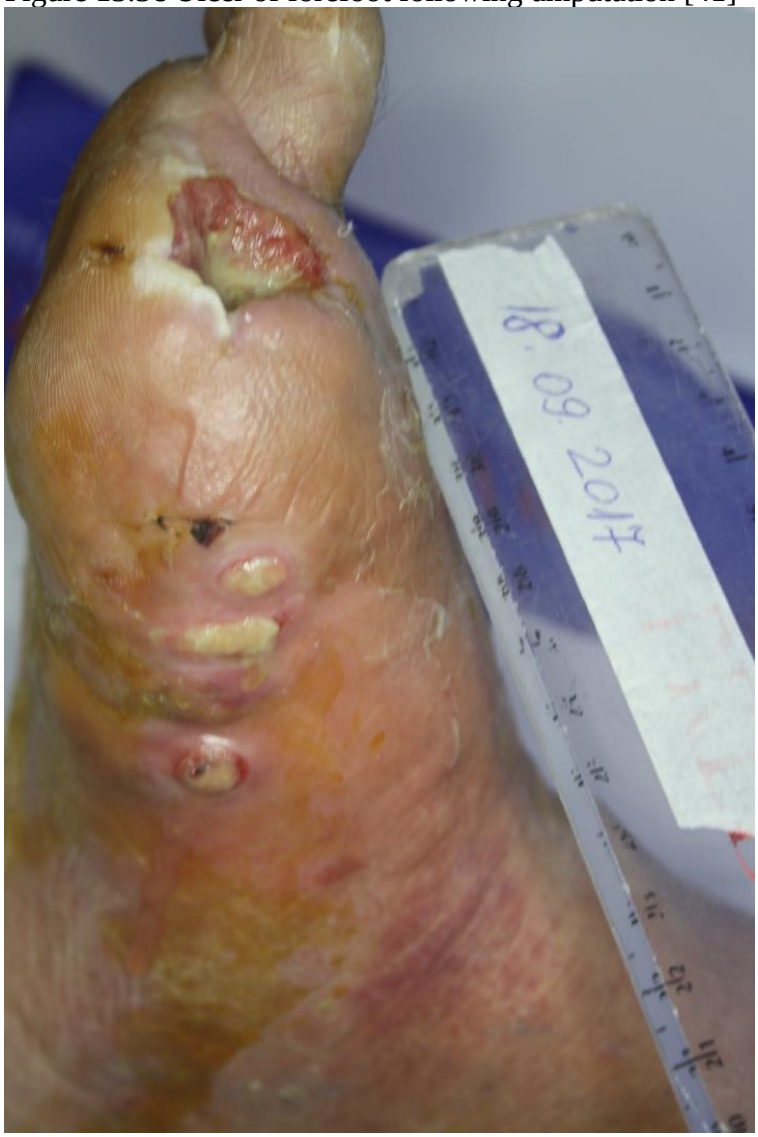
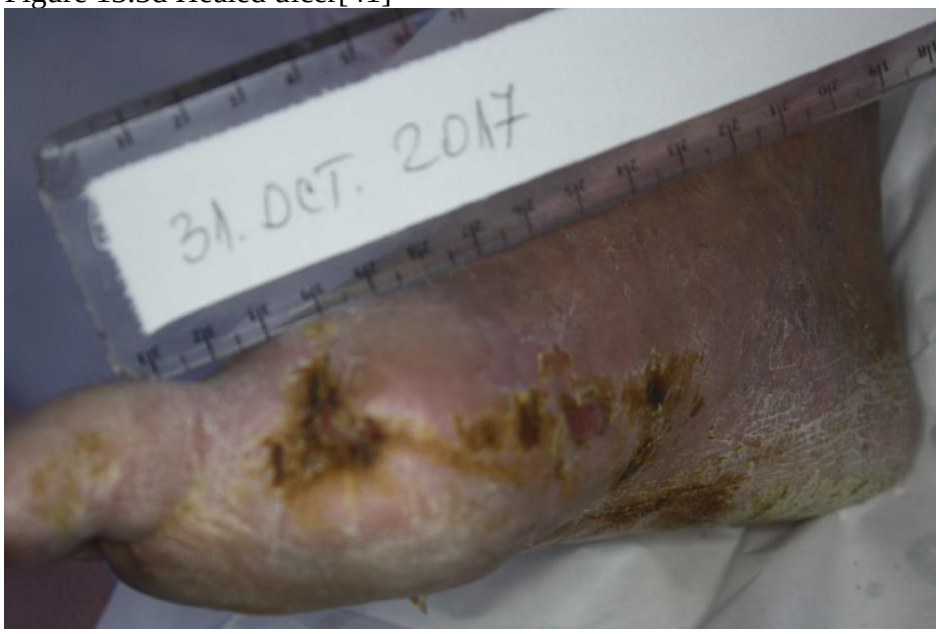


Figure 13.3d Healed ulcer[41]



14 Approach to difficult-to-treat ulcers.

14.1 "Customised approach to the difficult ulcer in limited-resource settings – a Romanian experience." [42]

Diabetic foot ulcers are a costly disorder to treat and the economic burden of this disorder is continuously increasing. In countries with very limited healthcare budgets, prioritisation could lead to neglect of some disorders. In such situations, the economic burdens of patient care fall to the patient. For the patient with a chronic foot ulcer, this burden of care encompasses the cost of purchasing medication, of laboratory tests, transportation to and from clinics, the costs of paying for consultations where health insurance may be unavailable and, in certain cases, the costs of home care. This does not take into account the other human and economic costs, such as time taken off work or even loss of work, as well as pressures of disability on other family members. These costs are even greater in cases where patients may have to travel from one city to the other in order to be consulted by their foot ulcer physician.

Many patients are unable to afford the necessary medication and the frequent visits to their physician, hence amputation becomes an inevitable end-point. In such situations, patient self-care needs to be taught, as a necessary aid to achieving wound healing and avoiding amputation.

I present a case of a patient with a difficult to treat foot ulcer, severe co-morbidities, including diabetes mellitus, who was bed-ridden and cared for by her family, after instruction by myself[42].

Case presentation - A 67-year old female, who was bed-ridden and suffering from type 2 diabetes, presented with a necrotic foot ulcer on her right heel. Her medical history was significant for a previous ulcer on her left heel that had healed following successful angioplasty. Angioplasty on the right lower limb had failed. Amputation was being considered. Her medical history was also significant for severe coronary artery disease and a colostomy for colonic cancer, which was in remission. She also suffered from chronic renal failure. The high economic and physical toll of daily transportation for outpatient care made it imperative to attempt a customized therapeutic approach, which included home care, with weekly visits by the attending physician (this author) and the training of the patient's daughters (who had no medical experience or training), in wound dressing by this author (an approach, which I regularly utilise in our outpatient clinic).

On examination, there was an ulcer encompassing most of her right heel, which had a base covered by moist, black, necrotic tissue. There was minimal malodour and probe-to-bone test was positive. Her peripheral pulses were not palpable.

Initial treatment included copious betadine solution (povidone iodine) dressings. This helped diminish the microbial load and reduce the level of humidity and secretion of the wound. When these effects were achieved, treatment was continued with topical enzymatic debridement using a clostridiopeptidase-containing ointment, as well as sharp surgical debridement of loose, partially lysed tissue whenever the need arose.

This was followed by the use of an "old ally", in the form of 1% silver nitrate (Miculicz pomade), which rapidly accelerated the process of wound granulation and, at the end, a zinc hyaluronate gel to finalise the process of epithelialization.

Systemic therapy in the form of clindamycin 300mg bd was given continuously for about 9 months to impede spread of infection, especially anaerobic organisms, from necrotic tissue. Oral sulodexide, which contains a dermatan sulphate (20%) and a fast-moving heparin (80%) combination, often used in diabetic patients as it aids endothelial repair, increases microvascular blood flow and possesses anti-inflammatory properties was used to facilitate wound healing - at a dosage of 1000LSU/day for one year (when the wound healed). Although she was prescribed tramadol, as well as oral nonsteroidal anti-inflammatory agents for pain relief, this often proved inadequate and she continued to suffer from pain. Thus, in addition, the homeopathic medicines *Hypericum perforatum* CH30 and *Capsicum annum* CH30, *prn* were also deployed for her pain, with good results. Alpha-lipoic acid tablets were prescribed orally at a dosage of 600mg/day. The patient healed fully over a period of one year.

Discussion:

This approach to delivering cost-effective, efficacious medical care to patients with foot and lower limb ulcers is frequently practiced in our out-patient clinic. It has the advantage that it enables patients, some of whom live in other cities and towns, to have access to therapy in their home environments, which are familiar to them, delivered by themselves or a trusted person. It is a cost-effective measure, as it reduces pressure on health services, reduces costs of transportation and empowers the patient to take charge of his healthcare needs. This may improve patient autonomy and compliance, as well as bring about better outcomes.

Our experience shows, however, that there are risks, such as inability of patients to identify emerging pathologies on time, due to lack of medical training and complications such as new or increased infections and the development of ecchymoses or hematoma. Also, there is no guarantee of sufficient hygiene in the patient's environment or of how well the patient might carry out what was taught. All of these are factors, which might negatively influence wound outcomes. In spite of this, our experience indicates that most patients are able to effectively care for their wounds when taught to adequately do so and they are capable of recognising simple signs of infection and initiating antibiotic therapy prescribed to them for this purpose.

Patient selfcare is an increasingly discussed approach to caring for chronic diseases. Selfcare has the potential to improve overall patient health. It may reduce patient access to tertiary services, but not to primary care services, which may be an advantage, as the former tend to be more expensive and difficult to access. This approach to patient care requires patient education and changes in attitudes of healthcare professionals. The UK government has been actively involved in the implementation of selfcare. A government paper on impact assessment (Department of Health, 21 Sept 2009), estimated that costs of implementation of a prospectus aimed at educating patients, with a view to increasing selfcare approaches, were £533million, with an estimated benefit by way of cost savings from reduced health care use of £1,306million[43]. Selfcare week is regularly marked in the UK in November. A meta-analysis came to the conclusion that educational programmes for self-management of cases of asthma brought about improved lung functions and increased feelings of self-control, reduced absenteeism from school, number of days of restricted activity, number of emergency room visits and possibly number of disturbed nights. There is no reason to believe that a significant level of benefit might not be obtainable also with regard to foot ulcers.

In some societies, patient selfcare for chronic disorders is an unavoidable necessity, as there is a lack, or even total unavailability, of other options. In such settings, selfcare also becomes a significant cost-saving method for the patient who must shoulder the burden of these costs, allowing him to also receive care in a familiar environment at a more affordable cost.

The use of the homeopathic medicines *Hypericum perforatum* CH30 and *Capsicum annum* CH30, *prn* as adjunctive pain therapies proved to be successful. They reduced the use of conventional medications, therefore diminished risk of complications, such renal and gastric side-effects arising from frequent use of nonsteroidal anti-inflammatory drugs.

Homeopathic medicines are gentle therapies with an almost ideal safety profile. They also do not have drug-drug interactions with conventional medicines. Thus, their use in this patient's case were a distinct advantage, given her list of severe co-morbidities and their reduced cost.

The patient's daughters were not medically trained, but were happy to be involved in this way in the medical care of their mother. This case is an example of our daily experience at our wound care practice and this shows that, with the right approach on the part of the physician, as well as dedicated patient collaboration, it is possible to deliver adequate health care to patients in their community, thereby reducing burdens on limited healthcare services. Our patient-centred approach to wound care has been discussed in greater detail elsewhere.

Our experience is supported also by the observation that collaboration with patients in the direction of selfcare can improve outcomes for many chronic diseases. Such collaborative care includes assessments of patient education and awareness, goal-setting and active follow up.

Figure 14.1a patient with necrotic ulcer, covering the heel area[42].

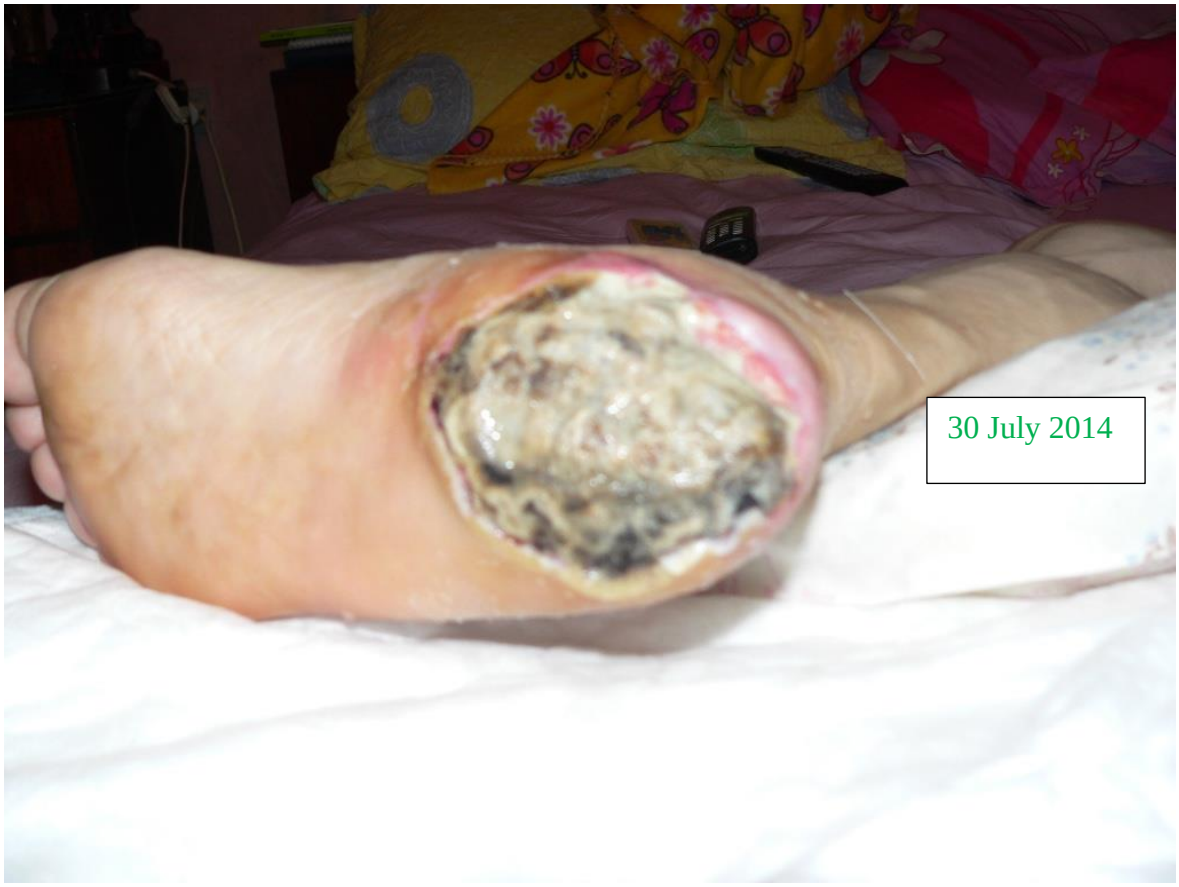


Figure 14.1b patient's ulcer showing necrotic tissue interspersed with granulating tissue at 4 months of treatment[42].

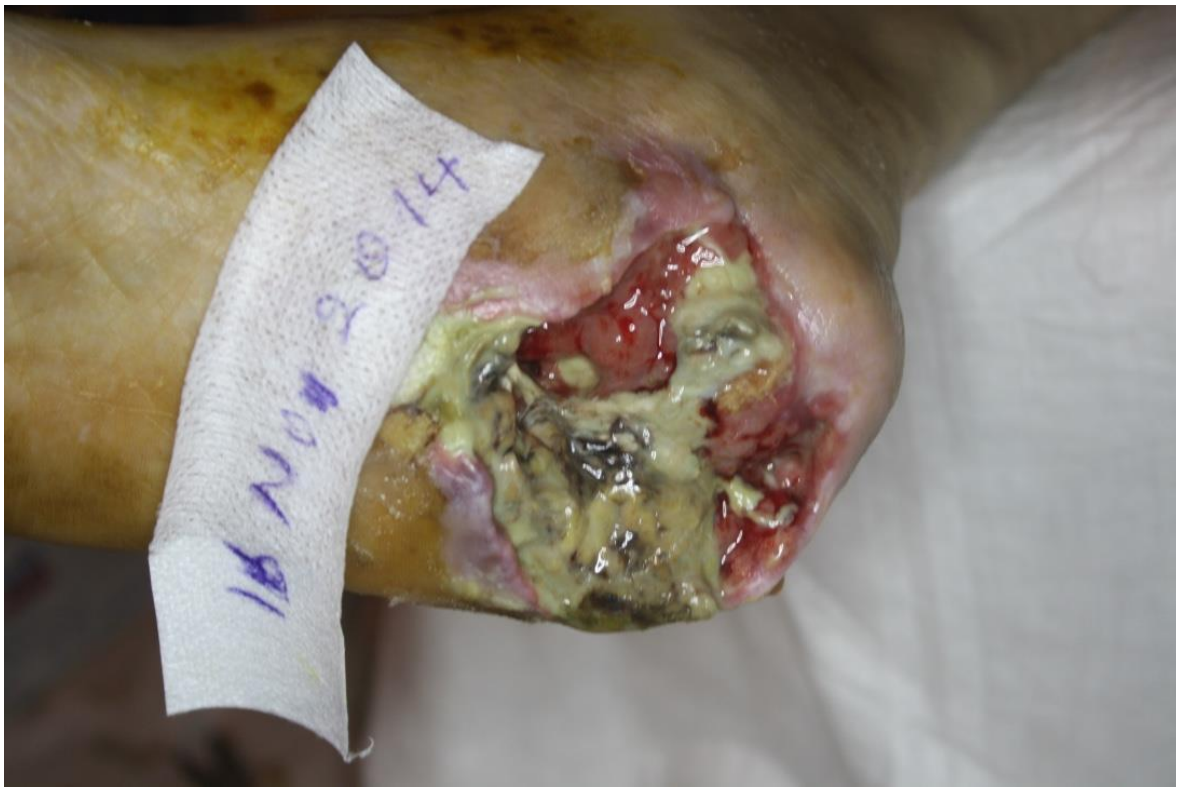


Figure 14.1c at 6 months of treatment, ulcer with reduced size and minimal necrotic tissue[42].

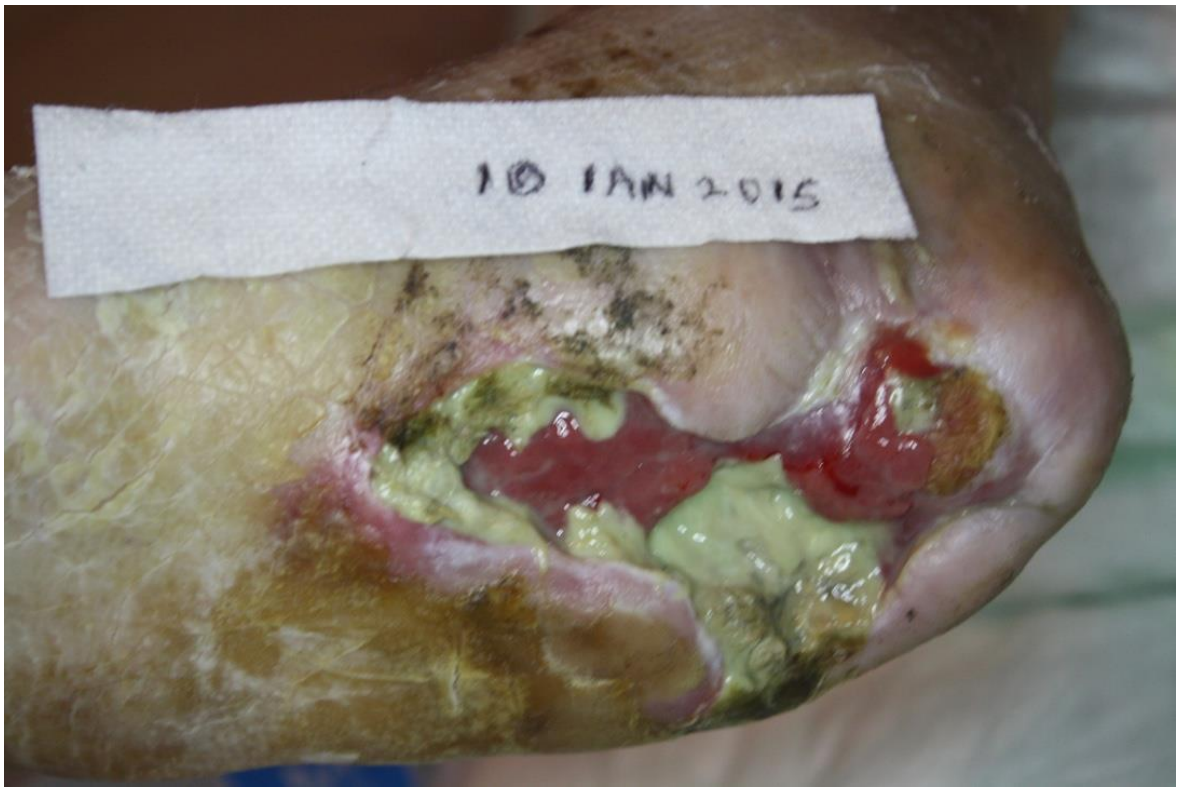
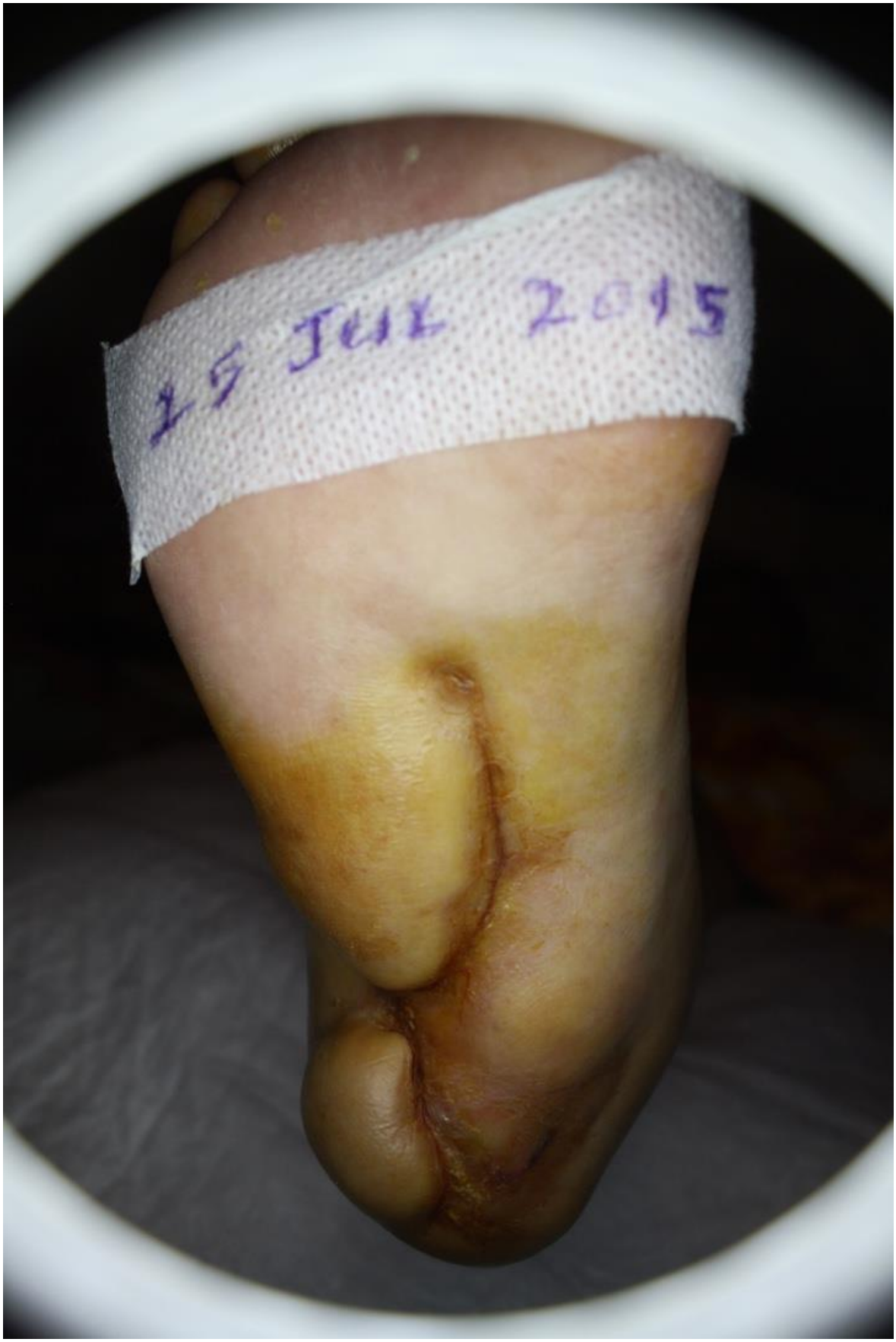


Figure 14.1d patient's ulcer healed[42].



14.2 "Outcome of a case of granulomatous slack skin, recalcitrant leg ulcers and pruritus, managed with Miculicz ointment and homeopathy." [44]

Introduction:

Granulomatous slack skin is a rare, indolent form of mycosis fungoides or cutaneous T-cell lymphoma. It is reported to affect mostly adult males in their third to fourth decades[45]. There is no established therapy for this disorder and some workers argue that it might be a distinct entity. I present a case of a 44-year old male treated with a 6-year history of histopathologically confirmed granulomatous slack skin, severe generalised recalcitrant pruritus and large leg ulcers, who had failed to respond to conventional therapy for his ulcers and for his pruritus.

Case presentation:

A 44-year old male presented with a history of granulomatous slack skin of 6 years duration. It had initially begun on the healed graft site of an old gunshot wound. He also complained of severe pruritus, pronounced generalised weakness and ulcers on both legs lasting the previous 4 years. His history was significant for dyslipidemia and chronic renal failure. The diagnosis of granulomatous slack skin had been made following histopathology at a specialist centre where he had been treated. He had been treated with systemic corticosteroids, psoralen and ultraviolet A light therapy (PUVA) and interferon. Standard wound dressings had been applied to his leg ulcers.

Examination revealed a thin-looking male, with areas of indurated, excessive folds of skin in his left inguinal and axillary areas and on his right forearm. Additionally, there were large, ulcers with irregular margins and with necrotic bases and with no signs suggestive of infection, which almost encompassed the circumference of his legs. The right leg ulcer size was 20 x 10cm and there were two small 3x3cm ulcers on anterior right ankle. There was a 20 x 7cm ulcer on his posterior leg and a small 3x3cm ulcer on his anterior leg.

Systemic review showed an underweight gentleman with generalised weakness, as shown by his difficulty with ambulation.

Following discussion with the patient and spouse, consent was given for a prescription of daily wound dressing with Miculicz ointment (magistral preparation of 1% silver nitrate, 10% Peru balsam in a cream/ointment base) for his leg ulcers; the homeopathic medicines *Rhus toxicodendron* C30 potency, *prn*, was recommended for the itching; *Carbo vegetabilis* C30 potency, *prn*, was recommended for his weakness and *Lachesis mutis* MK

potency daily for underlying granulomatous slack skin. He was taught how to do his wound dressings. His conventional therapy was not interrupted or modified in any way.

At 1 week follow-up, the patient was able to walk unaided and reported improvement of the pruritus; by 1 month his ulcers were showing improvement with granulation tissue at their base and reduced necrotic tissue. At 7 months, the ulcers were significantly diminished in size and the pruritus was completely gone with no relapse. There was no significant change in the status of his granulomatous slack skin. At 2 years, he showed complete healing of the left leg ulcers and almost complete healing of the right leg ulcer. There was no longer any pruritus and weakness in spite of continued interferon and steroid therapy. There was no significant change in granulomatous slack skin. The patient became lost to follow-up and his wife later reported his death.

Conclusions:

Miculicz ointment is an old therapy for chronic wounds. It is very efficacious and though its main ingredient – Balsam of Peru – is a known allergen, my personal experience is that in this form, it does not seem to be sensitising. It's use may be of potential value as a therapy of chronic recalcitrant ulcers in patients with granulomatous slack skin.
Homeopathic medicines may be of value in managing unremitting pruritus and severe weakness in the context of granulomatous slack skin, systemic chemotherapy and chronic renal failure.

Where conventional wound care and conventional pruritus therapy fail, other treatments may potentially be useful and physicians may wish to take these into consideration.

About 34% of US adults have been found to use integrative therapies without consulting their physician. Being aware of, and discussing, such possibilities in a non-judgmental fashion may benefit patients and improve patient confidence in their physicians.

Figure 14.2a – Ulcer on right leg, with necrotic base and irregular margins.

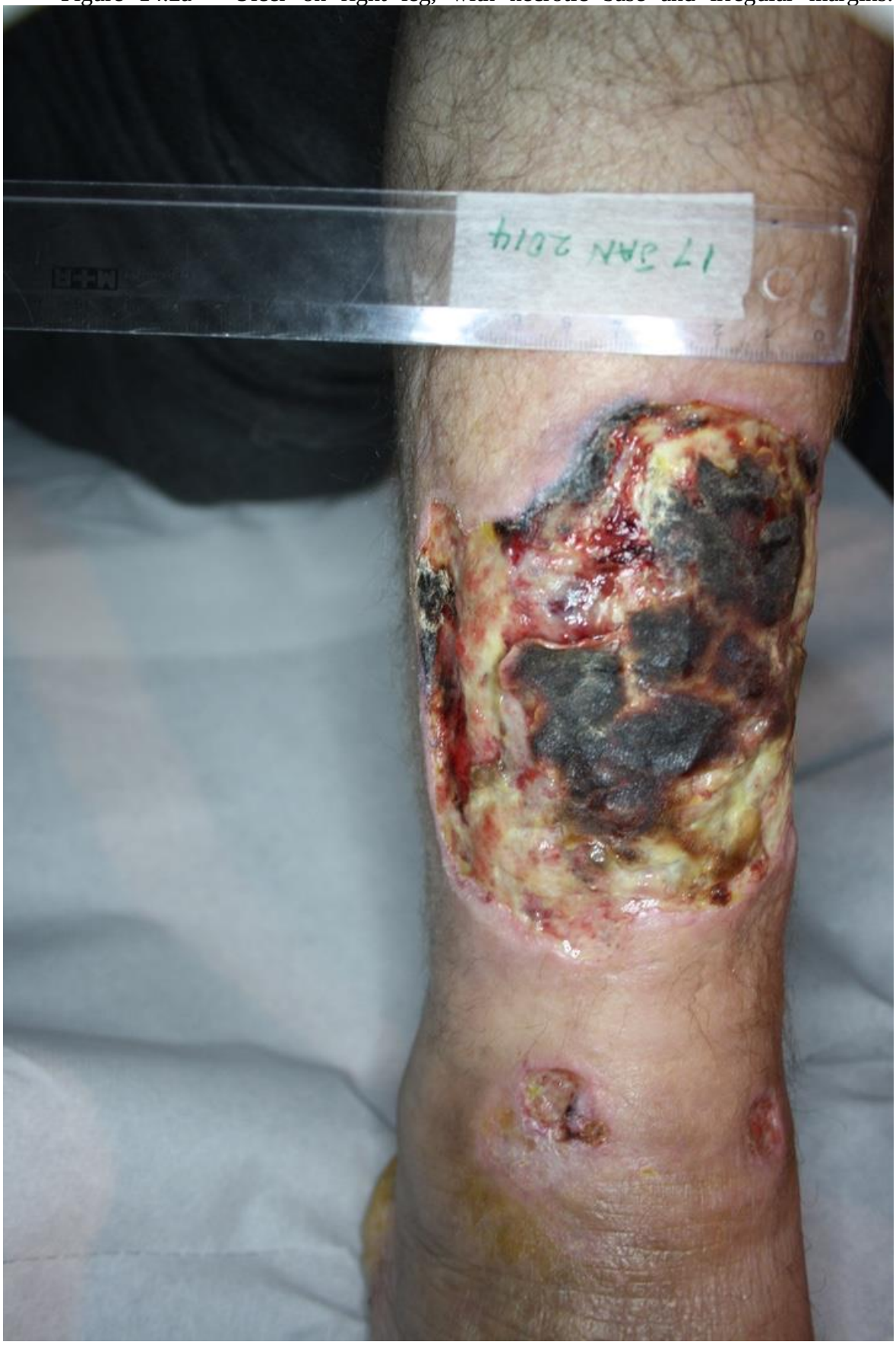


Figure 14.2b – Ulcer on right leg, showing granulation tissue and healing of the margins.

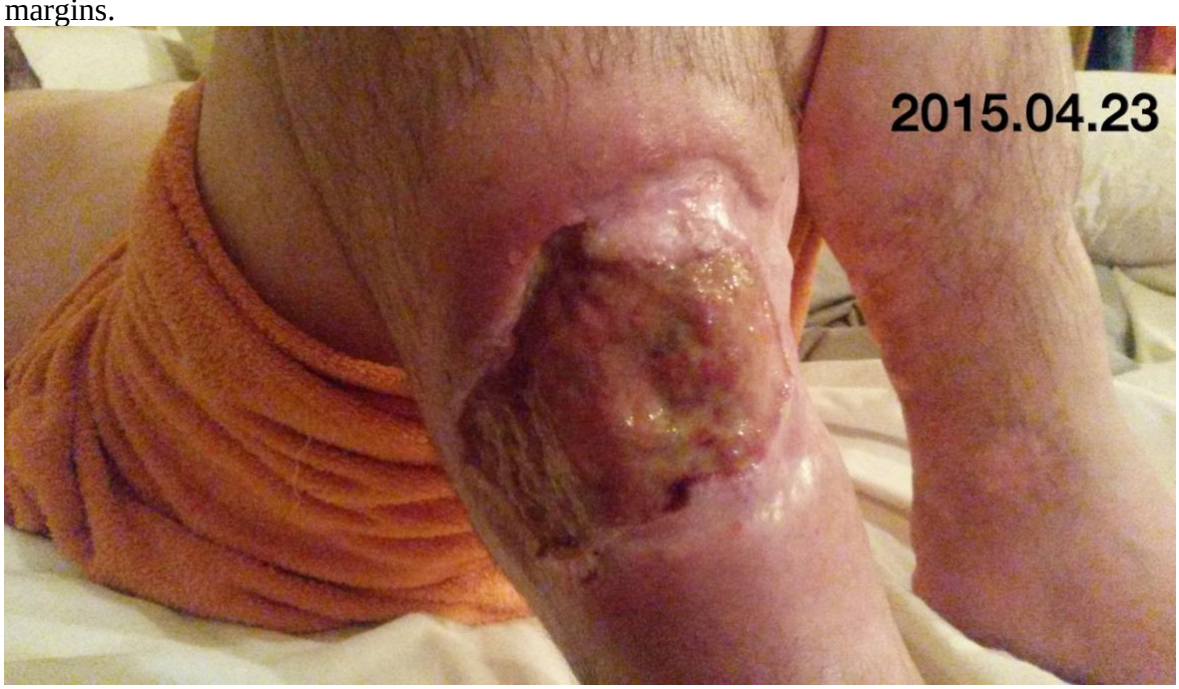
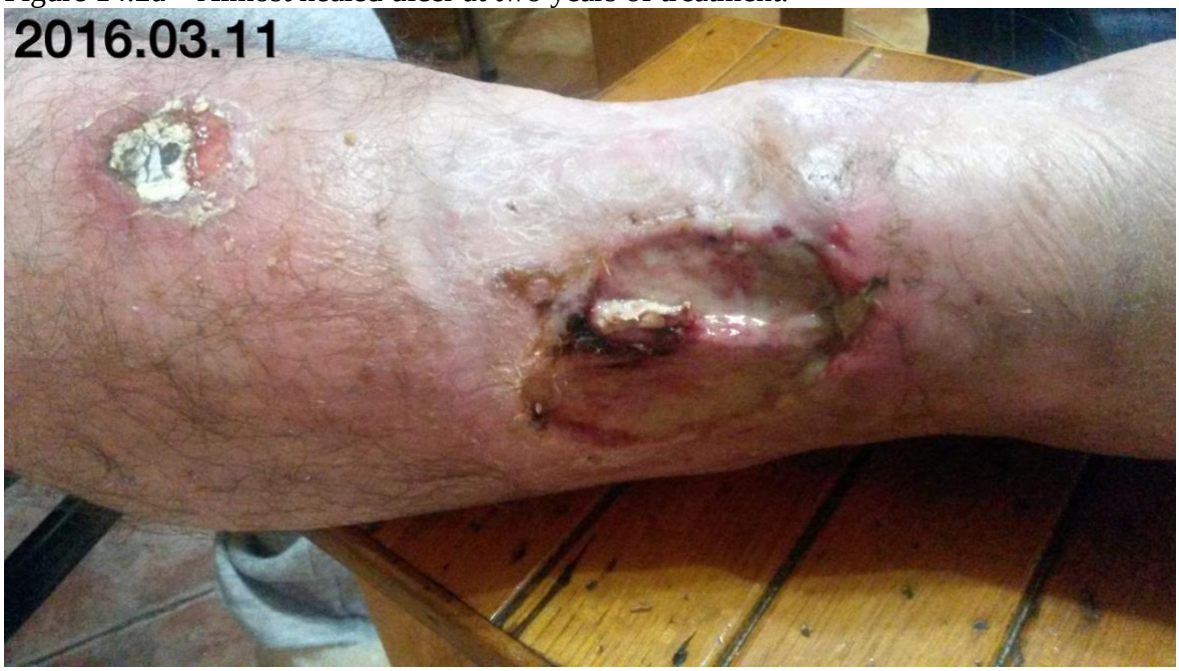


Figure 14.2a – Almost healed ulcer at two years of treatment.



Discussion:

Cutaneous ulcers can occur in a number of situations. Their differential diagnosis is vast. They are a significant public health problem and their treatment is often complicated and expensive.

A number of naturopathic methods may be of use in the treatment of lower limb ulcers. My work has shown the potential of Miculicz ointment, containing 10% Balsam of Peru, a known sensitising agent, in the treatment of ulcers. It is a powerful stimulant of granulation tissue and can help shorten time to healing of chronic ulcers. My work has also shown that Miculicz ointment (1% silver nitrate, 10% Balsam of Peru) could be a useful treatment for ulcers that do not respond to other therapies. It is also an inexpensive therapy, which can be used in a magistral preparation. This latter option makes it possible to add other treatments as necessary, such as antibiotics, steroids or even local anaesthetics.

Also, I have shown the potential of medical grade honey in the treatment of ulcers. Medical grade honey is a well-established therapy for cutaneous ulcers. My work showed that in patients with diabetes and lower extremity ulcers, wound dressings with medical grade honey is of value, even when the patient suffers significant co-morbidities or may be non-compliant.

Enzymatic debridement derived from various bacterial sources are an important alternative to surgical debridement, as my work shows. In such situations, there is less underlying tissue destruction, which could further aggravate the ulcer, when surgical methods are employed. Although the process is slower, it does not damage adjacent or underlying healthy tissue and allows for the simultaneous, gradual formation of granulation tissue beneath and at the margins of the ulcer.

Finally, hyaluronic acid derivatives stimulate the growth of granulation tissue and the more rapid production of epithelial tissue and are therefore useful in the therapy of cutaneous ulcers.

All these therapies can be considered natural or natural-derived products and my published work, some of which is presented here, suggests these therapies can be of potential value in the therapy of chronic cutaneous wounds.

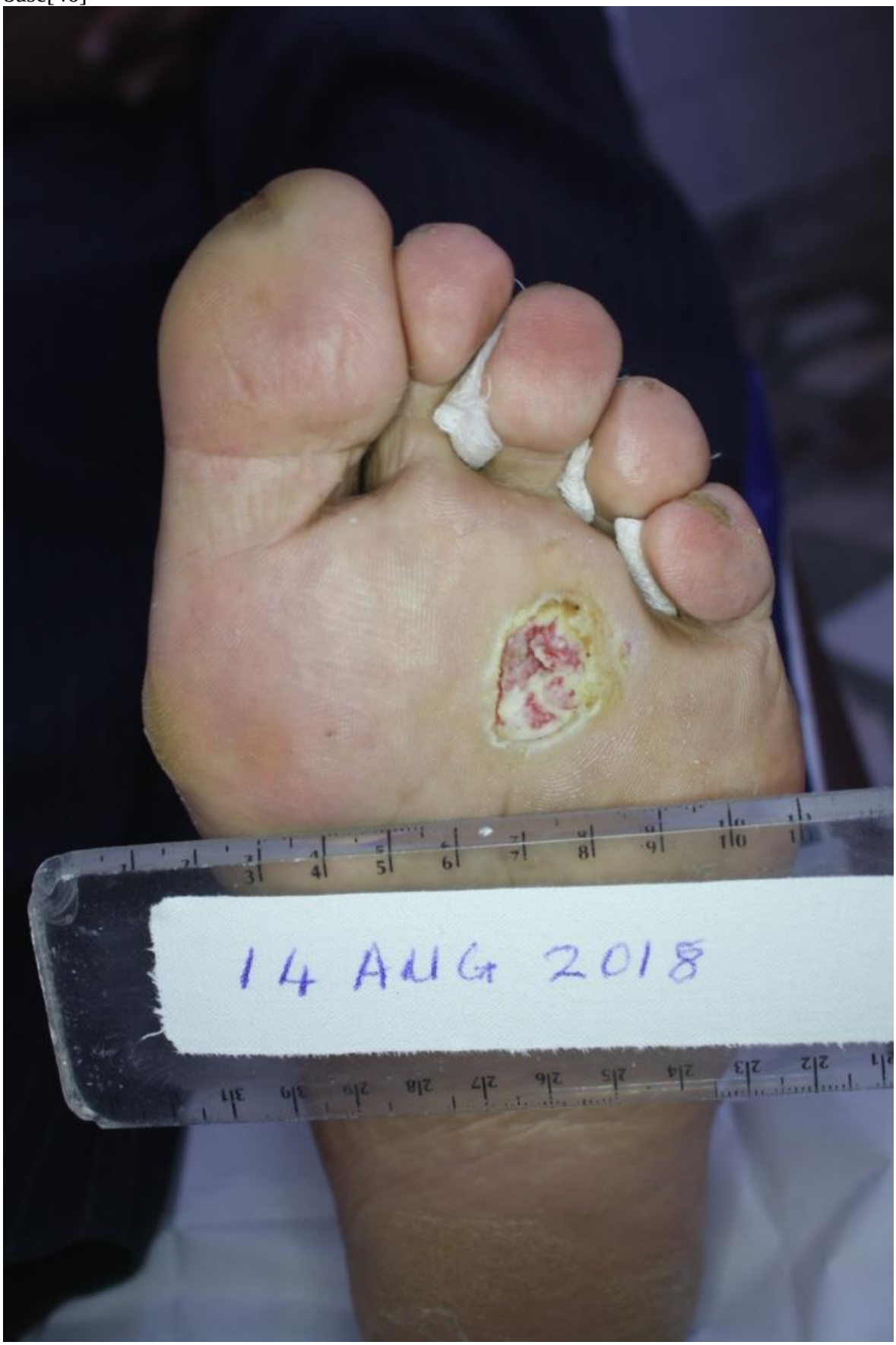
14.3 “Missing the wood for the trees: a case of recalcitrant foot ulcer”[46]

A 78-year-old male patient with longstanding type 2 diabetes presented with a 3-year history of non-healing left foot ulcer. He reported occasional pain at the lesion. His ulcer had been managed as a neuropathic diabetic foot ulcer with different topical agents. Usage

of offloading therapy was not confirmed. Clinical examination revealed a plantar ulcer on the left foot, in the area of the third and fourth metatarsal heads. It had well-defined margins surrounded by callus and there were no signs of infection. The ulcer base was pink and had several islands that suggested epithelialization. The wound margins did not appear undermined. The patient had a glycated haemoglobin level of 7.12%. The provisional clinical diagnosis was squamous cell carcinoma (possible Marjolin ulcer). A biopsy was taken for histopathology. This showed areas of polygonal cells containing abundant, eosinophilic cytoplasm, some with large nuclei. There was vesiculation with areas of keratinization forming keratin pearls. The final diagnosis was a well-differentiated squamous cell carcinoma based on histology.

Diabetic foot ulcers are a common and serious complication of diabetes with a global prevalence of 6.3% and a lifetime incidence of 25%. Some 85% of nontraumatic lower limb amputations occur in patients with diabetes. Foot ulcers precede 85% of all such amputations and 15% of diabetic foot ulcers result in amputation. The 5-year relative mortality rate for diabetic foot ulcers is about 48% and 20%–25% of all hospital admissions for diabetes are due to foot complications. Thus, correct identification and therapy of diabetic foot ulcers is critical. Diabetes itself is associated with increased risk of development of cancer. Therefore, it is important to consider other diagnoses in a case of nonhealing ulcers, which are resistant to therapy. Here, the role of dermatologists in foot ulcer care as part of a multidisciplinary team becomes essential. The classic neuropathic diabetic foot ulcer is located in an area of increased pressure, and is painless, with a pink base with minimal or no necrosis and a surrounding callus. The presence of pain in an apparent neuropathic ulcer, without an obvious cause such as infection, the protracted history (3 years) in spite of treatment and the presence of islands of epithelialization informed the need for a biopsy, which confirmed the diagnosis of SCC.

Figure 14.3 – Plantar ulcer with well-defined margins and epithelial islands on a pink base[46]



14.4 "Therapy Delayed is Therapy Denied: A Case Report of Melanoma Misdiagnosed as Diabetic Foot Ulcer"

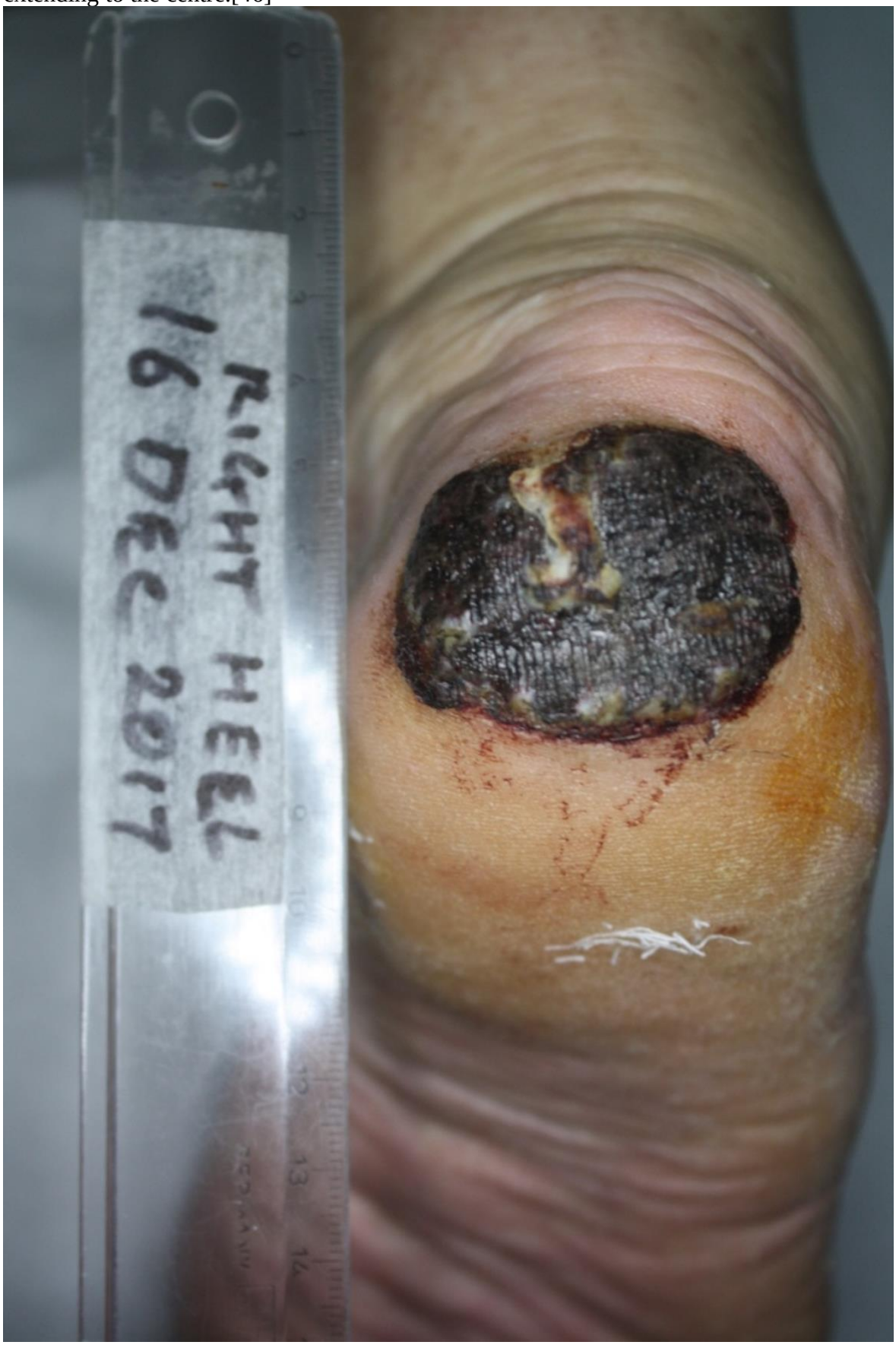
Malignant melanoma is a deadly type of skin cancer. There are multiple treatment options for malignant melanoma. Surgery alone can be curative in the early stages. Patient education is an essential aspect of prevention and therapy. Many cases of malignant melanoma are discovered by the patients themselves. Inadeqate therapy or delayed diagnosis can have unfortunate consequences. Diabetic foot ulcers are a common, but serious, complication of diabetes. Quite frequently patients fail to inform their doctors about new lesions on their feet. Therefore, foot examination is important each time patients present, in order to more easily detect these lesions. The differential diagnosis of diabetic foot ulcer is vast and encompasses cancer (squamous cell, Merkel cell and basal cell carcinoma, Kaposi sarcoma, malignant melanoma, mycosis fungoides); infections (deep and superficial cutaneous fungal infections, mycobacterial infections); ulcerated necrobiosis lipoidica, pressure ulcers, varicose ulcers, vasculopathies (warfarin-induced necrosis, Factor V Leiden deficiency, cholesterol emboli, calciphylaxis), pyoderma gangrenosum, hypertensive (Martorell) ulcers. Specialist, multidisciplinary input, may help differentiate malignant from benign ulcers, which might otherwise go undetected for long periods. Such cases are denied prompt and adequate therapy due to misdiagnosis or delayed diagnosis.

The case A male 75-year-old Caucasian, with type 2 diabetes mellitus, presented with a 2- to 3-year history of painless, right heel ulcer. The ulcer had been increasing slowly in size, despite adequate foot ulcer therapy. Physical examination showed a black, fungating, ulcerated plaque covering his right heel, with a white fissure running from 12 o'clock to the centre of the lesion (Figure 14.4). There was minimal bleeding and no inguinal lymphadenopathy detected. A biopsy was done revealing BRAF-negative malignant melanoma, with a vertical growth phase, Breslow 3.1 mm, ulceration, 11 mitoses/mm,2 Clark level IV, with no lymphatic or vascular invasion observed. Right inguinal lymph node sampling suggested no involvement, but PET-computed tomography indicated pulmonary, right inguinal lymph node and bone involvement. The patient was referred to the oncologists. Discussion Acral lentiginous melanoma or acral melanoma was first described in 1977 by Arrington et al and is the least common form of melanoma. It accounts for 1–2% of cases and has a lower survival rate than other types of melanoma.

Acral lentiginous melanoma is frequently found on areas of the foot prone to pressure and trauma, such as the heel, lateral aspect of the foot and the forefoot. These are also areas in which diabetic foot ulcers commonly present. Confusion may result in misdiagnosis,

thereby delayed diagnosis and as such a bleaker prognosis, as in this case. This patient presented with a heel ulcer of several years duration, which, due to its location and the patient's underlying diabetes, was diagnosed and managed as a diabetic foot ulcer. Literature shows that acral melanoma has previously been misdiagnosed as interdigital tinea pedis, illustrating the vastness of the differential diagnoses of diabetic foot ulcers. Failure to heal with worsening of the ulcer, despite appropriate treatment, did not seem to trigger earlier re-evaluation for a cutaneous malignancy or for other differentials, possibly because diabetic foot ulcers notoriously heal with difficulty. A referral to a specialist (dermatologist) might have uncovered the diagnosis, which had been missed. In many centres around the world, wound care is not usually carried out by dermatologists, but by primary care staff, therefore such cases may "fall through the cracks". This study's limitation is that it is a case study and not a large review. Yet, the case illustrates why the differential diagnoses of diabetic foot ulcers must always be borne in mind in each patient and why multi-disciplinary teams are required to provide adequate care.

Figure 14.4 – Black, well- delineated, fungating lesion on heel and a white fissure extending to the centre.[46]



15 Koebner phenomenon

15.1 "Reply to Happle R. et al. Koebner's sheep in Wolf's clothing: does the isotopic response exist as a distinct phenomenon?" [49]

The Koebner isomorphic phenomenon is well-known in dermatology as a diagnostic sign. It was first described by Heinrich Koebner (1838-1904) in 1872. It has been observed in a number of skin diseases, most notably in psoriasis, vitiligo and lichen planus. Variants of the phenomenon have been described. It is defined as the appearance of skin lesions of a particular disease in a previously unaffected area, following trauma. In contrast to this is the Wolf isotopic phenomenon, which is the appearance of a new disease at the site of a previously healed skin disease[48].

There has been considerable debate over the nature of the Koebner phenomenon and it has been classified into 4 distinct types[48] –

I or true Koebner phenomenon (psoriasis, lichen planus, vitiligo);

II or pseudo-Koebner due to seeding from infection (warts, mulloscum contagiosum)

III occasional lesions following trauma, which have been well-documented (Behcet, pyoderma gangrenosum, Darrier disease, Kaposi sarcoma)

IV Poor or questionable trauma-related processes (pemphigus, eczema, lichen nitidus)

We posited that the Koebner phenomenon may be a consequence of a localized or generalized *locus minoris resistentiae* or immunocompromised district in which skin diseases occur due to an underlying predisposition, which has been brought about by local or systemic immune dysfunction and that subsequent trauma triggers the appearance of isomorphic lesions[49]. We also argued that the Koebner isomorphic and the Wolf isotopic phenomenon may, in consequence, be one and the same disorder. We expressed the view that the Wolf isotopic phenomenon be considered a type V Koebner, based on the of *locus minoris resistentiae* or immunocompromised district principles, which we believe to underlie both phenomena[49]. We based our position on the following arguments –

1. Human leucocyte antigen predisposes to psoriasis, possibly generating a generalized *locus minoris resistentiae* or immunocompromised district. The appearance of new lesions in a patient with psoriasis, who might possess the relevant human leucocyte antigen, would be considered Koebner isomorphic phenomenon, but might also, by virtue of the human leucocyte antigen – i.e. a new disorder on another healed lesion

on skin with underlying human leucocyte antigen - might itself be considered the Wolf isotopic phenomenon.

2. The leucoderma that is sometimes the consequence of a healed pityriasis versicolor or of inflammatory disorders such as psoriasis or eczema as well as the melanoderma following simple sunburns, could also be viewed as a manifestation of Wolf isomorphic phenomenon, since there is clearly *locus minoris resistentiae* or immunocompromised district as these are prior, unrelated, albeit benign skin diseases. Although such a connection appears not to have been made yet and may imply expanding the scope of diseases associated with the Wolf isotopic response.
3. Also, we asked if, in this vein, the residual leukoderma following the disappearance of a Sutton naevus, for example, could be considered a manifestation of the Wolf isotopic phenomenon and the healing of that leucodermic patch then be viewed as a 'reverse' Wolf isotopic phenomenon. Following, in this manner, a pattern already seen with the Koebner phenomenon.
4. Direct or indirect hypersensitivity to herpes simplex virus was a putative pathogenetic mechanism for the Wolf isotopic response in pseudolymphoma. Yet pseudolymphoma has been shown to follow treatment with leeches, where herpes simplex virus hypersensitivity is highly unlikely to be an issue. Therefore, this suggested pathogenic mechanism is in doubt.

In consequence, we have proposed that the Wolf isotopic response be considered a form of Koebner reaction, rather than a stand-alone phenomenon in dermatology. Clearly, this position will be one that will give cause for debate, but it may contribute to simplifying our specialty and to making the understanding of the underlying mechanisms of the Koebner isomorphic and the Wolf isotopic phenomena easier to comprehend.

15.2 A unique case of Koebner phenomenon in Pityriasis Rosea

"Does Pityriasis Rosea Koebnerise?"[50]

Introduction:

Pityriasis rosea is a common inflammatory skin disorder of unknown aetiology. It is most frequently observed in children and young adults and is self-remitting, with a duration of 6-8 weeks. Treatment, when needed, is usually symptomatic, often for mild pruritus. It is important to try to distinguish this disorder from the rash of secondary syphilis, which has very different public health implications.

I presented a rare case, which has not previously been reported in the literature to the best of my knowledge, of pityriasis rosea that appears to have manifested the Koebner phenomenon.

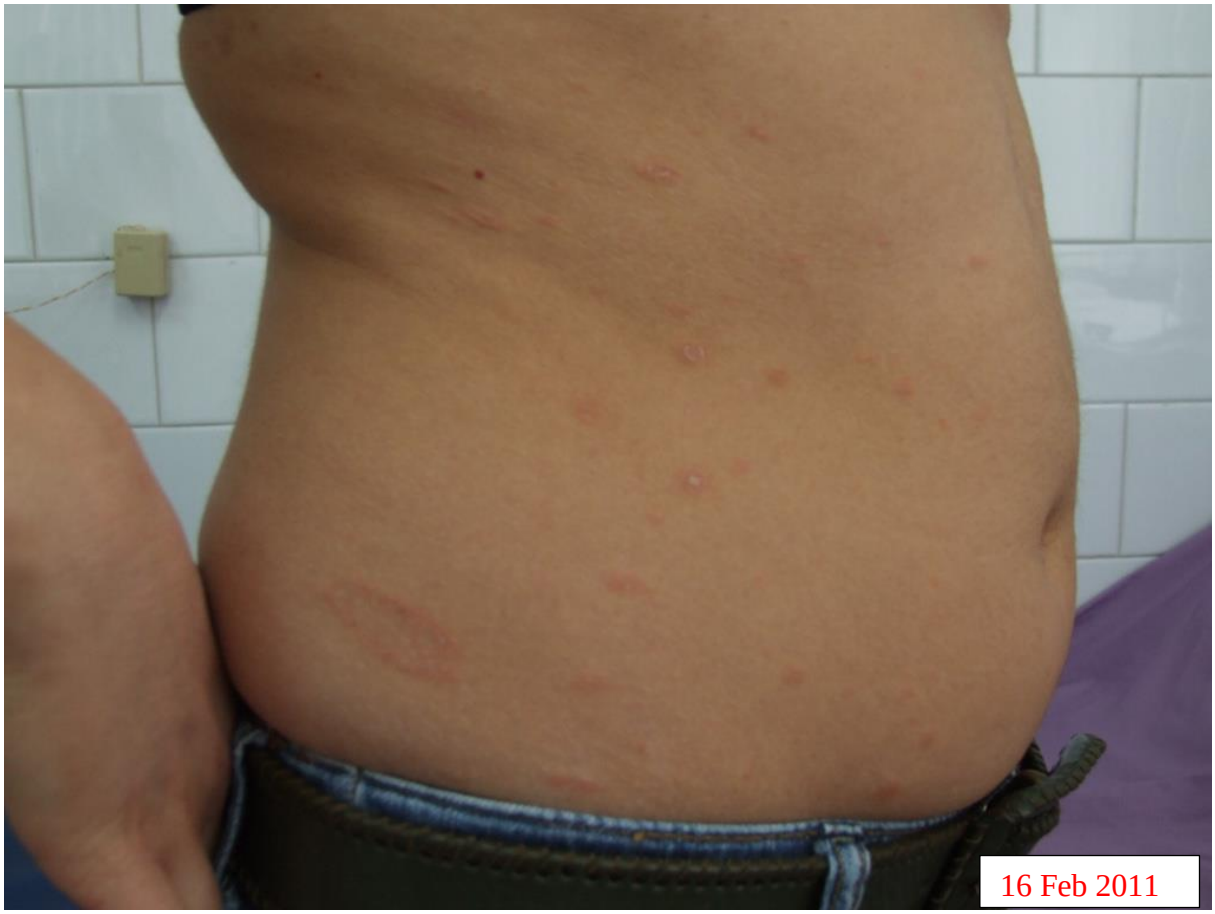
Case presentation:

A 35-year old female presented with a 2-3-week history of a rash. It had been preceded by a single lesion on her right flank. The rash was accompanied by a mild sensation of itch when she had thought about the lesions. It had spread gradually to involve her trunk. There was no family or contact history of similar rash elicited. Her medical history was significant for an appendicectomy at 5years of age and a benign breast nodule at 26 years of age. On examination, there was a cutaneous eruption comprised of small, well-defined erythematous, slightly squamous plaques on the anterior and posterior trunk, with a large patch on the lumbar area, with a clear centre and active margins. Similar lesions were noted - one in each cubital fossa. There was no involvement of the upper and lower limbs. No adenopathy was found. There were no significant findings on systemic examination. Upon further questioning, she stated that the cubital lesions appeared about 1 week after venepuncture for routine, work-related, blood testing. The results were normal including a VDRL that was negative. Since the clinical diagnosis was clear and the patient unwilling to consent, no biopsy was taken. She was placed on observation and consulted 3 weeks later. At this follow-up visit, the lesions were almost completely remitted. She was still asymptomatic and was therefore discharged from the outpatient department.

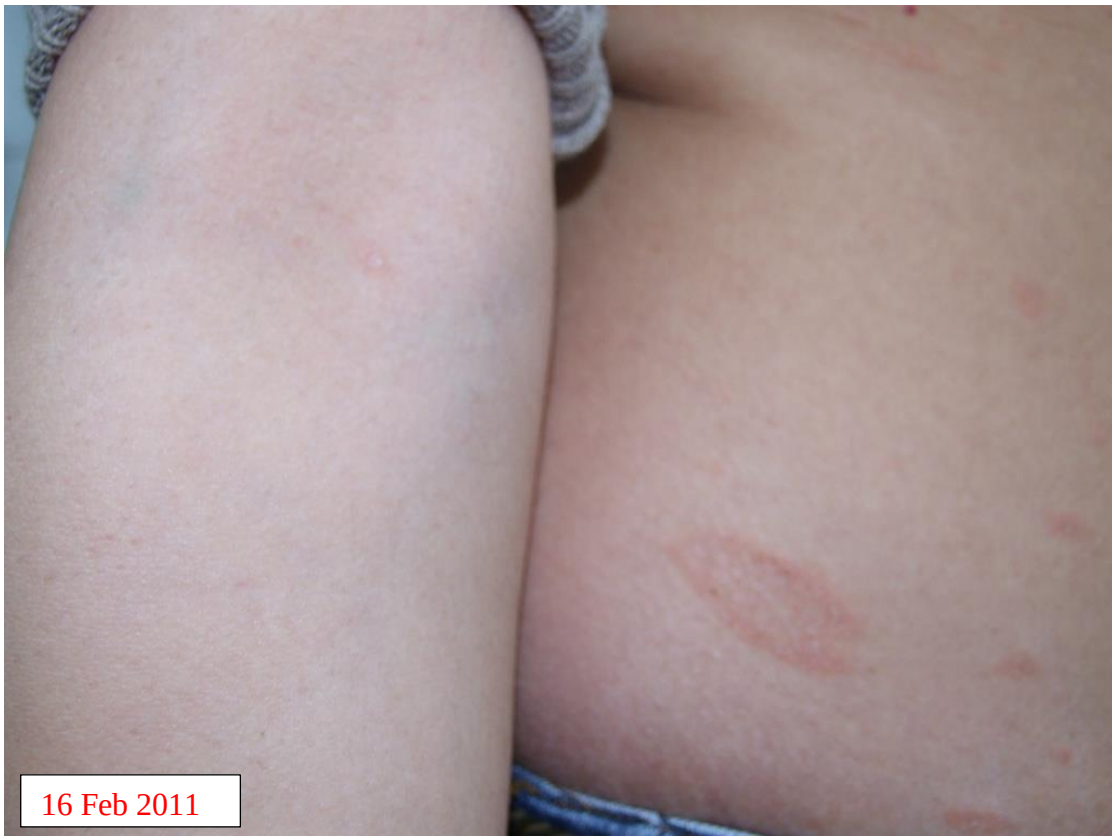
Discussion:

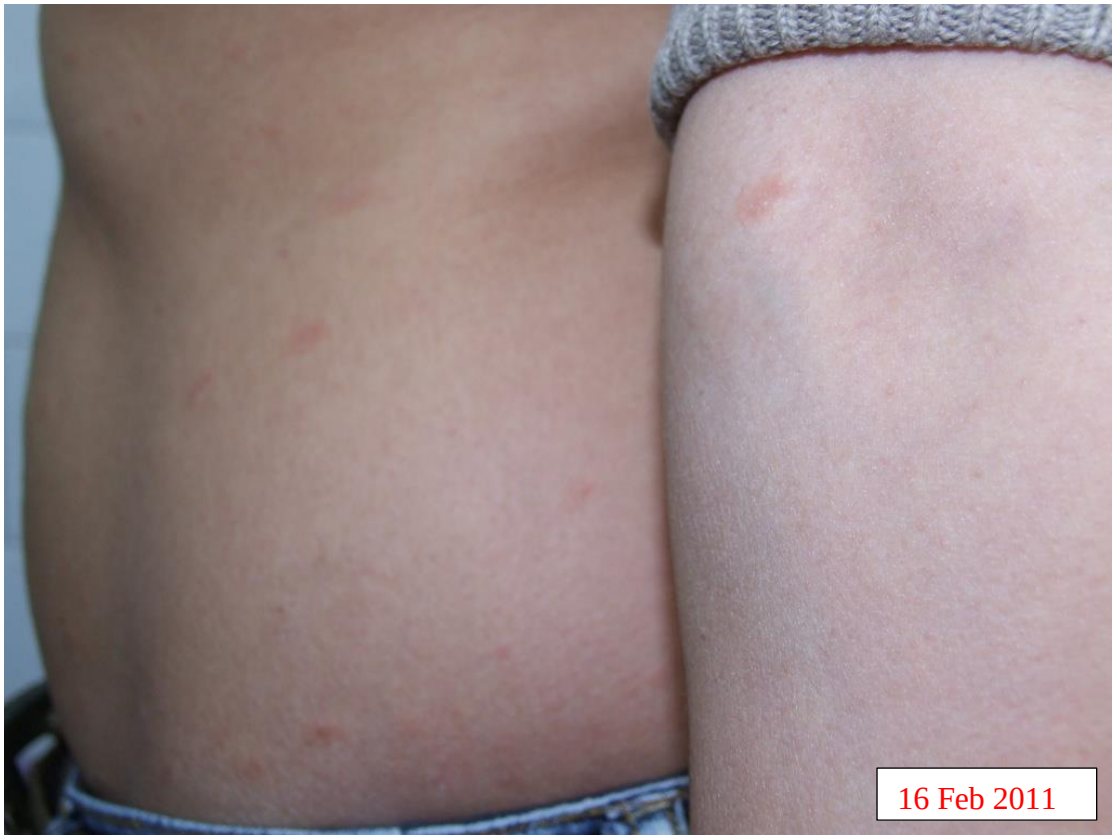
This was a rare case of pityriasis rosea presenting with post-traumatic lesions that were suggestive of the Koebner phenomenon. No such case has been reported in the literature, to the best of my knowledge. Koebner phenomenon has been divided into types I-IV. According to this classification, our case would be classified as a type IV Koebner phenomenon. It would remain type IV until and unless a significant number of similar cases are seen, so it is no longer so rare. We hope that this phenomenon would be observed and reported by others in the future, thereby confirming the validity of our observations.

Figure 15.2a – erythematosquamous plaques on trunk, with herald patch on flank[50]



Figures 15.2b and c – Erythematosquamous papules in the area of the cubital fossae, at the sites of venepuncture, suggestive of the Koebner phenomenon[50]





16 Development of cutaneous neoplasms

16.1 Field cancerisation

"Reply to Gambichier T et al: Altered epigenetic pathways and cell cycle dysregulation in healthy appearing skin of patients with koebnerised squamous cell carcinomas following skin surgery."[51]

The work cited above could potentially contribute to our understanding of cutaneous carcinogenesis and of the Koebner phenomenon. It was our effort to contribute with our own opinions on this article, by raising some issues we deemed relevant.

We attempted to clarify the concept of field cancerisation and koebnerisation of squamous cell carcinoma.

We noted that Slaughter *et al* were the first to propose this concept of "field cancerisation" as an explanation of their observations of the multifocal histopathologic origin of oral epithelial cancers [52]. This concept could also help explain why subjects could develop multiple primary tumours in the same tissue or organ. Höckel and Dornhöfer went further to categorise this phenomenon as *in situ* recurrence, as opposed to scar recurrence [53]. Both phenomena tend to be localised. *In situ* recurrence relates to the remnant tissue or organ (not to the scar) after removal of the primary tumor.

The Koebner phenomenon has been observed in the form of Kaposi sarcoma presenting in scar tissue of a transplanted heart, in AIDS-related Kaposi sarcoma and in Bowenoid papulosis in a person who was found to be immunocompetent. In consequence, overt immunosuppression may not always constitute an explanation for the Koebner phenomenon in skin cancers.

Since the patients in the paper by Gambichier et al were on treatment with dimethylfumarate and azathioprine, we postulated that it might be possible for drug-induced immunosuppression to be the basis of a generalised "field cancerisation", which might be the underlying mechanism for the occurrence or tendency to manifest the Koebner phenomenon in some cutaneous cancers.

The concepts of *locus minoris resistentae* and immunocompromised district have been proposed as mechanisms to help explain the Koebner phenomenon and Wolf isotopic response. This provides a basis to explain why certain disorders occur in some locations. We have also suggested that the Wolf isotopic response be classified as a variant of the Koebner reaction, possibly as a type V Koebner reaction. We argued that the concept of *field cancerisation*, which is a localized phenomenon, but might also be generalised, as we

suggested for the cases by Gambichier et al., may in reality be a form of *locus minoris resistentae* or *immunocompromised district*. The vastness of medicine often means that apparently disparate works, such as those discussed in this chapter, that express apparently differing viewpoints at first sight could help us perceive unified concepts. This unification of concepts could ease and simplify our professional life. We noted that whether one was considering field cancerisation or locus minoris resistentae, both of which are immunocompromised districts, it would appear that the Koebner phenomenon might exist for certain skin cancers and might occur independently of immunosuppression.

The concepts of field cancerisation, locus minoris resistentiae and immunocompromised district, seem to speak to the concept of predisposition to disease, which has been recognised since the time of Hippocrates. Increasingly there is literature suggesting that some common medications may be involved in induction of skin cancers. One example of medications leading to raised cancer risk is the tetracycline class of medications. It had been reported that this class of medications was associated with an increased risk of non-melanoma skin cancer [50]. They postulated that the phototoxic effect of this family of drugs might be the basis for this observed carcinogenic effect. To this end, they might have been labelling tetracyclines as a photocarcinogenic class of drugs. While we did not dispute the authors' conclusions, we felt that this was not the complete picture [51]. We argued that tetracyclines are known anti-inflammatory agents. Their anti-inflammatory effect is brought about by a series of immunomodulatory effects, including tumour necrosis alpha blockade, reduction of leucocyte chemotaxis and of leucocyte phagocytosis, amongst others. We posited that these, and other anti-inflammatory activity of tetracycline drugs, which are used to good effect in a number of inflammatory diseases, may contribute to the observed effect of increased risk of non-melanoma skin cancer [54]. We also wondered whether this observed effect of increase in non-melanoma skin cancer, which was only reported for basal cell carcinomas and for squamous cell carcinomas [53] might extend to other non-melanoma skin cancers such as Merkel cell carcinoma, cutaneous lymphomas, actinic keratoses, amongst others.

We expressed the opinion that, if this effect of increase in prevalence of non-melanoma skin cancers is confirmed other studies, then it may be necessary for product information to include this fact, for patients to be informed [55]. We were also of the opinion that other alternatives to tetracyclines for the treatment of acne, for example, and perhaps other diseases, might be offered to patients. To this effect we cited my work in relation to

the therapy of acne with homeopathic medicines[5]. Homeopathic medicines are not known for side-effects and are cheap and widely used.

In relation to the concepts of *locus minoris resistentiae*, immunocompromised district and field cancerisation, it may be helpful to wonder whether tetracyclines, as well as other commonly used medications such as hydrochlorothiazide for hypertension and statins for blood cholesterol reduction, which appear to be associated with an increased risk of non-melanoma skin cancer, may be a source of these phenomena. We have written reviews that discuss the increased risk of skin cancer in patients that use these medications [56,57]. The increase in risk of skin cancer has often been attributed to ultraviolet light exposure. I postulate now that this increased risk of non-melanoma skin cancer and melanoma as such, may be a basis for the production of lucus minoris resistentiae, immunocompromised district or field cancerisation, all of which may ultimately be the same phenomenon, i.e. a localised or generalised immune suppression that increases the risk for various disorders including skin cancer, could also have an iatrogenic basis. This increased risk of (iatrogenic?) skin cancer needs to be addressed, in order to deliver better care.

16.2 Novel case of seborrheic keratosis

"Nodular, ulcerated seborrheic keratosis" [58]

Skin disorders may present in unusual ways, which may differ radically from the classic forms described in the literature. These non-classic presentations are considered variants of that disorder. Sometimes rare, previously unreported forms of a skin disorder are seen. We presented a case of nodular, ulcerated seborrheic keratosis, which has never, to the best of our knowledge, been documented in the literature.

Case presentation - A 31-year-old female with Fitzpatrick II skin presented with 6-month history of a mildly itchy lesion. It had been growing gradually and was located just inferior to her right clavicle. The lesion had been preceded by another dark lesion, which had been present for several years prior to presentation. The patient had a history of occupational sun exposure. Physical examination revealed a brownish, well-defined, translucent nodule measuring 10x10 mm. Its surface appeared ulcerated and was mildly oozing. There was no palpable lymphadenopathy. Dermoscopy showed a pink background, as well as a central polymorphous vascular pattern of hairpin vessels, with fine arborizing vessels and dotted vessels, which were associated with white streaks that appeared throughout the tumour centre. There were small areas of ulceration with some grey-blue blotches/globules/nests, blue-grey nests and milia-like cysts, which could be seen at the periphery of the lesion. The differential diagnoses at this point included fibroepithelioma of Pinkus, basal cell carcinoma, lichen planus-like keratosis, achromic melanoma and squamous cell carcinoma.

Histopathology showed a well-circumscribed, nodular, outward epithelial proliferation based at the level of the epidermis, with horn cyst formation. More detailed examination uncovered the basal and squamous nature of the proliferating cells. The squamous cells formed roundish horn cysts, with layered orthokeratin, while the basaloid cells were round with monomorphous nuclei. Cellular atypia was not seen. There was also some spongiosis and inflammation with parakeratin formation inside the horn cysts, suggesting irritation.

The final diagnosis was surprisingly seborrheic keratosis.

Discussion:

Seborrheic keratosis is a common benign neoplasm of uncertain aetiology, presenting as sharply demarcated, slightly raised, brownish papules or plaques that often have a 'stuck-on' appearance. Forms of this disorder include common seborrheic keratosis, stucco

seborrheic keratosis, melanoacanthoma and dermatosis papulosa nigra. Differential diagnoses may include melanoma, pigmented basal cell carcinoma, squamous cell carcinoma and actinic keratosis. Our case has not, to our knowledge, been previously described in the literature and needs to be taken into consideration as a differential diagnosis of nodular, achromic lesions on sun-exposed skin.

Figure 16.2a – Nodular, translutent lesion under the right clavicle[58].

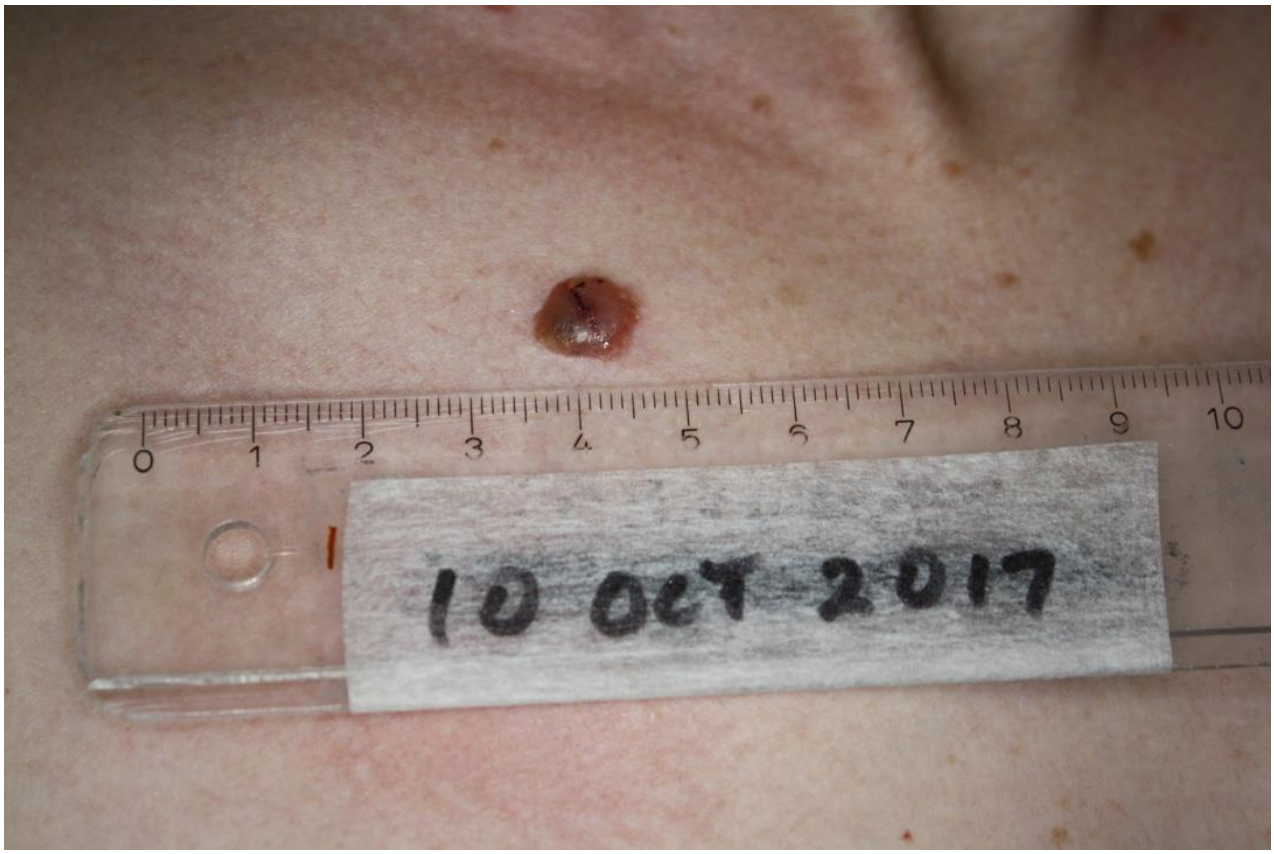


Figure 16.2b – Dermoscopy showing pink background with central polymorphous vascular pattern of hairpin vessels, fine arborizing vessels and dotted vessels; there are white streaks, throughout the tumour centre. Small areas of ulceration and some grey-blue blotches/globules/nests with blue-grey nest and milia-like cysts are visible at the periphery of the lesion [58].

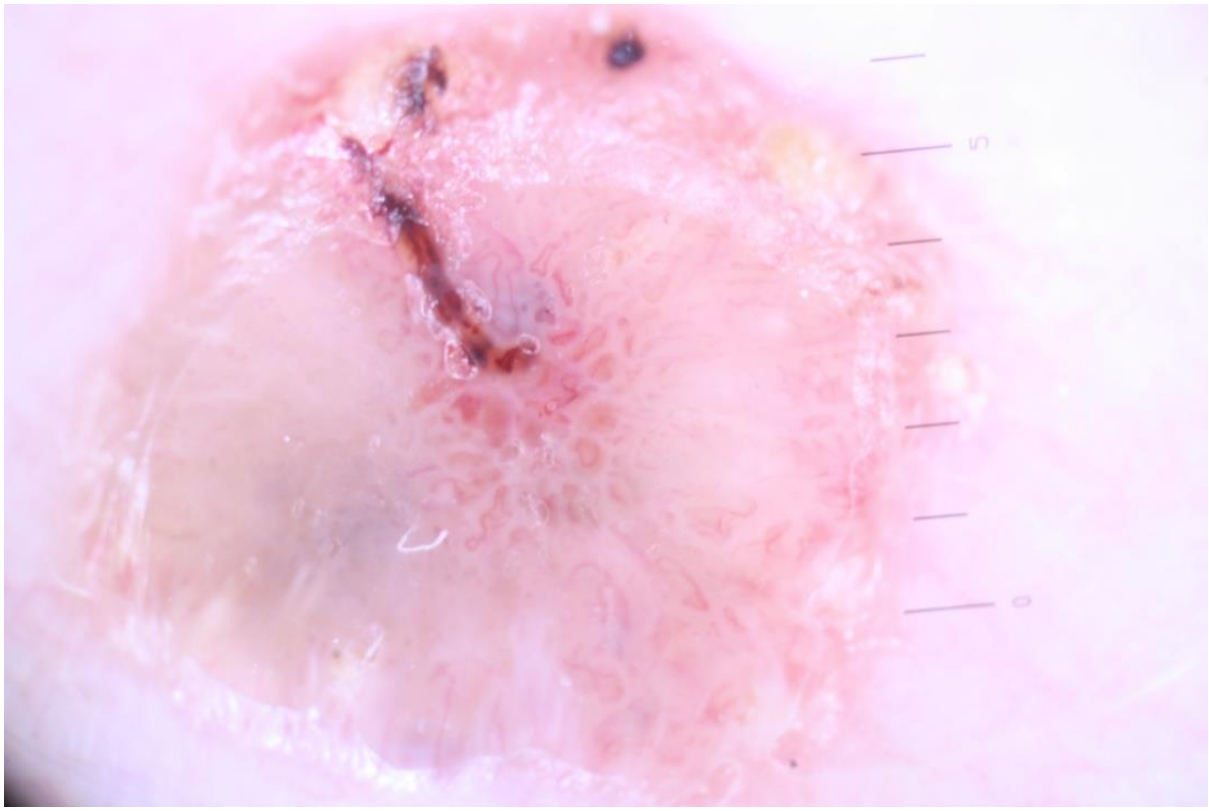
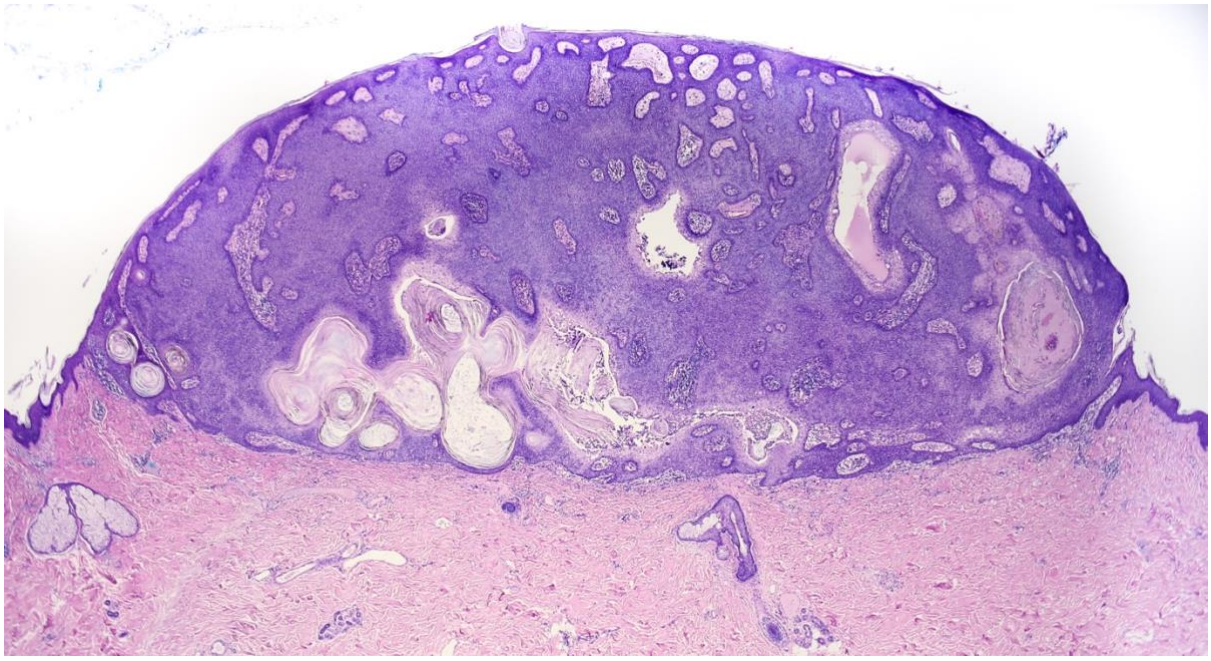


Figure 16.2c - Histopathology, showing a well-circumscribed, nodular, outward epithelial proliferation based at the level of the epidermis, with horn cyst formation[58].



16.3 Cutaneous reactions to cancer therapy
"Pustular Eruption (Iododerma?) in a Patient With Cancer Treated With Complementary and Alternative Medicine."[59]

Patients with advanced-stage cancers, which have not responded to conventional therapy, attempt complementary and alternative (integrative) methods in an effort to find a solution to their suffering. This is understandable, as the patients seek to prolong their lives. Some of these therapies may result in cutaneous reactions, which may sometimes be severe. The question of whether these reactions, in themselves, should suffice to prevent people from trying these therapies, or whether we as physicians should dissuade patients from this, was raised by me[58].

A male patient in his 60s was seen for a skin rash on his face and back, which was predominantly pustular in nature. This rash was exacerbated by consumption of seafood. His medical history was significant for a stage IV lung cancer and he had undergone pneumonectomy, chemotherapy and radiotherapy for this disorder. He was not on epidermal growth factor inhibitors. He was found to be consuming a herbal tonic, that contained high levels of potassium iodide. The removal of potassium iodide from the patient's formulation resulted in remission of the pustular rash. The authors of this presentation subsequently warned against the use of complementary and alternative (integrative) therapies by patients with cancer.

I took issue with this position. I based my stance on the fact that the patient had survived for much longer than could be expected, bearing in mind the advanced nature of his lung cancer and the statistically low probability of survival with such an advanced stage of lung cancer. I advanced the argument that his survival might be connected to his herbal therapy. As such, although he had suffered a severe reaction to his therapy, this had been resolved and that he – and others – need not be discouraged wholesale from the use of complementary and alternative (integrative) therapies for their diseases, simply because of the potential for adverse reactions. Rather, as in this case, I argued that it might be better to be aware of evidence-based complementary and alternative (integrative) methods, in order to be in a position to properly advice our patients in this regard. Also, it would help us more easily treat cutaneous adverse reactions resulting from complementary and alternative (integrative) medicine use. Finally, since this patient appeared to have prolonged his survival long past the expected survival for patients with stage IV lung cancer, it might be postulated that his herbal treatment may have helped achieve this prolonged survival. A question arising from such a situation should also be whether such a treatment does not warrant further

investigation in order to demonstrate its potential efficacy or lack of efficacy for stage IV lung cancer.

In conclusion, a wholesale rejection of complementary and alternative (integrative) therapies may be ill-advised. Rather, an open-minded attitude that would also allow us to benefit where the possibility arises for this, might be the way forward. In following this path, more treatments might be discovered for many disorders, including cancers, which may have hitherto had no efficacious response.

17 Psychodermatology

17.1 "Knowledge Removes Discomfort."[60]

Psychodermatology is an important and growing field of dermatology. Many dermatoses have either a psychological basis, result in psychological or psychiatric disorders or may have both components. It is therefore important for dermatologists to not only be aware of this, but to be competent and confident in making diagnoses of psychodermatoses.

In principle, psychocutaneous disorders are often catalogued as primary psychiatric skin disorders, in which there are psychiatric disturbances such as obsessive compulsive disorder or delusions of parasitosis, which may lead to picking of the skin, with secondary skin lesions; skin disorders that may result in psychiatric disorders like depression, anxiety and suicidal ideation and examples include atopic dermatitis, acne or psoriasis; psychophysiologic disorders are another category of disorders, which do not result from psychiatric disease nor do they often lead to psychiatric disease, rather, they are skin diseases that often result from psychological stress, such as bereavement, shock, etc.. These psychocutaneous disorders are at the boundary of dermatology and psychiatry. We argued that it is important for dermatologists to be aware of their existence and to be comfortable and confident in making diagnoses in this regard. Although they may need to refer such patients to psychiatrists or to other relevant specialists, dermatologists will still be needed to make the diagnoses of skin disorders and to contribute to the treatment of such disorders.

My work, which I showcased in this habilitation thesis, has demonstrated the efficacy of homeopathic therapies for many skin disorders, including acne, psoriasis, rosacea and atopic dermatitis. All these disorders are known to be potential sources of secondary psychiatric illnesses and some of these disorders, such as psoriasis are exacerbated or ameliorated by the psychiatric state of the individual. Classical homeopathic therapy relies on treating the patient according to their personality traits, therefore is predominantly psychophysiologic or "mind-body based" in its mechanisms. As such, psychocutaneous, and, potentially, psychodermatoses in general, may benefit from the treatments, which homeopathy has to offer.

Discussion

The mind-body connection is a complex area, which we are only beginning to understand in medicine. Their connection with dermatology is very intricate and also very strong. It is very important for dermatologists to be aware of the nature of psychodermatoses and to be comfortable making these diagnoses. It is also important for them to be able to

confidently refer to psychiatrists and to be intimately involved in the therapy of the dermatologic aspects of these disorders.

Naturopathic treatments are often based on the mind-body connection. This mind-body connection has been shown to be of relevance in the pathogenesis of many cutaneous diseases. Homeopathy, acupuncture, meditation and yoga, for example, are therapies, which are based on the mind-body connection, that have been shown to be of value in the therapy of skin diseases. Therefore, while being aware of the importance of psychodermatoses, i.e. of the relevance of the mind-body connection in dermatology, it is also important for dermatologists to be aware of the value of naturopathic treatments in the management of these disorders.

18. Adverse cutaneous reactions to medications

Introduction:

Medications utilised in medicine for the treatment of various disorders, whether dermatologic or non-dermatologic bear the risk of adverse effects. These adverse effects can manifest as various dermatoses. It is therefore crucial for the dermatologist to be aware of these adverse reactions in order to be in a position to manage them adequately.

18.1 "Immunologic adverse reactions of β-blockers and the skin (Review)" [61]

β-adrenergic receptors are present in large numbers in the skin. Keratinocytes possess exclusively β2-adrenergic receptors, which are densest at the basal layer of the epidermis. Although β-adrenergic receptor blockers have been shown to be of use in various dermatoses, including hemangiomas, wound healing, pyogenic granulomas and even Kaposi sarcoma and melanoma, they may also be associated with dermatologic side-effects. We reviewed the immunologic side-effects that may arise from β-adrenergic receptor blockade[61].

These disorders include psoriasis and psoriasiform disorders. β-adrenergic receptor blockers may trigger psoriasis in individuals with a prior history of psoriasis or may bring about psoriasis *de novo* in individuals treated with these drugs. Nail involvement appears to be a prominent feature in patients treated with β-adrenergic receptor blockers. We reported a case of psoriasis and psoriatic arthropathy in a patient that was on treatment with metoprolol for hypertension[62]. He manifested with typical erythematosquamous skin rashes on the backs of the hands. There was some improvement following topical steroid therapy and withdrawal of the oral metoprolol. Rheumatoid arthritis and systemic lupus erythematosus may be associated with β-adrenergic receptor blockade. This phenomenon may be a result of T-lymphocyte sensitivity to β-adrenergic stimulation. Anaphylaxis may result from β-adrenergic receptor blocker treatment and the underlying mechanism may result from mast cell priming. This has been noted with metoprolol and this effect appears to be augmented when it is used in combination with angiotensin converting enzyme inhibitors. Periocular and ocular disorders such as keratitis, eyelid and periorbital disorders have been documented with β-adrenergic receptor blocker treatment. *In vitro* cytotoxicity has been observed in association with β-adrenergic receptor blockers such as propranolol, metoprolol, atenolol, bisoprolol, alprenolol, pindolol, timolol and labetalol, on corneal cell and retinal pigment cell lines. Patients suffering from vitiligo, who also receive β-adrenergic receptor blocker treatment may experience an acceleration of their disease. The mechanism

may be associated with cutaneous vascularisation, as there appears to be an increased cutaneous blood flow in vitiligo skin, as compared with unaffected skin using Doppler flowmetry. Alopecia, following timolol treatment in a patient with glaucoma has been documented. It manifested as telogen effluvium and hair volume was restored to pretreatment levels following cessation of the medication. β-adrenergic receptor blocker therapy may be associated with lichenoid drug reactions. Eosinophils are prominent in the histopathologic specimens of these cases. Hyperhydrosis has been associated with β-adrenergic receptor blocker therapy. The underlying mechanisms are not known. Contact dermatitis has been reported in patients using eyedrops and occupational contact dermatitis has been seen to propanolol on the hands of a pharmaceutical factory worker.

18.2 Contact allergy to topical steroids

"Contact allergy to topical momethasone furoate confirmed by rechallenge and patch test." [63]

Although topical steroids are potent anti-inflammatory agents and potent local immunosuppressors, in some circumstances, allergy to these substances may occur. Such allergies should be suspected when patients get worse while on topical steroid therapy. We described the case of a 65-year old woman who had been treated with topical corticosteroids by her general practitioner for a dry rash on her hands, which was exacerbated by cold weather and by dishwashing. In the three weeks prior to presentation, she developed a rash, with oozing, which had spread from her hands to involve her forearms and her cubital fossa. She was currently on therapy with mometasone furoate. The rash improved after cessation of the mometasone furoate and application of tacrolimus. Patch test confirmed allergy to mometasone and also to budosenide, although the patient denied ever using the latter. Accidental application on one occasion after cessation of mometasone yielded another reaction. We recommended patch testing at day 7, after cessation of the suspected allergen, as the immunosuppressive effect might still be present before then, thereby confounding the patch test results. Although mometasone is considered a drug with low potential for allergy, our case shows that this may still occur. Mometasone allergy should be considered in patients who do not respond or who even get worse on topical steroid therapy. Corticosteroid allergy may be the result of self-prescribing, or wrong prescribing by pharmacists or general practitioners. For these reasons, the general public, as well as pharmacists and general

practitioners need to be educated about the dangers of improper use of topical corticosteroids.

18.3 "Bullous reactions associated with COX-2 inhibitors." [64].

Adverse drug reactions can occur to non-steroidal anti-inflammatory agents. We reported a case of a bullous drug reaction, with the culprit being etoricoxib, a cyclooxygenase-2 inhibitor, with mucosal and cutaneous lesions.

A 52-year-old male presented with an eruption, which had been present for 2 days prior to his visit at the clinic. The skin rash began about 8 days after the initiation of oral treatment with etoricoxib, 60 mg o.d., for non-remitting pains of his joints. Examination revealed an eruption consisting of bullae, with some on an erythematous base and others on nonerythematous skin. There were associated erosions, which were located on the oral parts of the lips. Of interest, he reported that they were located in the area in which he had held the tablets with his lips. There were also bullous lesions and erosions around the affected joints. The lymphocyte transformation test was done and it came back positive. The basophile degranulation test was negative. A patch test was not carried out. The diagnosis of bullous mucocutaneous drug eruption secondary to etoricoxib ingestion was made and this diagnosis was corroborated using the Naranjo score. The patient was treated with sterile needle puncture of the bullae, with drainage of the liquid contained in it. He was prescribed desloratadine tablets and topical application of silver nitrate solution and a betamethasone–gentamicin cream. He was also advised to stop ingesting etoricoxib. Three days after this the condition improved, but the patient became lost to follow-up.

Discussion:

Adverse reactions to medications may be defined as noxious, unintended and undesirable effects of a drug, which is being used for therapeutic purposes. Most drugs have adverse reactions that also include involvement of the skin. In this habilitation thesis I have presented the immunologic adverse reactions to adrenergic receptor blocker therapy. The adrenergic receptor blocker class of drugs is very large and has diverse uses in medicine, including dermatology. These immunologic adverse drug reactions include the triggering of psoriasis, psoriatic arthropathy, lichen planus-like drug eruptions, rheumatoid arthritis, the acceleration of vitiligo, alopecia and contact dermatitis.

Although corticosteroids are considered an indispensable category of medicines in dermatology, for their anti-inflammatory and immune suppressive effects, they are capable

of producing allergic reactions. We presented a case of allergic contact dermatitis to topical mometasone furoate, which was confirmed by the patch test and an accidental rechallenge test, when the patient took the medicine once more.

Finally, we presented a case of bullous reaction to the cyclooxigenase-2 inhibitor etoricoxib. The patient developed cutaneous reactions to the medicine and bullous and erosive lesions on the lips, especially at the place of contact with the tablets.

It is important to bear in mind the cutaneous adverse reactions to various medications. These may include the exacerbation or triggering of various cutaneous disorders or may manifest as allergic or irritant reactions to medications.

19. The SARS Cov-2 Pandemic and the skin

19.1. "Observations about sexual and other routes of SARS-CoV-2 transmission and its prevention." [64]

The Severe acute respiratory syndrome 2019, caused by the coronavirus led to a pandemic and an almost total shutdown of the economies of all countries in the world. A number of routes of transmission of the novel coronavirus have been documented, as well as a plethora of cutaneous manifestations associated with this infection. We discussed some of the potential routes of transmission of the Severe acute respiratory syndrome coronavirus-2 infection in a recent paper. One of the proposed routes was via sexual contact and it raises the question of alternate routes of transmission. Angiotensin converting enzyme-2 receptors have been found in the epidermal basal cells, including at the base of hair follicles, sebaceous and eccrine glands, smooth muscle cells, vascular endothelial cells, renal epithelial cells, and potentially even the testis. More recent work suggests that although the testicles carry angiotensin converting enzyme-2 receptors and that some patients might show clinical symptoms indicative of viral orchitis, viral DNA has not yet been found within seminal fluid after infection. It is postulated in some quarters that the viral load may be to be too low to cross the blood–testis barrier, and that angiotensin converting enzyme-2 receptor concentration in the testis may be too low to allow viral penetration. However, other avenues of sexual intercourse, such as oral–anal contact, may also be involved in the transmission of the virus. This is because rectal swab testing is positive even with negative nasopharyngeal swabs. It therefore appears relevant to ask whether all tissues, which express angiotensin converting enzyme-2 receptors are receptive to viral entry, and if they may also be sources of viral shedding. Although some authors have suggested that there is no evidence of sexual transmission for the severe acute respiratory syndrome coronavirus 2019, this possibility still remains an interesting hypothesis to bear in mind, as some sexual minorities could be placed at disproportionately higher risk as a result.

We felt that, for the present time, nasopharyngeal swabs will probably remain the standard of diagnosis. The faecal–oral route, whether through sexual contact or not, is rapidly becoming a recognized route of viral transmission. This brings us to the wildlife markets that were at the epicentre of the outbreak in China and which are notoriously overcrowded and unhygienic. In such places, faecal contamination of food would likely be a commonplace

occurrence, but could remain an overlooked source of human–human transmission, in a manner that is similar to what has been seen in outbreaks of diseases such as cholera and dysentery. Should this be shown to be true, then the potential for severe acute respiratory syndrome coronavirus 2019 to spread rapidly in refugee camps or in the neglected slums of cities and towns in poorer nations is a very real prospect. This possibility certainly needs to be addressed urgently as part of overall global strategies for severe acute respiratory syndrome coronavirus 2019 containment. It would be necessary to rethink containment measures in such areas so that public health authorities, who are already enforcing social isolation, do not lock people down in situations where the virus can spread with great ease because of lack of access to clean water. With all these in mind, we suggested strict adherence to certain simple hygiene rules such as: nails cut as short as possible, hair tied back as it too can be contaminated with the virus and avoidance of eyelash extensions. It would also be good to shave beards wherever possible due to the sebum secretion in beard hair; absolutely all tools used for personal hygiene (tweezers, scissors, combs, etc.) need to be disinfected as often as possible and of course there should be no sharing of such instruments.

19.2 "A Working Hypothesis on Vesicular Lesions Related to COVID-19 Infection, Koebner Phenomena Type V, and a Short Review of Related Data." [65]

The COVID-19 infection has been associated with vesicular rashes in some subgroups of patients. It is pertinent to establish if these manifestations unique to COVID-19 and to differentiate them from similar vesicular rashes that may be seen in other exanthemas. Some work from an observational study that included twenty-two whose nasopharyngeal swabs tested positive for SARS-CoV-2 indicated that a vesicular eruption may be associated with, or even be characteristic of this infection. It is still unclear why these lesions occur only certain patients. We postulated that such vesicles are occurring in already susceptible skin, for example that, which has previously suffered from a cutaneous lesion thereby creating a *locus minoris resistentiae*, the underlying basis the Wolf isotopic phenomenon or Koebner type V reaction. We also hypothesized that trauma from scratching or other mechanical forms may lead to either autoinoculation (pseudoKoebner reaction) or even a type I Koebner as seen in other disorders such as lichen planus and psoriasis.

19.3 Koebner phenomenon with lichen planus in an area of previous vitiligo after COVID-19 vaccination and the creation of a locus minoris resistentiae. [66]

The type V Koebner reaction seems to underpin the case of lichen planus appearing in an area of vitiligo, following the mRNA COVID-19 vaccination. We postulated that a cascade beginning with an occult trigger leading to the release of damage-associate molecular patterns in tissues may trigger a cascade of proinflammatory cytokines leading finally to the recruitment of T cells to the areas affected by disease. The T cells maintain and exacerbate the inflammatory reaction bringing about these autoimmune reactions. We felt that this might also be an underlying mechanism for the *locus minoris resistentiae* that may cause a coexistence of vitiligo and lichen planus. A similar cascade may occur in patients following the mRNA COVID-19 vaccine, who then develop autoimmune disorders including lichen planus, vitiligo or subacute lupus erythematosus.

Discussion:

The current severe acute respiratory syndrome coronavirus 2019 pandemic has had an impact on the health and economies of the population of the entire planet. We are still learning about its impact on the body's organ systems and the accumulated evidence shows that it has a wide range of cutaneous manifestations. All its possible modes of transmission have not been fully elucidated. Aside from the respiratory route, the sexual route of transmission is becoming an increasingly probable possibility. It is also possible that the fecal-oral route is another significant route. It may have been an important route for the initial spread of the virus in the city of Wuhan, which was at the epicentre of the pandemic. If such a route were to be valid, then the public health impact on poorer countries and those living in the poorer areas of the world could be very significant.

Some manifestations have shown themselves to be associated with COVID-19 infection. Vesicular skin lesions are commonly seen and they are reminiscent of those seen in varicella. The exact cause of these skin lesions is unknown.

Cytokine cascades have been associated with COVID-19 and such a cascade might help explain the apparent Koebner reactions in patients following the mRNA vaccines.

Conclusions:

The research work I have presented showcases some of the work that I have done since the successful defence of my Ph.D. thesis. The majority of the work has been in the field of complementary and alternative (integrative) methods in medicine in general and in dermatology in particular. Much of the work has been done using homeopathy, which experiences an enormous amount of resistance in medical circles. This reticence to homeopathy is difficult to comprehend, bearing in mind the fact that homeopathy is consistently one of the top three choices of complementary and alternative methods used by patients. Its principles are, nonetheless, the same principles that can be found in conventional medical practice.

My research has been clinical, as it has not been possible, due to lack of resources, to carry out more complex research. My research has shown the potential efficacy of homeopathy in many dermatoses.

I have been able to show, in two case series and one case study, that acne may potentially benefit from treatment with homeopathy. More than 80% of patients responded to individualised homeopathic therapy. About the same percentage responded to individualised homeopathic therapy for the treatment of long-standing, recalcitrant viral warts, which shows that homeopathy can be efficacious in the therapy of viral infections. I presented three case reports (n=9), of generalised, long-standing psoriasis, nail psoriasis, palmoplantar psoriasis, as well as erythrodermic psoriasis, which all responded fully to individualised homeopathic medicines. Generalised lichen planus with mucosal involvement appeared to be responsive to homeopathic therapy in a case study of 4 patients. Mycosis fungoides (cutaneous T-cell lymphoma), which is usually not spontaneously remitting, responded completely to individualised homeopathic medicine, in a case study involving 3 patients. Recurrent urinary tract infections are a commonly encountered problem. I published a case study (n=3, all females) of recurrent bacterial urinary tract infections that responded to classical homeopathic therapy. Two cases were *E coli* and 1 case *Klebsiella spp.* This study again showed that homeopathic treatment could be of value in infectious diseases. Rosacea is a commonly encountered problem that is quite difficult to treat. My case study (n=3, all female) showed that individualised homeopathic therapy could have potential value in the treatment of this disorder. Atopic dermatitis may also respond to classical homeopathic medicine. My case study (n=3) of patients with atopic dermatitis treated with individualised homeopathic medicine showed that these cases could remit with treatment. Another case study (n=2, both female) of long term, non-remitting seborrheic dermatitis

treated with individualised homeopathic therapy showed that these cases could potentially remit with such treatment. I published a case of dermatitis herpetiformis (Duhring's disease) of 35 years duration, which remitted with individualised homeopathic therapy. In this case, the patient's digestive disorder also remitted with the same homeopathic treatment. Another case of longstanding melasma was treated with classical homeopathic medicine. This patient remitted and remained in remission, even though she did not use sunscreens during the period of treatment. Elephantiasis nostras is massive lymphedema, which is not generally spontaneously remitting. Therapy for this condition is difficult and may be fruitless. I presented a case of elephantiasis nostras treated with furosemide and homeopathy. Diuretics are not considered particularly effective therapies for elephantiasis nostras, thereby underlying the significance of homeopathic therapy in this case. This case may provide a basis for future research into the potential efficacy of homeopathy and furosemide in the treatment of elephantiasis nostras.

Naturopathic therapies can also be of value in the management of cutaneous ulcers. Amongst the therapies that I have used and published are Miculicz ointment (which contains 1% silver nitrate and 10% Peru Balsam). I published a case report of a patient with an arteriopathic foot ulcer and diabetes mellitus, who was under consideration for a lower limb amputation. This patient benefitted from Miculicz ointment, applied daily. Miculicz ointment was used in the therapy of a female diabetic patient with arteriopathy, chronic renal failure and a history colonic cancer in remission. The patient benefitted from a combined treatment, which began with betadine solution (10% povidone iodine) applied topically to diminish bacterial load and to reduce subsequent secretion; enzymatic debridement using a clostridiopeptidase (collagenase derived from *Clostridium hystioliticum*), followed by treatment with Miculicz ointment, which helped to stimulate rapid growth of granulation tissue, followed by epithelialisation using a zinc hyaluronate gel. All the products used in wound dressing were naturally derived agents, showing how useful naturopathic agents can be in wound healing and that these products can also be used in a customised approach. This case study was published as an E-poster. Again, Miculicz ointment was applied to large, recalcitrant leg ulcers in a patient with granulomatous slack skin and unremitting, generalised pruritus. Aside from daily dressing with Miculicz ointment, this patient was prescribed homeopathic medicines for his pruritus and the ulcers healed and the pruritus remitted. Medical grade honey is an established therapy for the management of chronic wounds. Our experience was published as case reports. The first was a male patient, aged 85 years with Type 2 diabetes and renal failure, with an ulcer (20x20cm) on his anterior right

leg. This ulcer healed completely in 3 weeks. We also published another case study of a non-compliant patient with diabetes mellitus and a foot ulcer, which became gangrenous. The affected toe was amputated and the subsequent post-surgical ulcer responded to daily medical grade honey dressings.

The default diagnosis of foot ulcers in patients is often diabetic foot ulcer. These ulcers are generally difficult to treat and heal slowly. However, the differential diagnosis of foot ulcers is vast, therefore it is important to bear in mind other – sometimes sinister – diagnoses, when consulting a patient with diabetes and foot ulceration. I presented two cases of malignant foot ulceration – one patient with squamous cell carcinoma and the other with malignant melanoma, that had been diagnosed and treated as diabetic foot ulcers over a period of two-three years. These cases illustrate some of the potential areas of difficulty that may be encountered in the therapy of diabetic foot ulcers, as well as the need for a multidisciplinary approach to their treatment, especially in difficult, recalcitrant cases.

The Koebner – isomorphic - phenomenon is a well-known dermatologic sign. It has been documented in various diseases, most notably vitiligo, lichen planus and psoriasis. There are four forms of the Koebner phenomenon that are recognised. The classic form, the form known also by some as pseudo-Koebner, seen in molluscum contagiosum or verruca vulgaris (thought to be produced by seeding), the form seen occasionally (Behcet syndrome or pyoderma gangrenosum) and the form rarely seen (pemphigus or lichen nitidus). We argued in a paper that the Wolf isotopic phenomenon be considered a type V Koebner. This is because the Koebner and the Wolf phenomena are both based on the locus minoris resistentiae or the immunocompromised district. In a separate paper, I showed that it may be possible for pityriasis rosea to show a type IV form of Koebner, in a case study featuring a female patient who developed lesions of pityriasis rosea at points of venepuncture, associated with an episode of classic pityriasis rosea, with a clear herald patch. We also argued that the phenomenon of field cancerisation may be a form of locus minoris resistentiae brought about by immunosuppression. We also argued that this field cancerisation might be a generalised phenomenon and this might be behind the koebnerisation seen in some cases of squamous cell carcinoma.

This phenomenon of field cancerisation may be the same as the locus minoris resistentiae or immunocompromised district. We believe that this might be the underlying effect of the increasing number of medications that have been associated with a heightened risk of skin cancers. We have discussed the effects of tetracyclines, hydrochlorothiazide and statins in this regard.

Seborrheic keratosis is a common cutaneous lesion. There are several forms. We published a unique case, which, to the best of our knowledge, has never been documented in the literature. This is a case of nodular, ulcerated seborrheic keratosis in a healthy woman. This case could clearly be diagnosed as a melanoma, basal cell carcinoma or fibroepithelioma, amongst others. Irritated seborrheic keratosis should be borne in mind when such lesions are seen.

Also, we were able to present our thoughts on possible routes of transmission of the novel, severe acute respiratory syndrome coronavirus 2019 disease. We postulated that oral-anal contact, as well as faecal contamination of food could be possible routes of transmission of the disease. The former would be important with regard to sexual minorities, while the latter would be important in overcrowded, poorer parts of the world, where access to clean water may be very limited.

The immunological and inflammatory reactions underpinning the appearance vesicular lesions in patients with COVID-19 infection, as well as the possible type V Koebner reactions were also analysed and discussed in papers published with my colleagues.

Complementary and Alternative (Integrative Medicine) may be useful for some dermatoses, thereby providing patients with more options to choose from. Since it is a rapidly growing field, more research is required to establish its place in dermatological therapeutics. Diabetic foot ulcers continue to be a major source of morbidity and mortality. Multidisciplinary research is required to provide effective care, especially in difficult to heal cases.

I hope that I will be able to continue to contribute to these areas, following the defence of my Habilitation Thesis.

PART II

ACADEMIC ACTIVITY

Introduction:

Since I do not hold a university teaching position, this section will only contain material produced by me, in collaboration with colleagues who held academic positions at the time.

Therefore, my academic contribution is limited to published didactic material, which has served as teaching and study material for residents and specialists in the field.

My academic activity serves as proof of the fact that it is possible to produce sound academic work without being formally affiliated to an academic institution. However, a clear advantage of holding an academic position is the greater access to funding that this provides, which makes it easier to do much more elaborate and comprehensive research.

My main areas of academic interest are –

1. Integrative Dermatology (Complementary and Alternative treatments in dermatology alone or combined with Conventional therapies)
2. Diabetic Foot Ulcers
3. History and Philosophy of Dermatology and Medicine in general

2.1 - Chapters in books

Already, *prior to the completion of my doctoral thesis* I contributed to the production of a number of scientific works that were published at national and international conferences. Also, I contributed four chapters to three books. These books were published at prestigious national and international publishing houses.

The books chapters are:

1. **Nwabudike LC** „A matter of Honour" in The Re-Discovery of Insulin (1996), C. Ionescu-Tîrgovişte, Geneze Publishers, Bucharest

2. Chapter – **Nwabudike LC**, Ionescu-Tîrgovişte C „Piciorul diabetic(Diabetic foot)" in Tratatul de Diabet Paulescu (Paulescu Textbook of Diabetes) (2004), C. Ionescu-Tîrgovişte (Editor), Romanian Academy Publishers, Bucharest

3. Chapter - **Nwabudike LC**, Ionescu-Tîrgovişte C. „Tegument în diabetul zaharat (Skin in diabetes)" in Tratatul de Diabet Paulescu (2004), C. Ionescu-Tîrgovişte (Editor), Romanian Academy Publishers, Bucharest

4. Chapter - **Nwabudike LC** „Vascular factors in diabetic foot ulcers" in Vascular Involvment in Diabetes (2005), D. Cheţa (Editor), Romanian Academy Publishers (Bucharest) & Verlag Karger (Basel, Switzerland). ISBN 973-27-1120-5 and 3-8055-7962-4

The first book was a historical account that attempted to make the case for the priority Romanian physician Professor Nicolae Paulescu in the discovery of insulin. My contribution to this work was a chapter, which outlined the ethical aspects of the award of the Nobel Prize for the discovery of insulin to others, who might have plagiarised Professor Paulescu's work, as well as the perpetuation of this error in the history of medicine to this day. This book was published at the Geneze Publishing House.

The second book was a textbook of diabetes meant for trainees in the field of diabetes, nutrition and metabolic diseases, as well as for specialist physicians. This textbook was published at the prestigious Romanian Academy Publishing House in 2004. My chapters were review chapters that discussed the cutaneous disorders associated with diabetes mellitus and the disorders that are to be found in patients with the diabetic foot syndrome, especially ulcers and ways to prevent lower limb amputation. Both chapters are unique, as they look at the subjects from the viewpoints a dermatologist who has worked constantly on patients with diabetes mellitus.

The third book was a specialised work on the vascular complications of diabetes mellitus. My chapter was dedicated to vascular pathogenesis of diabetic foot ulcers. In this chapter I outlined various aspects of vascular diseases that bring about the production of ulcerations and to amputation in connection with the diabetic foot syndrome. This book was published at the prestigious Karger Publishing House (Switzerland) and the Romanian Academy Publishing House.

After the successful completion and defence of my doctoral thesis, I contributed other academic work, which consisted of chapters in books dedicated to specialist physicians and to residents in dermatology, diabetes, endocrinology, surgery and to medicine in general.

The following books were published, which included chapters written by me.

1. **Chapter** – **Nwabudike L.C.** (2021) *Homeopathy in the Therapy of Acne and Rosacea.* In: Rupani R.N., Lio P.A. (eds) *Integrative Dermatology*. **Springer, Cham**. https://doi.org/10.1007/978-3-030-58954-7_12

2. **Chapter –** F.C. Bujoreanu, D.S. Radaschin, **L.C. Nwabudike,** A.L. Tatu *Cutaneous melanoma from the anterior thorax: a case report* in *Clinical Cases in Melanoma* Lotti, Torello, Tirant, Michael, Wollina, Uwe (Eds.) 2020**. Springer Nature Publishers ISBN 978-3-030-50820-3**

3. **Chapter – L.C. Nwabudike,** A.L. Tatu, A.M. Oproiu, M. Costache *When Dermoscopy exonerates a suspect and "indicts" another lesion* in *Clinical Cases in Melanoma* Lotti, Torello, Tirant, Michael, Wollina, Uwe (Eds.) 2020**. Springer Nature Publishers ISBN 978-3-030-50820-3**

4. **Chapter –** A.L. Tatu, D.S. Radaschin, F.C. Bujoreanu, **L.C. Nwabudike**. *Homogeneous black, pigmented lesion of the fifth toe* in *Clinical Cases in Pigmentary Diso*rders Lotti, Torello, Tirant, Michael, Parsad, Davinder (Eds.) 2020. **Springer Nature Publishers ISBN 978-3-030-50823-4**

5. **Chapter – L.C. Nwabudike**, A.L. Tatu, D.S. Radaschin, V Ardeleanu *The dermatologist's fingernail* in *Clinical Cases in Pigmentary Disorders* Lotti, Torello, Tirant, Michael, Parsad, Davinder (Eds.) 2020. **Springer Nature Publishers ISBN 978-3-030-50823-4**

6. **Chapter – L.C. Nwabudike**, A.L. Tatu. *Dark facial spots and a rash* in *Clinical Cases in Pigmentary Disorders* Lotti, Torello, Tirant, Michael, Parsad, Davinder (Eds.) 2020. **Springer Nature Publishers ISBN 978-3-030-50823-4**

7. **Chapter – Nwabudike LC** *„Diabetic Foot Ulcers"* in *Diabetic Complications. New Insights and Solutions.* Cheta D (ed) 2014 **Agir Publishers, Bucharest. ISBN 978-973-720-545-2**

8. **Chapter** – **Nwabudike LC**, Ionescu- Tîrgovişte C, *"A tale of diabetic neuropathy"* (2013) in Istoria neuropatiei diabetice în România (The History of Diabetic Neuropathy in Romania). **Sanatatea Press Group Publishers ISBN 978-973-0-15565-5**

My most recent academic chapter is on the applications of homeopathic therapy in treating acne and rosacea *(item number 1)*. This was part of a work introducing dermatologists and physicians in general to the possibilities of treating patients suffering from these disorders with naturopathic or integrative therapies. It serves as a rich source of data for research and teaching, as well as a source of information for physicians wishing to counsel their patients or contemplating using one of therapeutic methods discussed. This work was published at the prestigious Springer Nature Publishers.

Together with colleagues I contributed to two chapters related to melanoma*(items 2&3)*. One chapter was written as a co-author and one as lead author. The chapters help to elucidate some controversies in melanoma knowledge. These works were part of a book published at the prestigious Springer Nature Publishers.

I contributed three chapters to a book on pigmentary disorders. One chapter as a co-author and two as a lead author *(items 4-6)*. They present challenges and possibilities for the diagnosis and management of pigmentary cutaneous disorders. They will hopefully add to the body of knowledge of these disorders. These chapters were published at the prestigious Springer Nature Publishers.

The book on diabetic complications was published at the historic and prestigious Agir Publishing House, Bucharest*(item number 7)*. It was a book on new insights into the complications of diabetes mellitus. Insights and solutions to these were proposed by each author. My chapter comprised new developments in the field of diabetic foot ulceration and how to prevent the progression towards amputation. I also was privileged to contribute to this work as an Assistant Editor on the Editorial Team of this book.

The book on the history of diabetic neuropathy reviews contributions made to research and therapy in Romania regarding diabetic neuropathy*(item number 8)*. In this work, I wrote a chapter, which detailed achievements and contributions from the N. Paulescu National Institute of Diabetes, where I work, to the elucidation of diabetic neuropathy. It serves as a historical guide to the progress made in Romania on this subject. The work also included my personal contributions to the subject of diabetic neuropathy in Romania.

2.2 - Teaching activity

I taught dermatology and homeopathic therapy of skin diseases on the Homeopathy Competency Course of the Romanian Association of Clinical Homeopathy, which is run under the auspices of the Romanian Ministry of Health. I have also taught courses at international conferences, such as the course titled *"Keeping an open mind series: what is homeopathy and can it help my aesthetic practice?",* given at the 5-Continents Conference, Barcelona, 2019.

Speaker and Lecturer -

1. *2009* - I was an invited Speaker at the 4th International Conference of Chinese Medicine on Diabetes (ICCMD) and gave the lecture – "Acupuncture in peripheral diabetic neuropathy". In this work, I outlined the role acupuncture can play in the therapy of peripheral diabetic neuropathy. I also drew comparisons between the philosophies of Western conventional medicine and Traditional Chinese medicine.
2. *2017* – I gave a lecture at the Romanian Society of Dermatology meeting titled *"What is homeopathy and how useful is it to dermatology?".* This lecture explained the basic principles of homeopathy to the participants and also presented theoretical and practical clinical evidence of the basis of homeopathy, thereby illustrating its usefulness to dermatology.
3. *2018* - I was an invited Speaker at the European Academy of Dermatology and Venereology Congress, History Symposium and gave the lecture *"The cyclical history of the origin of disease – from miasms to germs and back again".* This was a historical and philosophic work, which outlined the history of our understanding of disease, using the germ theories. It also posited possible directions for future research and thinking in medicine.
4. *2019* - I was an invited Speaker at the European Academy of Dermatology and Venereology Congress, History Symposium and gave the lecture *"From archfiend to partner – the changing role of the microbiome and the skin"*. Here, I outlined the history of the microbiome and how it has changed, from being considered a hostile "force", to being considered a partner and its potential utility in modern therapeutics.
5. *2019* - I was an invited Lecturer at the 5-Continent Congress on Aesthetic Medicine and Dermatology and gave the teaching course *"Keeping an open mind series: what*

is homeopathy and can it help my aesthetic practice?", which was meant for specialists in the fields of dermatology and aesthetic medicine. Here I explained the meaning of homeopathy, its scientific basis and its usefulness in aesthetic medicine, using examples from my practice.

6. *2019* - I was an invited Speaker at the 5-Continent Congress on Aesthetic Medicine and Dermatology and gave a lecture on *"Complementary medicine in dermatology – another approach to cosmesis".* Here I spoke on the potential of complementary and alternative medicine to be useful in cosmesis.
7. *2019* – I gave a lecture at the Romanian Society of Dermatology meeting titled *"The cyclical history of the origin of disease – from miasms to germs and back again".* This was an adapted version of a lecture with the same title given at the European Academy of Dermatology and Venereology in 2018.

These lectures have served as teaching sessions for specialists and trainees in the fields of dermatology and the subjects of my lectures have been an expression of my strong interest in the application of complementary and alternative (integrative) therapies in dermatology and medicine in general. They have also served to showcase my results as evidence that these therapies may be useful in dermatology and medicine in general. Through my lectures on history and philosophy of medicine, I have tried to delve into the deeper meaning of the aetiology of disease and to use historical changes in our approach to disease to suggest future paths forward in our approach to skin disease in general.

2.3 – Editorial Activity

Guest Editorship –

1. I am the Guest Editor to the Special Edition of **Dermatologic Therapy**, which has an **impact factor of 2.851** (Web of Science/Journal Citation Reports). The Special Edition is titled *"Indigenous Therapies for Skin Diseases in Sub-Saharan Africa"*

2.4 - Reviewer Activity

Peer Reviews – (see publons)

1. Children;
2. Atmosphere;
3. Alternative Therapies in Health and Medicine;
4. Pharmaceuticals;
5. Diagnostics;
6. Journal of Integrative Medicine;

7. Homeopathy;
8. Clinical and Experimental Dermatology;
9. Dermatologic Therapy;
10. International Journal of Dermatology;
11. British Journal of Pharmacological Research (not on publons)

2.5 - Editorial Board and Faculty Membership –

Editorial Board Membership

1. Member of the Editorial Board – Our dermatology online journal (www.odermatol.com), 2011 – date

Faculty Membership

2. Member of the Teaching Faculty – 5-Continent Congress, 2019-Date

PART III

PROFESSIONAL DEVELOPMENT, ACTIVITY AND ACHIEVEMENTS

3.1 Professional Education and Qualifications

1. MRCP(UK) diploma (Membership of the Royal Colleges of Physicians, by examination) – Royal Colleges of Physicians, United Kingdom, 2017
2. Certification as Lecturer in Acupuncture – Romanian Ministry of Health, 2012
3. Senior Specialist in Dermatology (by examination) – Romanian Ministry of Health, 2009
4. Doctor in Philosophy (Ph.D.), [Dermatology]– (Carol Davila University of Medicine and Pharmacy, Bucharest, 2007)
5. MD – United States (United States Medical Licencing Exam/Educational Commission for Foreign Medical Graduates, 1998)
6. Specialist Qualification – Specialist Certificate in Dermatology (Romanian Ministry of Health, 1995)
7. Certificate of competency in Homeopathy – Romanian Ministry of Health, 1995
8. Certificate of competency in Acupuncture – Romanian Ministry of Health, 1995
9. Medical Degree – MBBS (University of Lagos, Nigeria, 1989), with Attestation/Equivalence from Ministry of Education.

3.2 Professional Licencing and Registration

1. Registered - Colegiul Medicilor, Romania
2. Registered – Colegiul Medicilor, Bucuresti (Romania)
3. Registered - General Medical Council (UK)
4. Registered – Nigerian Medical Council

3.3 Membership of Professional Bodies

- Member of Romanian Society of Dermatology (SRD)
- Member of Romanian Association for Clinical Homeopathy (ARHC)
- Member of the American Academy of Dermatology (AAD)
- Member of the American Academy of Dermatology ERG on Integrative Medicine
- Member of the European Academy of Dermatology and Venereology (EADV)

- Member of the European Society for the History of Dermatology and Venereology (Sister society to the European Academy of Dermatology and Venereology)
- Secretary of the European Society for the History of Dermatology and Venereology
- Member of the Royal College of Physicians of London.

3.4 Prizes and Awards

1. Romanian Ministry of Education (UEFISCDI) research award for research in 2021 *(for Q2 paper - Yesudian PD, **Nwabudike LC**, de Berker D. Nail changes in diabetes. Clin Exp Dermatol. 2022;47(1):9-15. doi: 10.1111/ced.14859.)*
2. Romanian Ministry of Education (UEFISCDI) research award for research in 2020 *(for Q1 paper - Gagniuc PA, Ionescu-Tirgoviste C, Gagniuc E, Militaru M, **Nwabudike LC,** Pavaloiu BI, Vasilăţeanu A, Goga N, Drăgoi G, Popescu I, Dima S. Spectral forecast: A general purpose prediction model as an alternative to classical neural networks. Chaos. 2020;30(3):033119. doi: 10.1063/1.5120818.)*
3. Best Abstract Award (Innovations), Naturopathic Products in Wound Healing 5-Continent Congress, Barcelona, Spain, 2018
4. Poster Prize, First Congress of the Romanian Diabetes Federation, Cluj-Napoca, November 2002

3.5 Non-Academic Professional Activity

1. Regular contributor to Libertatea National Newspaper on Medicine (2002-2007)
2. Regular contributor to Formula AS National Newspaper on Complementary Therapies for Various diseases (2007-date)
3. Regular interviews on medicine on National Television and Radio.

PART IV

FUTURE DIRECTIONS AFTER DEFENSE OF HABILITATION THESIS

Following (successful) defence of my habilitation thesis, I would like to continue my work in several main directions –

4.1 First direction –

The first direction is to continue research into complementary and alternative medicine in dermatology (integrative dermatology), thereby contributing to making potentially new therapeutic options in dermatology, and medicine in general, available for the use of humanity. Amongst these options are homeopathy, acupuncture and herbal medicine. I also intend to continue research into the care of diabetic foot ulcers and into strategies for the prevention of lower extremity amputations. These areas of prevention include patient education, which I began during my doctorate. Also, I hope to be able to establish teaching courses for healthcare workers. Finally, I am passionate about the concept and philosophy of disease as part of the human condition. I would like to further explore the meaning of the concepts of disease and health, including how disease came into being, what it has to teach us and, in consequence, how this can aid us in understanding ourselves as individual human beings and as a species. This will involve incursions into the history of dermatology and medicine. I hope I will be able to research into these areas and contribute to bringing more knowledge to humanity.

4.2 Second direction –

The second direction dovetails into the first. This will be to supervise doctoral theses into the fields of integrative (complementary and alternative) dermatology, diabetic foot ulcer research, as well as history and philosophy of dermatology and medicine, especially with regards to the essential meaning of the concepts of disease and health. This will help train a cadre of scientists, who will hopefully be able to contribute meaningfully to new fields of research in medicine.

4.3 Third direction –

The third direction is to be able to help train students and physicians (trainees and specialists) in the fields of integrative dermatology, diabetic foot ulcer care and philosophy and history of disease in dermatology and in medicine generally. I hope to be able to organise

courses and seminars to this end also. This way, a new generation of healthcare workers will arise that would view these concepts differently from the previous generation and hopefully be in a better position to offer this different outlook to their patients in the form of novel therapies and approaches.

4.4 Fourth direction –

The fourth direction is that of educating the general public on the benefits of integrative medicine, especially with regard to dermatology. I am already well known for my articles published in the written mass-media (I write regularly for the Formula AS national health weekly), which inform the general public on the different integrative therapies for dermatologic and other disorders that are potentially available. I hope to continue educating the public on the importance of good foot care in diabetic patients and the need for urgency of treatment for patients with diabetic foot ulcers. Finally, my continued references to the meaning of life in my writings in the mass-media are meant to help educate the public on the deeper meaning of disease and life in general. This should help encourage and empower people take some responsibility for maintaining their personal health, thereby serving as a means of preventing disease and of living a healthier, happier, more fulfilling life.

These plans can probably be better achieved in the context of a university appointment, as this will provide stature that can attract funding and that can provide a greater platform for the spread of ideas. Therefore, I hope that the successful completion of my habilitation thesis will open doors for me into an academic institution. Such an opening would create opportunities for the generation of funding for the plans enumerated above. It would also create an environment conducive to preparing doctoral students as well as trainee and specialist physicians and healthcare staff in the directions mentioned. Also, it would contribute to providing a greater platform for the dissemination of ideas via publications in the specialist literature (journals and books) as well as greater legitimacy to speak to the general public.

Final conclusions:

This habilitation thesis covers complementary and alternative (integrative) therapies in dermatology. This trend is an ever increasing one and deserves our attention as dermatologists and physicians in general. The evidence presented shows the potential of integrative or holistic methods to alleviate a range of dermatoses. This evidence can be used as proof of concept for further, more elaborate research, which can offer more conclusive data. This can only be to the benefit of mankind and to the improvement of medical practice. The evidence that I have presented has included the presentation of published research into the use of homeopathy for the treatment of a variety of dermatoses, including acne, rosacea, verucca vulgaris, dermatitis herpetiformis, atopic dermatitis, psoriasis, mycosis fungoides and recurrent urinary tract infections. It also includes the use of various naturally derived products such as medical grade honey, *Clostridium hystioliticum*-derived (clostridiopeptidase A, used for enzymatic debridement), Miculicz ointment (containing the herbal derived product Peru balsam) and hyaluronic acid derivatives for wound healing.

I have also presented works related to the aetiology of disease, i.e. to the concept of predisposition and how certain drug therapies such as the tetracyclines, hydrochlorothiazide and statins, amongst others, can contribute to the aetiology of cutaneous cancers. This concept of predisposition was also utilised by us to provide an explanation for the Koebner reaction.

Two unique cases were presented. Neither case has, to the best of my knowledge, been reported in the literature. One was a case of koebnerisation in pityriasis rosea and another was a case of nodular seborrheic keratosis.

I have taught courses at national and international specialist conferences and as part of official training courses and plan to continue to do so. These courses bring to the attention of colleagues new data on the pathogenesis and management of diabetic foot ulcers and have provided the opportunity to share my experience in this field from a personal, unique perspective. Also, these courses have helped me share my perspectives in the areas of the history of dermatology and the philosophy of medicine. I strongly feel that the concept of disease should not be viewed as a strictly material one, but as a holistic one. Therefore, my arguments in my recent papers have been to try to emphasise this point of view. Closely connected with this holistic view of the concept of disease is the presentation of my experience with using complementary and alternative (integrative) therapies in the treatment of various diseases.

This holistic and integrative approach to medicine requires a different understanding of the concept of “human being”, since we are catering to the most intimate needs of our patients, who are human beings. Therefore, I believe that it is imperative that every physician be also a philosopher of life, in order to be in a position to be a great helper to mankind.

My experience as speaker and lecturer at various international meetings and my publishing experience have hopefully provided me with a professional profile, which will serve as an instrument for the promotion of these concepts. It is my hope that the successful defence of this habilitation thesis will open the path to a university career, which will make it much easier to find the necessary financial and manpower resources to further research into, and to promote, these fields of endeavour.

PART V

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