Clinical Presentation and Approach to Treatment in an Unusual Case of Sarcoidosis

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SUMMARY: Steroid treatment reduces immunological hyperactivity in a one-sided way (which is helpful in acute situations). The treatment outlined above aims to stimulate the energy structures of the whole organism from opposite poles and so activate spontaneous recovery.

KEYWORDS: sarcoidosis, mistletoe treatment, phosphorus process
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History

A woman aged 42 came to see me for her sarcoidosis in October 1983. As a child, severe pneumonia, with pleural involvement; appendectomy at 21; gynecological operation at 22; sterilization at 42. Patient had had repeated mammographies. Four years earlier, a painful nodule had been removed from the right clavicle. Pain radiated to the right arm. The diagnosis was sarcoidosis. Two years later a further nodule developed in the same area. This too, was removed and diagnosed as sarcoidosis. She was given steroids and tuberculostatics (Neoteben and Myambutol) for a year. In spite of this, a further nodule developed, this time in the right axilla, and she developed a swelling above the right wrist over the radius. The histology of both was tuberculosis. This diagnosis was revised some months later to atypical sarcoidosis. The patient was then given high doses of cortisone (60 mg/die). When she came to us 51/! months later she was still taking 50 mg/die. There were no other symptoms or signs of sarcoidosis and, above all, no X-ray evidence of pulmonary changes.

Social aspects

The patient had been married for 17 1/2 years and divorced. She had an adopted child 10 years of age.

When she came to us, the nodule above the right radius was still present. This local change appeared as follows: immediately above the right distal end of the radius of the wrist, was a hard, nodular plate, 6 x 2 1/2 cm in size and 1 1/2 to 2 cm high. It was subcutaneous and firmly seated on its bony base. The skin above it was moderately movable. X-ray of the radius showed no change to the bone. A reddened scar ran lengthwise across the swelling. Palpation established slight pain on pressure. No other nodules were found.

The hard swelling over the right radius continued to increase to 6 x 4 cm a year later (October 1985), though slightly reduced in overall height. Two cherrysized lymph nodes were then palpable in the right axilla. The patient had spontaneous pain in the right upper arm, and there was increasing tension in the region of the nodule above the wrist when she worked in the office. She had been feeling debilitated for some time.

Diagnosis

Well-established sarcoidosis nodule on right radius (Besnier-Boeck disease).

Treatment

Steroids were gradually reduced over 3 months. The nodule increased in size after this (see above). The patient took no cortisone for 2 months, then went back on it for 3 months. After this, cortisone was discontinued for good.

We started to treat her with Phosphorus 5x, 15 drops b.d., and PhosphorusIscador Pini c. Hg strengths 2 and 3 in alternation 3 times a week. The injections increased the pain, and after 6 months we reduced them to twice a week. The Phosphorus 5x drops were discontinued, and Viscum mali 5% ointment prescribed for a change of external application. Also Iscador Pini c. Hg strengths 2 and 3 in alternation 3 times a week. The injections increased the pain, and after 6 months we reduced them to twice a week. The Phosphorus 5x drops were discontinued, and Viscum mali 5% ointment prescribed for a change of external application.

This treatment continued for 3 years until October, 1986 with no appre- ciable change. The nodule was 6x4 cm in size, with only minor variations.

As the injections continued to be painful with slight redness in the injection site, it was decided to use higher dilutions. It also seemed advisable to change the host tree.

As this was a neoplasm in the periphery of the body, I chose maple (Acer), a tree with differentiated, fine-form principles, and also because the form principles of individual plant organs seemed to match those of the extremities. The patient injected herself 3 times a week with Abnobaviscum Aceris lOx (the district nurse had done it before). It was planned to continue for a maximum of 6 months. If no change occurred, a change would then be made to Fraxini.

After 6 weeks, the nodule began to loosen up, and after 6 months it had disappeared except for two residual nodules the size of pinheads. The pain had gone. Treatment was reduced to twice weekly injections for 2 months, then once a week for 6 months, followed by a break in treatment.

No recurrence developed from 1987 to 1992. Only the non-irritating scar remained in the site. At the last visit, no nodule could be palpated; the patient's tiredness had gone. She sent postcards whenever she went on holiday with her son, reporting that she was well and no new nodules had appeared. She did not return after 1992, having probably moved away, as a letter was returned with a note to this effect.

The case history is unusual in that there was not only the rarity of an awkwardly-placed lesion, a subcutaneous nodule, but it also presents finding the indicated medicine. The patient was initially treated in the usual way (for too long), and did not improve. She would not give up her belief that this approach to treatment would help her, and bore with the pain of it and also with having to make a trip of several hours by car each time. It was her reference to the pain that induced the physician to consider a change of treatment, with some inner reluctance and no systematically-developed strategy. A new therapeutic idea was taken up more or less from an emotional impulse. The main motive was to have a change of treatment. Relatively limited powers of imagination seem to have been enough for the right

idea to arise. The desire to make a change and letting the patient's symptoms make an impression were the elements that led to finding the right medicine (the new idea consisting of an individual approach to the basic treatment strategy).

When the nodule had disappeared, injections were only given when the very small residual nodules made themselves felt again. A single injection of Abnobaviscum Aceris lOx proved sufficient to make them vanish on every occasion. No injections were needed in the last year of treatment.

Usual treatment of sarcoidosis

A special case has been presented. Below, some general, brief notes on sarcoidosis.

In 90% of sarcoidosis patients, the disease manifests in the hilar lymph nodes of the lung, affecting 80% of them in the second stage. Alveolitis is assumed to be the initial trigger. It is a chronic granulomatous inflammation with a relatively high spontaneous cure rate, though of variable duration (a few months to many years). Almost all organs may be affected - lymph nodes, CNS, eyes, kidneys, liver, spleen, bones, heart, parotid glands, lacri- mal glands, prostate, subcutis, scar tissue, musculature. Calcium metabolism may be activated [alveolar macrophages produce increased amounts of 25-dihydroxyvitamin D which is converted to 1,25-dihydroxyvitamin D (calci- ferol)]. This mainly increases intestinal calcium absorption, but increased solar radiation also enhances conversion to active vitamin D. Arthropathies are common, with no evidence in the pathological anatomy of the joints.

Sarcoidosis patients with chronic lung disease suffer from dyspnea, with the right heart affected. This is in about 15% of patients, with the process generally continuing for years. Women are slightly more frequently affected than men, black North Americans more frequently than white ones.

Apart from the specific organic lesions, tiredness is a common symptom with more than half the patients, often limiting life severely. It does not necessarily correlate with the spread of lesions. This symptom is a clear indication that the dynamic of the ether body is severely limited and is, in fact, a particular signature of sarcoidosis patients. Revitalization, refreshment in sleep, is impaired. The astral body is frozen, in a way, and the I is not much present. In the acute form, Loffgren's syndrome, this immense debility may be the dominant feature, with the frequently found pyrexia a further explanation. (Note: In some cases, the pathological constellation occurs so briefly that the patient is hardly aware of it or remains asymptomatic, though radiology shows definite involvement.) Astral body and ether body get too close to one another, literally interlocking in chronic cases. Help should ideally come from the I, which is brought back into the situation.

This is an indication for the treatment approach which, in typical cases with pulmonary involvement, begins with Phosphorus 6x, 20 drops b.d., and Ferrum 6x/Graphites 15x, V2 teaspoon t.d.s. as a first step. Phosphorus acts through warmth to stimulate internal light production, thus creating an opportunity for the I to take effect again in the respiratory sphere and initiate the healing process. With careful monitoring it is also possible to give Phosphorus 5x for a limited period (about 4 weeks). This process, which acts from below upwards, is met from above by a structuring process which also gives the I the opportunity to bring form principles into the organism through respiration. Graphite supports re-organization of the mobile carbon skeleton in the lower human being and in pulmonary function. As a polar principle it causes increased light production in the neurosensory system and brings clarity to thought.

Treatment is intensified in the second stage by giving twice-weekly, low- dose mistletoe injections (1 mg on average). It will be seen from the above case report that we begin with mistletoe grown on softwood trees. Here, activation of the warmth process around the granulomas plays the key role (lymphocyte activity around the granulomas is activated), especially in the chronic form, which is common. At this stage, phosphorus and mistletoe (which also has phosphorus nature) work closely together. The mistletoe action may well be called immunomodulatory, which is particularly appropriate with sarcoidosis.

For reasons of space, we can only touch briefly on the immunological aspect. Characteristically, lymphocyte counts are down in the blood and elevated in affected organs. Bronchoalveolar lavage shows lymphocytosis, with elevated CD4 helper cell counts. The CD4/CD8 ratio, normally about 1.8:1, is raised to between 5:1 and 20:1 with sarcoidosis. Lymphocyte function is generally reduced, i.e. they are not fully able to perform their defensive functions. The above mentioned energy structures of the organism are thus also reflected at this cellular level, with the astral body acting one-sidedly and severely limiting the activities of the ether body, and the I not adequately present.

Steroid treatment reduces immunological hyperactivity in a one-sided way (which is helpful in acute situations). The treatment outlined above aims to stimulate the energy structures of the whole organism from opposite poles and so activate spontaneous recovery.

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