

POSSIBILITIES OF HOMEOPATHIC TREATMENT OF RECURRENT ORAL APHTHAE

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ABSTRACT

In the entire medical world and particularly in dentistry we assist to a growing tendency of patients to seek natural remedies for their ailments; this attitude stems from distrust of pharmaceutical chemicals and an attempt to avoid their side effects. The recurrent oral aphthae is a common disease of the oral mucosa, affecting, according to some authors, between 20-60% of the population depending on the socio-professional studied categories. The classic local and general treatment of the oral aphthae, especially for the chronic recurrent forms is still incomplete and unsatisfactory, with a multitude of harmful side effects. We would like to bring into the attention of our colleagues the possibilities of homeopathic treatment of this category of diseases of the oral mucosa, without harmful side effects, with concrete results in reducing the duration of lesions and the severity of symptoms.

Keywords: oral aphthae, homeopathic remedies

INTRODUCTION.

Background: current state of knowledge. Aphthae is a widespread pathologic condition of the oral mucosa, affecting a large part of the population of all ages with a higher prevalence in females [1].

The etiology of the oral aphthae and aphthous stomatitis isn't yet fully known, but several causative factors have been identified. As bacterial factors, streptococcus sanguis and type A streptococcus are incriminated in producing local hypersensitivity [2]. Adenoviruses and herpes virus can be the etiological factors of the condition. Other etiological factors could

be stress, which is known to lower the body's immunity and increase the susceptibility to infections, local trauma, endocrine changes [3]. Their etiology may be correlated with various intolerances, such as gluten or lactose [4]. Certain substances from food can penetrate the mucosa and thus influence the antigenicity of the epithelium. These foods can be dairy, peanuts, nuts, honey, berries, chocolate, etc. [4]. In various types of anemia with deficiencies of iron, folic acid, vitamin B12 there is a tendency to form recurrent aphthae. By treating the specific form of anemia, the frequency of aphthae occurrence, the severity of

symptoms have been reduced [5]. Other factors involved in the etiology of recurrent aphthae could be certain histocompatibility groups: HLA-DR2, HLA-R12, HLA-A2 [5].

Cellular and humoral immunology are involved in the pathophysiology of recurrent aphthae [3,6]. Cellular immunological etiology has been identified by numerous studies that have shown autoantibodies directed against the cellular spinal layer from the structure of the epithelium. In these situations, the cellular spinous layer would have a modified antigenic structure due to multiple factors. Research has shown blastic transformation of autologous T lymphocytes that were incubated with mucosal homogenates of the same patients. Autologous T lymphocytes were cytotoxic for their own epithelial cells. Helper T4 cells were observed in epithelial chorion when keratinous cells were activated with HLA-DR antigens. Changes in the ratio of different subset of T lymphocytes in patients with this condition compared to a control group were also observed. The ratio of T4 (CD4) helper / T8 (CD8) suppressor has been changed [3,5].

The humoral immunity occurs by the attaching of circulating immune complexes to the blood vessels' endothelium. This results in the activation of some complement fractions, which causes the activation of endothelial cells and the migration of neutrophilic polymorphonuclear PMN cells to the lesion. The inflammatory infiltrate that forms at the site of the lesion therefore contains neutrophilic polymorphonuclear cells, red blood cells, macrophages attracted by complement fractions and mast cells. Histamine released by macrophage cells

becomes the conductor of the whole inflammatory process in which occurs vasodilation and the consequent increase of the vascular permeability, with the extravasation of macrophages and neutrophils [3,5,6].

Vascular alterations are also accompanied by microthrombosis. After this initial inflammatory phase, ischemia occurs at the level of the damaged blood capillaries with consequent epithelial necrosis. The epithelium is thus broken, the epithelial necrosis leads to the formation of ulcers which are the characteristic clinical sign of the oral aphthae [7].

In most cases, less severe symptoms prevent most patients with this condition from seeking medical advice. Serious lesion forms due to the suffering caused and the persistence of injuries require medical treatment and monitoring by a dentist or a general physician. Still, there are conditions in which recurrent chronic oral aphthae can be signs of serious general conditions such as Behcet's disease, Crohn's disease or ulcerohemorrhagic colitis [3].

The clinical appearance is typical [1-7]: after a short onset of up to 24 hours, accompanied by erythema, pruritus or burning sensation, an ulceration of 2-7 mm round or oval appears, with a clear outline, unrelieved edges, covered with a deposit of white or yellowish fibrin. There is a congestive halo around the ulceration and the surrounding mucosa is edematous. Ulcers are located on the labial, jugal, lingual mucosa, buccal floor, tonsillar pillars, soft palate. The consistency of the aphthae is supple, elastic.

The evolution of the aphthae occurs in seldom or frequent outbreaks, which can be separated by different time intervals: weeks, months or even years. When the intervals between eruptions are very short we are dealing with recurrent oral aphthosis. In the absence of a treatment, the lesion lasts 1-2 weeks, the healing being done without sequelae [4-7].

Clinical forms. There are three main types of recurrent aphthae [3,6]. *Minor recurrent aphthous ulceration or minor aphthae (Mikulicz's aphthae; MiRAS)* is the most common clinical form. It is characterized by one or several well-defined, painful ulcerations, with an evolution over 7-10 days and a healing without scars.

Major aphthae (Sutton's aphthae; MaRAS) affect about 10% of patients with canker sores. The lesions are atypical, with the aspect of crateriform ulcerations with a diameter of more than 1 cm, irregular contour, raised edges, surrounded by edema and a congestive halo and covered with yellowish or gray fibrin. They are very painful, evolving in weeks or months with functional limitations, without a tendency to spontaneous healing and leaving mutilating retractable scars. The lesions are very similar and must be differentiated from neoplastic, luetic and tuberculous ulcerations and atypical major aphthae which are common in patients with immunodeficiency.

Herpetiform aphthae (HeRAS) [6,7] is characterized by the appearance of groups of small ulcerations of 1-3 mm diameter, very painful, which disappear without treatment after about two weeks. They are located in most cases on the mobile oral mucosa.

Lesions may progress to coalescence and formation of a larger ulceration with an irregular contour. Healing takes place without scars. The lesions may be similar to those of the herpes rash or herpangina.

DISCUSSION. Classic treatment of the oral aphthae [3,7,8] differs depending on the etiology, location and severity of the lesions and includes local and general treatment. Local treatment includes corticosteroids (Triamcinolone, Hydrocortisone, Orabase, Betneval), antibiotics (Penicillin, Tetracycline in combination with Stamycin), antiseptics (Chlorhexidine), local anesthetics (Xylocaine), anti-inflammatory and local caustics. All of these drugs are described as having multiple negative side effects, antibiotics being known to destroy the oral microbiocenosis. The general treatment is indicated for severe, acute forms, with repeated episodes and extensive lesions. Systemic corticosteroid therapy is used, with Prednisone in medium doses, immunotherapy with questionable results, Plaquenil, Colchicine and Thalidomide which has severe teratogenic effects.

Basics and principles of homeopathic pharmacology. Complementary medicine sees internal homeostasis as a physical but also mental and emotional balance, any change is a potential destabilizing factor that can eventually lead to disease. All forms of RAS have a significant impact on quality of life and interfere with activities of daily living.

The homeopathy's practitioners say that this particular part of medicine dates from 400 B.C., when Hippocrates used to prescribe very small quantities of mandrake root for mania treatment while large doses of the same plant cause mania. So, the same substances could have an opposite effect if administrated in very small quantities [9].

Homeopathy defines a therapeutic system based on the principle of similarity, resumed by Samuel Hahnemann in the seventeenth century. According to Hippocrates, the principle of opposites corresponds to drugs that act in the opposite direction of the disease, the drug substance thus directly compensating for the present symptoms. This principle is the basis of modern pharmacology, also called "allopathic". The principle of similarity also stated by Hippocrates involves treating the patient with drugs similar to the factors that caused the disease. In other words, a substance that could have produced the symptoms of the present disease can even become the medicine of a similar clinical picture.

Homeopathy as a complex modern therapeutic system started from this phenomenon of similarity, completed with 3 more major principles based on which the prescription of the medication is chosen.

Thus, the condition for the principle of similarity to be pharmacologically applied is that the medicinal product will be prepared by specific standardized methods involving the dilution of the substance considered to have a pathogenetic picture corresponding to that of the patient.

The principle of dilution is combined with the principle of dynamization, thus defining the methodology of preparation of

homeopathic medicine - practically, starting from the primary substance capable of producing symptoms which is considered pathogenetically similar to a certain clinical picture, also called mother tincture, successive stages of alcohol dilution are performed in 1% steps, also called centesimals; between 2 dilution steps is performed the so-called dynamization or sequential kinetic activation, consisting in the intense agitation of the solution [10-12].

Modern research shows that during the dynamization process chemical and physical phenomena occur that lead to the transfer of information from the substance to the solvent, while the dilution process leads to the disappearance of the substance's toxicity. Through incompletely elucidated specific functions, the membrane receptors are able to trigger effector responses in the body following the influence of the homeopathic medicine thus prepared, activating their own compensatory mechanisms against existing symptoms [13-18].

Taking into account the fact that different organisms react differently to similar etiological factors, corresponding to the field and individual reactivity, the 4th principle of homeopathy is that of individualization. Thus, the symptomatic picture with which the patient presents is called "individual reaction of the patient" and is part of the criteria based on which the medication is chosen, following the anamnesis and clinical examination specific to homeopathic semiology [10-12].

Homeopathic medicines are most often presented in the form of sucrose granules impregnated with the solution obtained

following the process of dilution and successive dynamization. Their label includes the Latin name of the substance of origin followed by an index indicating the degree of dilution, namely the percentage of dilution (CH - centesimal) and the number of dilution-dynamization sequences (CH7, CH9, CH15, etc.) [10].

Homeopathic treatment of the oral aphthae. Most simple mouth aphthae, with moderate or rare recurrences, will respond to

the administration of the homeopathic medicine Borax CH 15. It corresponds to painful sores, sensitive to touch, with white deposits of fibrin, regardless of location [11,19].

Nitricum Acidum CH15 is indicated for extensive clinical forms (Fig. 1), bleeding prone, with stinging pain, very sensitive to touch, accompanied by angular cheilitis [10,12].



Fig. 1. Recurrent aphthae accompanied by angular cheilitis

Mercurius Solubilis CH15 is indicated for aphthosis stomatitis with white or yellowish-white fibrin deposits, inflammatory halo, accompanied by swelling of the tongue highlighted by the presence of marginal dental impressions, whitish deposition on the tongue, filthy viscous salivation, gingival swelling with bleeding tendency [20].

Mercurius Corrosivus CH15 is indicated in more severe stomatitis, in which intense painful ulcerations appear, with a burning pain, ulcerohemorrhagic appearance with extension in the pharynx causing a hyperalgesic swallowing and possible painful lymphadenopathy [10,12].

Kalium Muriaticum CH15 corresponds to the forms with a tendency to chronicity and slow evolution, with gray fibrin deposits. [11, 19]

All the homeopathic remedies described above have been shown to be effective in reducing the time of evolution of various forms of recurrent aphthae and the severity of symptoms. Whatever homeopathic medicine is chosen, for the pathology described above 5 sublingual granules will be administered every hour in the first hours if the pathological condition is diagnosed from the beginning, then gradually the administration will be reduced at intervals of 2, 4, 6, 8 hours as the symptoms improve, until they disappear. In chronic oral aphthae,

5 granules are administered 3 times a day until remission [10,12]

CONCLUSIONS. The use of these therapeutic remedies is effective and free of the side effects which are present in the use

of classical drugs for the treatment of the oral aphthae. The possibilities given by the homeopathic treatment open a new way of therapeutic approach to diseases in the field of the oral pathology.

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