Homeopathy as an alternative in PFAPA: case report

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ABSTRACT

Periodic aphthous pharyngitis with cervical adenitis (PFAPA) is a clinical entity recognized since 1987, relatively common in children and usually presents a self-limited course. Its mainstay treatment consists of exceptional use of corticosteroids and antibiotics, as well as follow-up, with selective surgical conduct. The persistence of the syndrome can, over time, impair the activities and day-to-day lives of patients, even leading to reassessment by specialists and routine complementary exams. Homeopathy has been used in cases of tonsillitis and pharyngitis, as a complementary and alternative aid. In this study we transcribe a case of periodic pharyngitis in a six-year-old child treated with the homeopathic medicines *Mercurius solubillis*, *Belladonna*, *Arsenicum album* and *Phosphorus*, successively, based on Characteristic Symptomatic Totality and syphilitic diathesis. Initially, the result was a considerable spacing of febrile crises, a reduction in the number of complementary exams and use of medication, with remission of the condition occurring between the fourth and fifth month of treatment.

Keywords: Homeopathy, Aphthous stomatitis, Fever of unknown cause

INTRODUCTION

Periodic fever, aphthous stomatitis, pharyngitis and cervical adenitis (PFAPA syndrome) is the most common periodic fever syndrome in pediatrics and was first described by Marshall et al. in 1987 [1,2].

The syndrome is characterized by episodes of fever that last an average of three to six days, recurring regularly every three to eight weeks, being associated with at least one of the three main symptoms: aphthous stomatitis, cervical adenitis and pharyngitis [1,3]. Generally, the disease starts before the age of five and resolves in adolescence [1,3]. In the inter-crisis period, the child remains asymptomatic and grows normally [1,3].

The etiopathogenesis is unknown [1,3] and the diagnosis of the syndrome is based on clinical criteria, but these were not validated in a cohort study, and its treatment involves inflammatory control with corticosteroids in crises, although there is no evidence that this treatment can modify clinical outcome or prevent recurrences [1]. Within an integrative perspective, homeopathic treatment is used in acute inflammatory conditions of the upper respiratory tract, including pharyngotonsillitis, and was not inferior to conventional therapy [4]. A study based on a survey carried out in several European countries and Israel showed that, among 138 pediatricians, 59% prescribed Homeopathy as supportive therapy for the same conditions [5]. Palm J et al. (2017), in an international randomized controlled trial involving 256 patients, both adults and children, on a homeopathic medication used in recurrent pharyngotonsillitis (medication group with n = 128 and control with n = 120), sought to show the time interval between acute tonsillitis within one year for those who used the medication [6]. The study showed that the risk of developing acute pharyngotonsillitis was lower in the group
that used homeopathic medication compared to the control group (p = 0.0002), as well as the symptoms were reduced (p<0.0001) and the need for antibiotics was reduced (p = 0.0008) [6].

Considering the use of Homeopathy in pharyngotonsillitis, we present a case report of a patient with PFAPA treated with homeopathy.

MATERIAL AND METHODS

Case-taking, with symptoms presented along the clinical history of the patient.

The homeopathic method of analysis and treatment is then discussed. Homeopathic medications were given in a dosage of 6 drops, at night, for fifteen nights, or three times a day, if in acute condition. One medication, Mercurius solubilis 12cH, was administered in weekly intervals, as explained in the text below.

The disclosing of patient data was formally authorized by the parents on November 5th, 2023, to proceed with this publication. The study was approved by the Ethics Committee, and it is approved by CAAE - Brazil Platform (registration: 77047723.4.0000.5501) on April 25th, 2024.

CASE DESCRIPTION

KSG, six years old, feminine gender, referred for care complaining of chronic intermittent fever in January 2021. Since April 2020, she has had monthly episodes of fever, for which she had been using antipyretics, antibiotics and corticosteroids to control. The febrile condition appeared monthly, with an average duration of three days, four times a day, with gradual reduction a posteriori. The febrile crisis was sometimes accompanied by headache and abdominal pain, which improved with the cessation of the fever. Crises usually occurred at night, in which the child remained with fever and prostrated, additionally she had nausea and wanted to cover up because she felt cold. The child asked for water after the fever.

In June of the same year, submandibular lymph nodes associated with the fever were noticed, and the same signs were diagnosed again in November. In early December, a new febrile period was treated with corticosteroids only. On the 22nd of the same month, she presented the same condition again, with fever, worse at dawn, and purulent spots on the left tonsil, additionally small ulcers were noticed.

Meanwhile, the patient underwent several complementary tests, including serial blood counts and biochemistry, negative serology, as well as full-body radiographs and computed tomography, and she was also referrals to several subspecialists. In the last crisis in November, she was diagnosed with COVID by a positive IgM and ground glass lesion in the Chest Tomography, along with an amylase test with slight elevation during the crisis. In addition to antibiotics and corticosteroids during the crisis, she was using topical nasal corticosteroids and a leukotriene receptor antagonist between attacks, due to chronic nasal obstruction. The crises characteristically started at the beginning of the pandemic due to the new Coronavirus, when she left the school environment and moved to a new house.

According to the case-taking, during pregnancy there was placental abruption, and she was born too large for the gestational age, requiring cesarean delivery. She did not present neonatal jaundice and no reactions to vaccines. Sometimes she manifested pruritic atopic dermatitis in folds of the limbs, which were generally worse in heat. Regarding the food desires, she craved meat and chicken, and did not appreciate sweets.

Associated to the family, there was a history of anxiety and depression. Additionally, some members of the family had systemic arterial hypertension. Her father had anxiety and asthma, and her ten-year-old brother had a history of egg allergy.
The mental picture showed that she was a very active child, moving and questioning everything, non-stop, restless, happy, talkative and hugging those who she knew. Anxiously afraid, afraid that something might happen to her. As for the emunctories systems, she was constipated, sometimes presented blood in the stools; sporadic urinary loss and her perspiration, after a febrile episode, has no particularities.

On physical examination, at the time of consultation, a hyperemic oropharynx was noted, with hypertrophy of the tonsils, which presented small ulcerations; enlarged lymph nodes of an average one centimeter; mobile and painless in the anterior cervical chains.

A clinical diagnosis of PFAPA was made, with sulfuric biotype, lymphatic and miasmatic/diathetic temperament of preponderant syphilitic, in addition to Psora. In the repertorization, the main drugs found were Mercurius solubilis (Merc.), Belladonna (Bell), Arsenicum album (Ars.) and Phosphorus (Phos.). Treatment started with Merc. 6CH in a 6 drops schedule at night, for 15 nights, remaining 15 without taking it and then resuming for another 15 nights. The drug Bell. 6CH was prescribed in case of a febrile crisis.

In the first follow up, in March, the patient presented a febrile crisis, aborted using Bell., remaining afebrile for 40 days. However, a new crisis on March 19 was not controlled by medication, starting with abdominal pain and headache along with fever, in addition to cervical lymph nodes. At this time, it was decided to prescribe the drug Ars. as simillimum, in the same scheme as Merc. (6cH for 15 days). Merc. was used as a syphilitic miasmatic adjunct in 12cH, once a week, and Phos. for acute febrile syndrome.

On the second follow up, in April, she still had a similar febrile episode but with greater prostration shortly after starting Ars., and a hordeolum in the lower left eyelid appeared. Besides that, her general condition was better, more active, with remission of cervical lymph nodes. The prescription was maintained. On the third follow up, in early June, there was a new attack of hordeolum and an episode of severe constipation with large stools and painful evacuation; she no longer had fever, no signs of pharyngotonsillitis, was more active and returned to school. Only Ars. 12cH was maintained, also in solution at a dosage of 6 drops at night for 15 nights on and 15 nights off, for two more cycles.

In the fourth return, in July, she remained stable without new symptoms.

DISCUSSION
PFAPA is a recurrent and regular febrile syndrome, with debatable etiology, which encompasses cytokine dysfunction, infection, abnormal host immune responses, or even a combination of these [1,3]. Neutrophil dysfunction has already been demonstrated, especially affecting apoptosis and cellular oxidation [7]. There is still genetic potential, since family groups are involved [1], and the presence of variants in the NLRP3 and MEFV genes, related to inflammation, suggests a role for them in the development of the syndrome [1]. However, none of these variants alone seems to be relevant to the development of the syndrome, which also suggests an oligo or polygenic background [1].

From the point of view of the Homeopathic doctrine, Hahnemann described chronic diseases (miasms, diatheses) being responsible for the continued state of illness, and in those cases, the patient should use antipsoric medication to control the disease [8,9]. Miasms, according to Hahnemann, are hereditary, and the individual can be influenced by external or internal factors of illness or health, such as life habits and diet [8,9]. It is noted that this state can be considered as a background for the events studied for the PFAPA syndrome, for example [10].

Considering heredity, familial fevers are included as a differential diagnosis [1]. Familial Mediterranean Fever (FMF) is a differential for PFAPA, and colchicine is used
prophylaxis of recurrent crises, since its use can space FMF crises, but there are no studies that demonstrate its superiority, with few containing small patient samples [1,11]. In a randomized, controlled study of 18 patients diagnosed with PFAPA, eight treated with corticosteroids and 10 with colchicine, Aviel et al. showed that there was an increase in the inter-attack interval, but with six patients in the colchicine group carrying FMF mutations, and two patients in the steroid group [11]; Thus, when there is a response to therapy with colchicine, attention must be paid to the possibility of FMF [1,11,12].

Other medications used are cimetidine, IL-1 blockers and vitamin D, none of which, however, has been proven to be effective [1]. The surgical conduct of adenotonsillectomy is controversial, being indicated in selected patients, when the recurrence of the attacks is in a short period of time [1].

Although Homeopathy is not described as an adjuvant treatment for PFAPA, it is used as a form of treatment for pharyngotonsillitis, including recurrent ones [4,5,6], and PFAPA may be included in this list of syndromes.

From the perspective of Homeopathy [8-10,13,14], first is necessary to diagnose all the symptoms that the patient presents, relieving the acute crisis as the first step. Secondly, is important to diagnose the chronic miasm or diathetic syndrome, in this patient, it was considered to be syphilitic, given the preponderant clinical manifestations such as anxiety and restlessness, oropharyngeal ulcers, nocturnal worsening and family history of anxious-depressive syndrome, as well as psora (dermatitis and history of familial cardiovascular disorders); also considering that there were no incompatible differences or deviations in biotype and temperament (lymphatic), Merc. was chosen for systemic control and Bell. as the one most similar to the initial crisis. The selected drugs (Ars., Phos., Merc. and Bell.) have a syphilitic spectrum, which corroborates with clinical reasoning.

The patient initially had a longer period without acute crisis (average of 20 to 40 days), but still had them, with abdominal pain. Considered imperfect similarity, the characteristic symptomatic totality (CST) was reviewed and Ars. was prescribed with wide symptomatic coverage, also aiming at the miasmatic character, being prescribed as Simillimum (or systemic antipsoric). Merc. was kept as a weekly miasmatic aid. After the first doses of the Simillimum, the child had a febrile crisis, which resolved in one day, remaining on Ars. with total control of the crises.

New symptoms, such as hordeolum and constipation, as a manifestation of the chronic psora-syphilitic disease, were also controlled through continuous use of the medication, changing its potency (6 to 12cH).

PFAPA is considered a self-limiting disease, which usually resolves by adolescence, with no long-term sequelae being described [1,2]. However, different studies have shown the occurrence of the syndrome in adults [15-17]. On this aspect, one can infer the maintenance of attempts at miasmatic-diathetic control by the body and the continuity of chronic disease, which, through greater extrinsic or intrinsic causalities of aggravation, can determine new clinical syndromes.

CONCLUSION

We present a case of PFAPA, clinically diagnosed, demonstrating the adjunctive use of homeopathic medication in the syndrome. New studies, involving pharyngotonsillitis and chronic-recurrent syndromes, such as PFAPA, using Homeopathy, can be suggested using the knowledge bequeathed by Hahnemann for the relief of patients.

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References