

## Evidence based management for the Cholelithiasis using HOMOEOPATHY

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### ARTICLE INFO

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*Keywords:*

Gall stones  
Cholecystitis  
Biliary colic  
ERCP  
MRCP  
Homoeopathy

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### ABSTRACT

Gallstones form when there is an imbalance in the composition of bile resulting in precipitation of one or more of its components. Between 37 and 86% of gallstones are cholesterol-rich stones, 2-27% are pigment stones and 4-16% are mixed. This has been attributed to obesity and diets containing a high proportion of refined carbohydrates and fat. Low-calorie diets and rapid weight loss are also associated with cholesterol-rich gallstones. Gallstone disease increases with age. Women have a higher prevalence of gallstones than men, which is attributed to exposure to oestrogen and progesterone. Of those with gallstones, around 1 to 4% will develop symptoms annually. Most patients (> 80%) will remain asymptomatic throughout their lifetime and the likelihood of developing symptoms diminishes with time. Liver function tests and an abdominal ultrasound should be offered to patients with symptoms suggestive of gallstone disease (e.g. abdominal pain, jaundice, fever). They

should also be considered in patients with less typical but chronic abdominal or gastrointestinal symptoms. In patients with acute pancreatitis and evidence of ongoing bile duct obstruction and/or cholangitis, endoscopic retrograde cholangio-pancreatography and biliary sphincterotomy is commonly recommended within 24-72 hours of the onset of symptoms. Patients with acute cholecystitis should be referred for laparoscopic cholecystectomy. We review in this article current management strategies of gall stones using homoeopathy.

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## 1. Introduction

Gallstone disease affects up to 20% of the European population, and cholelithiasis is the most common reason for hospitalization in gastroenterology. Regular physical activity and an appropriate diet are the most important measures for the prevention of gallstone disease. Transcutaneous ultrasonography is the paramount method of diagnosing gallstones. Endoscopic retrograde cholangiography should only be carried out as part of a planned therapeutic intervention; endosonography beforehand lessens the number of endoscopic retrograde cholangiographies that need to be performed. Cholecystectomy is generally indicated for patients with symptomatic gallstones or sludge.

## 2. Presentation

Gallstone disease may be thought of as having the following four stages:

- The lithogenic state, in which conditions favour gallstone formation
- Asymptomatic gallstones
- Symptomatic gallstones, characterized by episodes of biliary colic

### *COMPLICATED CHOLELITHIASIS*

Symptoms and complications of gallstone disease result from effects occurring within the gallbladder or from stones that escape the gallbladder to lodge in the common bile duct.

### *ASYMPTOMATIC GALLSTONES*

Gallstones may be present in the gallbladder for decades without causing symptoms or complications. In patients with asymptomatic gallstones discovered incidentally, the likelihood of developing symptoms or complications is 1%-2% per year. In most cases, asymptomatic gallstones do not require any treatment.

Because they are common, gallstones often coexist with other gastrointestinal conditions. There is little evidence to support a causal association between gallstones and chronic abdominal pain, heartburn, postprandial distress, bloating, flatulence, constipation, or diarrhoea.

Dyspepsia that occurs reproducibly following ingestion of fatty foods is often wrongly attributed to gallstones, when irritable bowel syndrome or gastroesophageal reflux is the true culprit. Gallstones

discovered during an evaluation for nonspecific symptoms are usually innocent bystanders, and treatment directed at the gallstones is unlikely to relieve these symptoms.

### *BILIARY COLIC*

Pain termed biliary colic occurs when gallstones or sludge fortuitously impact in the cystic duct during gallbladder contraction, increasing the gallbladder wall tension. In most cases, the pain resolves over 30 to 90 minutes as the gallbladder relaxes and the obstruction is relieved.

Episodes of biliary colic are sporadic and unpredictable. The patient localizes the pain to the epigastrium or right upper quadrant and may describe radiation to the right scapular tip (Collins sign). The pain begins postprandial (usually within an hour after a fatty meal), is often described as intense and dull, and may last from 1-5 hours. From the onset, the pain increases steadily over about 10 to 20 minutes and then gradually wanes when the gallbladder stops contracting and the stone falls back into the gallbladder. The pain is constant in nature and is not relieved by emesis, antacids, defecation, flatus, or positional changes. It may be accompanied by diaphoresis, nausea, and vomiting.

Other symptoms, often associated with cholelithiasis, include indigestion, dyspepsia, belching, bloating, and fat intolerance. However, these are very nonspecific and occur in similar frequencies in individuals with and without gallstones; cholecystectomy has not been shown to improve these symptoms.

### **3. Physical examination**

Patients with the lithogenic state or asymptomatic gallstones have no abnormal findings on physical examination.

Distinguishing uncomplicated biliary colic from acute cholecystitis or other complications is important. Both often present with the same constellation of symptoms, and physical examination may help to differentiate the two.

Since the gallbladder is not inflamed in uncomplicated biliary colic, the pain is poorly localized and visceral in origin; the patient has an essentially benign abdominal examination without rebound or guarding. Fever is absent.

In acute cholecystitis, inflammation of the gallbladder with resultant peritoneal irritation leads to a well-localized pain in the right upper quadrant, usually with rebound and guarding. Although

nonspecific, a positive Murphy sign (inspiratory arrest on deep palpation of the right upper quadrant during deep inspiration) is highly suggestive of cholecystitis. Fever is often present, but it may lag behind other signs or symptoms. Although voluntary guarding may be present, no peritoneal signs are present. Tachycardia and diaphoresis may be present as a consequence of pain. These should resolve with appropriate pain management. The presence of fever, persistent tachycardia, hypotension, or jaundice necessitate a search for complications of cholelithiasis, including cholecystitis, cholangitis, pancreatitis, or other systemic causes. In severe cases of acute cholecystitis, ascending cholangitis, or acute pancreatitis, bowel sounds are often absent or hypoactive. The Charcot triad of severe right upper quadrant tenderness with jaundice and fever is characteristic of ascending cholangitis. Acute gallstone pancreatitis is often characterized by epigastric tenderness. In severe cases, retroperitoneal hemorrhage may produce ecchymoses of the flanks and periumbilical region (Cullen sign and Grey-Turner sign).

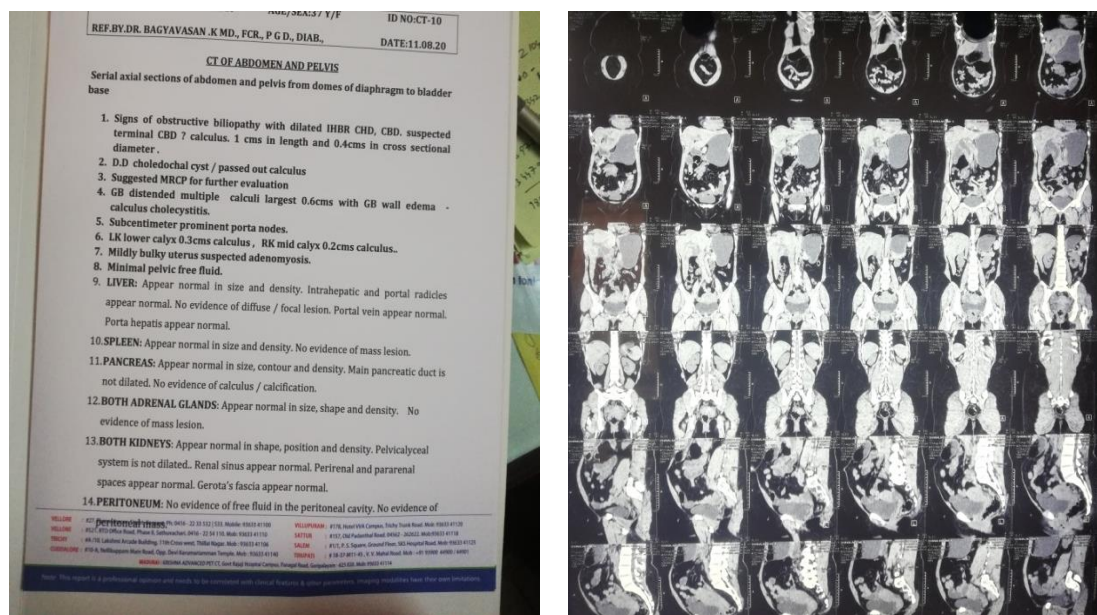
#### *DIAGNOSIS*

Diagnosis is typically confirmed by abdominal ultrasound. Other imaging techniques used are ERCP and MRCP. Gallstone complications may be detected on blood tests. A positive Murphy's sign is a common finding on physical examination during a gallbladder attack.

#### 4. Case presentation

A 37 year old female patient presented to the OP with symptoms of extreme pain in the epigastrium associated with severe eructations, vomiting and decreased appetite since 1 day. She was hypertensive and examination showed extreme tenderness in the epigastrium and rebound tenderness in the right hypochondrium. She had a past history of recurrent attacks of gall, CBD and renal calculi. She was sent for a CT abdomen and pelvis which revealed signs of obstructive biliopathy with dilated IHBD, CHD, CBD. Suspected terminal CBD calculus 1 cm in length and 0.4 cm in cross sectional diameter. GB distended. Multiple calculi- largest 0.6 cm with GB wall oedema. She was hence diagnosed as Calculus Cholecystitis.

**Fig 1.** CT ABDOMEN AND PELVIS DATED 11.08.2020



SIGNS OF OBSTRUCTIVE BILIOPATHY WITH DILATED IHBR, CHD, CBD. SUSPECTED TERMINAL CBD CALCULUS. 1 CMS IN LENGTH AND 0.4 CMS IN CROSS SECTION DIAMETER. D.D. CHOLEDOCHAL CYST/ PASSED OUT CALCULUS. SUGGESTED MRCP FOR FURTHER EVALUATION. GB DISTENDED MULTIPLE CALCULI LARGEST 0.6 CMS WITH GB WALL EDEMA- CALCULUS CHOLECYSTITIS. SUBCENTIMETER PROMINENT PORTA NODES. LK LOWER CALYX 0.3 CMS CALCULUS, RK MID CALYX 0.2 CMS CALCULUS. MILDLY BULKY UTERUS SUSPECTED ADENOMYOSIS. MINIMAL PELVIC FREE FLUID.

Post diagnosis she was treated with the following medications

## 5. Medications prescribed

### **CARDUS MARIANA:**

- The action of this drug is centered in the liver. Pain in the region of the liver. Fullness and soreness. Swelling of gall bladder with painful tenderness.

### **BERBERIS VULGARIS:**

- It has a marked action on the liver, promoting the flow of bile. Stitches in the region of the gall-bladder, worse- pressure.

### **HYDRASTIS CANADENSIS:**

- Gastro- duodenal catarrh. Liver torpid, tender. Gallstones.

### **PHOSPHORUS:**

- Causes yellow atrophy of liver. Sharp cutting pains in the region of the liver with a very weak, empty, gone sensation felt in the whole abdominal cavity. Liver congested. Jaundice. Large yellow spots on abdomen.

### **NUX VOMICA:**

- Liver engorged, with stitches and soreness.

### **CHOLESTRINUM:**

- Gallstones. Obstinate hepatic engorgements. Burning pain in side. Cholesterine is the physiological opponent of Lecithin and both seem to play some unknown part in the growth of tumours.

### **MYRICA:**

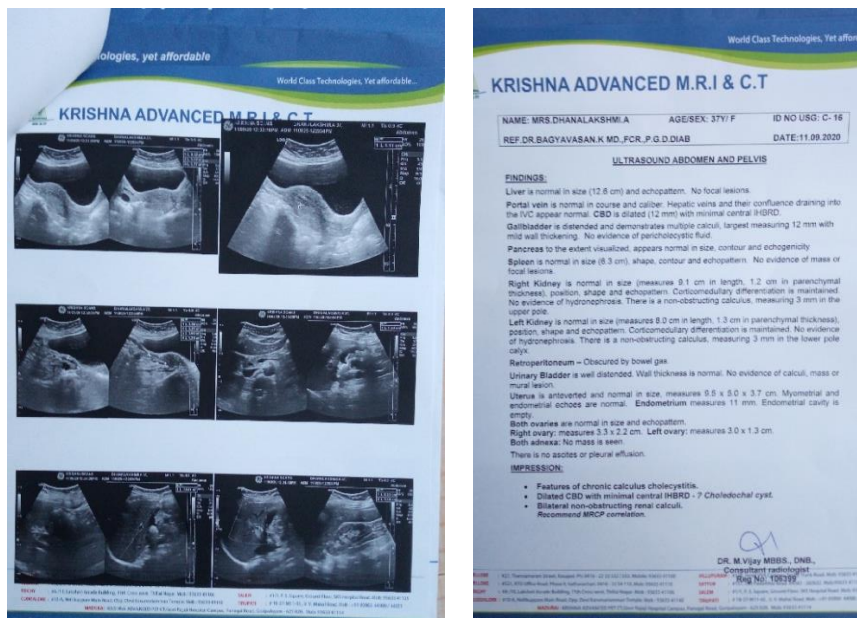
- Has action on the liver, with jaundice and mucous membranes. Persistent sleeplessness. Jaundice. Dull pain in the region of the liver. Complete jaundice, with bronze- yellow skin; loss of appetite. Fullness in the stomach and abdomen.

Post medications she showed substantial improvement and pain was relieved within 3 days of commencement of medications. What has made this case worthy of notice is that she was seen to report back to the OP within a course of 15 days with calculus passing out.

**Fig 2: CALCULI PASSED OUT OVER THE COURSE OF 15 DAYS.**



**Fig 3. CT ABDOMEN AND PELVIS DATED 11.09.2020**



**FEATURES OF CHRONIC CALCULUS CHOLECYSTITIS. DILATED CBD WITH MINIMAL CENTRAL IHBRD.**



## **6. Conclusion**

From the above study we conclude that the features of chronic calculus cholecystitis can be effectively treated using immune boosting homoeopathic medicines.

### **ETHICAL APPROVAL:**

None needed

### **AUTHOR CONTRIBUTION:**

Dr. Bagyavasan Kannan: role in concept production, writing of manuscript, editing and approval.

Dr. Nowshika Vijayakumar: role in writing of manuscript.

Dr. Jeba Delphin: compilation of data.