VADODARA SYMPOSIUUM MARCH 2026

DR. NILESH KARIA

OBJECTIVES:

1. **TO UNDERSTAND** STRUGGLE OF A SENSITIVE LADY IN BALANCING THE IMAGE IN SOCIETY, AND HOW CONFLICT IN HER PERSONAL LIFE PRODUCES INTERNAL IMBALANCE RESULTING IN SOMATIZATION.
2. **TO UNDERSTAND** THE CORE DISPOSITION OF A PERSON WHOSE SENSITIVITY TO HURT AND INABILITY TO REACT LEADS TO SUPPRESSION OF EMOTIONS, EVENTUALLY RESULTING IN THE DEVELOPMENT OF DISEASE.
3. **UNDERSTANDING** HOW AUTOIMMUNITY PROGRESSES TO A DEEPER LAYER OF DEFENSE-FROM THE CUTANEOUS TO THE MUSCULOSKELETAL LEVEL (ECTODERM TO MESODERM) – UNDER SUPPRESSIVE TREATMENT.
4. **LEARNING** TO DIFFERENTIATE CLOSELY RELATED REMEDIES BY KEEPING THE CORE OF THE CASE AT THE CENTER, WHETHER THROUGH REPORTORIAL OR NON-REPORTORIAL APPROACHES.
5. **LEARNING** HOW TO TAPER IMMUNOSUPPRESSIVE DRUGS IN AUTOIMMUNE DISORDERS IN COORDINATION WITH A MODERN MEDICINE PRACTITIONER WHILE MANAGING THE CASE.

DIRECTIVES:

1. PROVIDE YOUR CLINICOPATHOLOGICAL UNDERSTANDING OF THE DISEASE CONDITION BY ANALYZING THE DISEASE ACTIVITY AND THE IMPACT OF TREATMENT ON MANIFESTATIONS ACROSS VARIOUS SYSTEMS.
2. PROVIDE YOUR UNDERSTANDING OF THE PATIENT AS A PERSON BY ATTEMPTING LIFE SPACE TABLE (LST) AND ESSENTIAL EVOLUTIONARY TOTALITY (EET)**.**
3. PROVIDE YOUR FINAL CORRESPONDENCE BY OUTLINING THE APPROACH, TOTALITY, AND DIFFERENTIATION OF CLOSELY RELATED REMEDIES, FOCUSING ON THE CORE UNDERSTANDING OF THE PATIENT'S DISPOSITION.
4. PROVIDE YOUR PLANNING AND PROGRAMMING WITH THERAPEUTIC PROBLEM DEFINITION (TPD) AND THERAPEUTIC PROBLEM RESOLUTION (TPR)**.**
5. CONDUCT A FOLLOW-UP ANALYSIS AND PROVIDE YOUR ACTION WITH JUSTIFICATION.

Send your working to Dr. Nilesh Karia – hetvik@gmail.com

PRELIMINARY INFORMATION

Date of consultation – 17-10-2020

Name – Mrs X	**Age – 45**	**Sex – Female**	**Religion – Hindu**	**Vegetarian**
Education – 6th std	**Occupation – Housewife**	**Father-Farmer-78**	**Mother - Housewife + Farming-72**	
Sister – 1 Elder/3 Younger		**Brother – 1 Elder – 1 Younger**		
Referred By - One Physician Friend	**Husband – 50 Yrs- Businessman**	**Son -20 yrs. Study BBA**	**Daughter – 25 - B Pharm – Service in hospital**	

CHIEF COMPLAIN

LOCATION	SENSATION AND PATHOLOGY	MODALITY	ACCOMPANYMENT
Since 2012 -13 scalp occipital region relapsing off and on depends on modality nail presently 2020 scalp occipital region	Itching ++ scaling ++ big thick patch gradually increased scratching □ bleeding – hair fall from the patch every year it re appear in mild form but never completely gone brittle and easily breaking – pain 2 sometime scaly patch with itching still persist	?a/f anxiety about family issue <3 winter < a hair wash >applying oil >temp with allopathic ointment and shampoo off and on <2 mainly in winter >using medicated shampoo	
Since dec 2019 foot TMT and toe and ankle joints PIP and CMC joints WRIST joint presently small peripheral joint hand and foot	Pain 2 Swelling 2 Stiffness 2 more in morning for 2-3 hours Difficulty in doing house hold work Sometime there was fever and chill with severe pain and swelling of joints (freq and duration not fixed) Pain and stiffness 30-40 min in the morning No much swelling no fever no chill But feels weak 2 exhausted Stiffness 30-40 min in morning	A/F Anxiety/ grief <3 morning <3 cold and dry environment >allo medicines <2 sour food >medicines <exertion 2 <3 morning Tab deflo 6 mg od Tab hcqs 200 od Tab methotrexate 7.5 mg 2/7 Tab akilos p sos for pain Antacids Multivitamins Calcium	
Face skin Since 2-3 years Malar region	Hyper pigmented spots Asymptomatic	< b menses <2 sun exposure >ointment given by allo doctor	
Metabolism Since last 1 years 2019	Dyslipidemia Sometime feels dyspnea	<exertion Tab atorvastatin 10 mg	

P/H - 2014 – pt had complain of sudden severe pain and swelling of joints hands, shoulder, elbow – done all investigations during that time – vit b 12 deficiency detected – treated accordingly – d 1-2 month

F/H

1. Father healthy – age related OA – knee
2. Mother – Hypothyroidism – Hernia (operated) – Hepatomegaly
3. Mother after son's death– she developed sever bouts of vomit and multi organ involvement – hospitalized
4. One younger brother – dengue and expired in the complication in that – 2006
5. One brother – having polycythemia vara – Hb – 22 – has to donate blood on and off
6. One sister – multiple joint pain (?diagnosis)

PHYSICAL GENERAL

- **Perspiration -** Profuse in summer – whole body; Odor **–** offensive in axilla; no **stain**
- **Skin -** dryness in general and cracks in soles < winter
- **Appetite –** good, can tolerate hunger
- **Craving -** Breads 3 pizza 2 spicy 3
- **Aversion -** Milk 2 potato 2
- **Food aggravation – not in general but** – joint pain **<** sour, lemon 2
- **< Riding in carriage – 2** – has to take anti emetics before travelling
- < **Bad odor** – 2 smells of allopathic medicines 2 – lead to nausea sometime vomiting (pt shared that I can't see blood even)

MENSRUAL HISTORY

- FMP – 13 years
- PMP –regular – 30 d/ 4 d bleeding; normal – red – not offensive - Stain 2 indelible
- But since last 3-4 years sometime there is heavy flow – shown to gynec – USG uterus normal

OBSTRETIC HISTORY - 2 FTND – no complain during pregnancy or delivery

SLEEP – sound – but sometime disturbed when there is pain in joints

DREAMS

1. Falling from high place
2. Falling from bed – startled during sleep
3. Robbers came in the house

LIFE SPACE

The patient was referred by a homeopath who is a friend of the patient's daughter. Therefore, the daughter was already aware of the kind of information required about the patient's life in order to understand the patient as a person and her complaints.

The patient reported that her childhood was spent in a village near the town G. Her father was a farmer and her mother was a housewife who also helped with farm work. Both parents were

quite loving, caring, and supportive. The patient was the third among seven siblings. She had one elder brother and one elder sister, three younger sisters, and one younger brother. Her childhood passed very pleasantly under the good care and guidance of her grandparents, as her parents were mostly busy with farm work.

The patient studied up to the 6th standard in the village school, where classes were conducted from 11 a.m. to 5 p.m. She was very good in her studies and usually scored good marks; however, she had difficulty with mathematics. She found it confusing to calculate sums and therefore experienced some difficulty in that subject. She wished to continue her studies further, but she was not allowed to do so for two reasons. First, there were no educational facilities available in the village beyond the 7th standard. Second, as her elder sister was about to get married, she was asked to learn household work, as it was expected that she would need these skills after her own marriage. The patient said that she requested her parents to allow her to continue her education, but they refused, and she had to begin doing household work. She felt angry for some time, but eventually she accepted it as the need of the time and started engaging in household responsibilities.

By nature, the patient was a very calm and cool-natured girl. She used to work carefully and perfectly; however, her work was time-consuming, so her speed of work was slow. The patient said that she gets confused if two or three tasks are given to her at the same time, but she performs well when tasks are given one by one. She was very close to her grandmother, who was very kind-hearted and also very religious. The patient said that she liked performing pooja and singing religious songs (bhajans and aarti) with her grandmother. She used to feel angry when someone teased her by saying things like, “You don’t know anything” or “You cannot do anything.” However, although she felt bad, she never said anything to elders. She believed that such feelings should be kept within and that one should simply concentrate on work.

The patient got married at the age of 20. Her in-law family consisted of her parents-in-law, her elder brother-in-law’s family, and five sisters-in-law. By the time she entered the family, all three sisters-in-law were already married. Her husband was the youngest in the family. The family owned farms in a village near the town G, which were managed by her father-in-law. Her elder brother-in-law was running a machinery shop in the town P, while her husband was handling the shop in Rajkot. They lived together harmoniously for about six to seven years and later separated mutually with equal sharing of the property. The patient described that period of staying together as a very good time. She cared for her parents-in-law as if they were her own parents, and therefore they continued to stay with the patient’s family. Her father-in-law was very kind-natured, whereas her mother-in-law had an orthodox mind set and often used to nag about household work. However, the patient accepted this, saying that her mother-in-law was simply like that.

The patient has two children. Her daughter has completed **B. Pharm** and is currently working in a multispecialty hospital in Rajkot. The patient mentioned that her daughter has an angry nature similar to her father. Her son, however, is very calm and cool-natured like the patient herself. He is currently pursuing **BBA** and wishes to pursue an **MBA from Australia**, for which he is preparing.

The patient shared that her husband is very angry and perfectionist by nature. He wants everything to be perfect and done on time. Being a housewife, the patient had many

responsibilities; however, her husband expected to be attended to first. Therefore, during the morning hours, the patient remained in an attentive state as her husband had to leave for the shop and she had to keep everything ready for him. In such situations, the patient would become agitated and sometimes make mistakes. Her husband would then shout and make comments such as, “You don’t know anything” or “You don’t have any capacity.” While sharing this, the patient became very emotional. She said that such comments hurt her immensely and made her feel angry, but she never expressed it. Instead, she would weep for some time, compose herself, and then start working again. At times, the children would also make similar comments. On such occasions, she would reply, “Amari vakhat e tamara jetalu bhanvanu ane ava mobile TV natha, etle amne badhi khabar padi jai.” (In our time we did not have as much education or access to things like mobile phones and television as you do now, so we did not know everything.) However, most of the time the patient does not react. She keeps her feelings within, becomes disturbed internally, and then tries to keep herself busy with work.

Suddenly, the patient asked whether there is any correlation between mental stress and physical complaints. She then shared that she went through significant personal tension during 2011–2012. During that time, she noticed a change in her husband’s behaviour, as he started becoming angry over trivial matters and would scold her for small issues. One day, he expressed his desire to develop a friendship with one of their relatives. The patient also knew this woman, who used to visit their house regularly. Initially, the patient strongly opposed the development of such a relationship. However, over time, her husband’s behaviour worsened. Eventually, the patient stopped resisting when her husband spoke to the woman on the phone, and the woman also continued to visit their house frequently. At times, her husband would return home late, and on many occasions he would eat outside rather than at home. All these circumstances increased the patient’s mental tension. The patient said that she was unable to share this situation with anyone, as it might affect the image of the family. If she resisted, it would lead to quarrels within the family, and both of them would then be unable to explain the situation to others. She said that she did not have the courage to retaliate, and therefore felt it was better to keep everything within herself and pray to God to give her husband the good sense to understand the situation. The patient said that she eventually felt it was better to allow her husband to maintain that friendship rather than face daily chaos and quarrels in the family. However, she felt deeply disappointed and hurt by the relationship. She mentioned that it was during this period that her psoriasis erupted. The relationship continued for a long time, but over the last one to two years her husband himself stopped the association, and now the situation in the house is comparatively stable.

The patient shared that her mother-in-law was very strict and had an angry nature. She used to nag the patient about household work throughout her life. However, toward the end of her life, when the mother-in-law suffered from paralysis and remained bedridden for about one year, the patient took utmost care of her until her last breath. The patient used to pray for her mother-in-law and regularly performed kirtan and bhajan so that she could at least hear them and attain peace in her final days. While sharing about the death of her mother-in-law, the patient became very emotional and started weeping. The patient expressed that she felt as if she had lost her real mother. She also felt that her responsibilities had increased after the death of her mother-in-law, as earlier there was someone in the family who used to take social decisions and attend to family matters. After her mother-in-law’s death, the patient began to feel alone and anxious, especially during social or family situations where she had to go alone or make decisions herself.

Following this event, the patient started experiencing joint pain. Gradually, the pain increased to such an extent that she was unable to perform her normal household work, particularly during the morning hours. Her daughter then took her to the hospital for consultation. After investigations and clinical history, she was diagnosed with **psoriatic arthritis** and was started on allopathic medication.

During the blood investigations, **dyslipidaemia** was also detected as an incidental finding, and she was started on anti-lipid medication as well.

Before beginning the life space data, the patient's daughter shared the following information about the patient:

She mentioned that the patient is a very innocent and simple kind of person who always tries to think positively even in tense situations. The patient often says that one should trust in God, as He will take care of everything. She also keeps many fasts and makes *manta/badha* (religious vows) for the successful outcome of any work. The patient is very strict about a non-vegetarian diet and does not allow non-vegetarian food to be eaten inside the house, although her daughter and husband are very fond of eating it.

The patient is very emotional and gets hurt easily, especially when someone says, "You don't know anything." On such occasions, she immediately starts weeping. If someone tells her that something is her fault, she becomes extremely angry and reacts by saying, "When I have not done anything, why do you blame me?" The patient is always busy with household work and remains somewhat agitated about finishing tasks. Although her speed of work is slow, she performs her work very carefully and perfectly.

The daughter also mentioned that the patient lacks confidence in herself and is often confused while making simple decisions, such as choosing clothes, deciding what to cook when guests arrive, or what to wear when going out. She also shared an interesting observation: the patient often starts explaining situations that are not directly related to her. For example, if something happens in the family outside the house, she feels the need to explain it because she fears being blamed for it.

Since the death of the grandmother (mother-in-law), all responsibilities have come upon the patient, and since then she has remained tense. The daughter also frankly expressed that the patient does not have much capacity to handle increased responsibility or decision-making.

EXHIBIT -2 FOLLOWS UPS

17/10/22 –O/E

WT	83.5 kg	JOINTS – OF HANDS	TENDER+; ROM IS GOOD
BP	130-90 mmhg	WRIST	TENDER+; ROM IS GOOD
P	87	ELBOW AND SHOULDER	OK
O2	99	KNEE	NO SWELLING
OCCIPUT	POWDERY SCALE ON SCRATCHING	ROM	PAIN ON FOLDING/ SQUATTING
NAIL	BRITTLE OF TOE AND FINGERS		
FACE	DARK SPOTS AT MALAR REGION		

FOLLOW UP CRITERIA

1	Multiple joint pain and swelling	6	Anti-lipid medicines
2	Allopathic drugs –STEROIDS/ MXT 0.25/ HCQS/ pain killers	7.	Reports
3	Psoriatic patch at occiput itching/ scaling	8.	o/e joint tenderness/ swelling/ WT/BP
4	Nail – brittle	9.	Action
5	Dark spot on face		

Date	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
17-10-20		Adv to tapper steroids/ pain killer sos				Atorvastatin 10 mg		Bp 130-90 wt -83.5 Joint exam-written	1
7-11-20	>	Only HCQS/ MXT 2/7	>			s		120-80 joints >	2
INVESTIGATION DONE - Hb 12 Tc 7510 Dc wnl Pc 2.92 Esr – 16 CRP – 1.83 S CREAT – 0.83 **Talk with physician – explain to tapper of steroids**									
27-11-20	< cold weather	s	Scalling itch +		Lighter	S		120-80 joint p/s +	3
12-12-20	No	S	>		Lighter	S		120-80 joints rom>	4
9-1-21	NO	S	>			S		JOINTS ROM OK	5

Date	1	2	3	4	5	6	7	8	9
18-1-21	+ < dry cold wind Rt knee pain 2 < a travelling	S	+			S		Small joint p/s + Knee	6
30-1-21	Knee pain ++	Stop – hcqs Mxt 7.5 once in week	>			S		Knee pain tned + rom reduced Wt 82.5	7
Shown to orthopedic surgeon – x ray – knee – early OA changes rt knee – adv - sos pain killers – and weight management Reports done - ESR – 10 URIC ACID – 3.12 – s.chol – 172 tirg – 102 hdl – 57 – ldl – 102 fbs – 89 – rest other reports normal **Talk with the allopathic physician – ready to stop - hcqs – now only – mxt 7.5 mg once in week , atorvastatin continued**									
19-2-21	>2 in knee pain	Only mxt 0.25 1/7	>	Photo	>	S		Knee > 120-80	8
6-3-21	OK	S	>			S		R	9
3-4-21	knee pain/swelling+ ortho advised pain killer	S	Ok	>		S		R (covid era)	10
3-5-21	Pt is covid positive – all investigations done – HRCT as well – mild intensity – antibiotics and temiflu given							R	11
19-6-21	Ok	Stopped	Ok mild scale	>	>	Stopped		130-90 joints ok	12
8-7-21	Ok	No	+ scale	Ok	>	No		120-80	13
5-9-21	Ok	No	Mild scale no itching	Ok	>	No		R	14 `
7-11-21	Joints pain < winter	No	Scale +	Ok		No		120-80 small joint tend +	15
	Pt was ok so not reporting – but In February – 22 end – she had allergic dermatitis around corner of mouth – dermatologist prescribed steroids to apply locally – which she is applying since last 15 d							Talk on phone Adv to tapper steroids oint	**16**
19-4-22	Ok				Patch is > Moisture application			R	19
4-4-22	OK	NO	+	OK	Patch ++ steroids	No	No	Dry rough ptach around mouth	18

Date	1	2	3	4	5	6	7	8	9
19-4-22	Ok				Patch > Moisture application			R	19
4-5-22	Ok	No			s			R	20
21-5-22	Ok				S applying steroids sos	No	No	110-70	21
1-6-22	Ok	No	Ok	No	>	Atorvastatin 10 restarted			22
Shown to physician- Done on 29-5-22 □ Hb – 11.9 tc – 5500 Dc – Wnl pc – 2.95 esr – 16 crp – 8.63 cholesterol – 221 trig – 82.5 ldl – 167									
20-7-22	No	No	Ok	No	>	S	No	81.5 kgs 110-70 Skin mouth >	23
17-8-22	No	No	Ok	No	Mouth patch >	S	No	82 bp 110-70	24
14-9-22	No	No	Scale and itch +	No	Mouth patch +	S	No	82 bp – 110-70	25
28-9-22	No	No	>	No	Mouth pathc +	S	No	81.5	26
12-10-22	NO	NO			++			112-70	27
2-11-22					>			R	28
10-11-22	NO	NO			>	S		R	29
30-11-22	NO	NO	>	NO	s			Ptahc ournd mouth + dry scally	30
28-12-22	No	No	Ok	No	>			Patch >	31
11-1-23	No	No	Ok	Ok	>	Atorvastatin 10 mg		120-80 wt 82.5 Patch at mouth >	32
22-2-23	No	No	Ok	No	>/ patch is till there	S		Patch at mouth +	33
29-9-23			Ok		Applying steroids at patch sos	S		Patch +	34
14-4-23					>	S		Patch >	35
10-5-23					>++	S		>2 ptach around mouth	36
21-6-23	Ok	No	No	No	>70%	S		Much clear	37

26-7-23	ON 12-7-23 □ PT HAD MENORRHAGIA □ SO CALLED UP □ ADVISED TO TAKE HEMAMALIS 30 TDS AFTER PERIOD WAS ADVISED TO USG AND GYNEC OPINION USG — UTERUS – 96/60 MM SIZE (NORMAL SIZE 80/50) MYOMETRIUM ECHOGENICITY INHOMOGENEOUS – ENDOMETRIAL THICKNESS GYNECOLOGIST – OPINION – UTERUS IS BULKY – WAIT AND WATCH SOS – TRENEXA FOR MENORRHAGIA		38
14-8-23	LMP – 6-8-23 D – 4 D – BLEEDING NORMAL – NO OTHER COMPLAIN	MUCH CLEAR	39
29-8-23	24-8-23 – PT HAD SUDDEN SEVER ATTACK OF VERTIGO AND VOMITING —BP 160-100- HOSPITALIZED IN DAY CARE FOR 12 HRS INVESTIGATIONS □ ECG – WNL – S SODIUM 137 S. POTASSIUM 3.7 S.CHLORIDE 106 S. BICARB – 22.8 CRP – 7.6 S CREAT – 0.82 TSH – 3.58 HB – 11.6 TC 12270 – PC 2.89 , CT SCAN BRAIN – SMALL GLIOTIC AREA AT LEFT BASAL GANGLION TREATEMENT GIVEN - ANTACID – ANTIBIOTICS – VERTIN – STAMETIL- TELMISARTAN 40 CLONAZEPAM 0.25 FOR 5 DAYS LATER ON – ANTI HYPERTENSIVE – TELMISARTAN 40 MG STARTED PRESENTLY – NO COMPLAIN OF PSORIASIS – ATOPIC DERMATITIS OR ARTHRITIS	BP 110-70	40
SEP 23 ONWARDS	**FROM SEPT – 23 TILL ONWARDS – THE CASE WAS MANAGED BY THE REFERRING PHYSICIAN – WHO WAS KNOWN TO PT'S DAUGHTER – SHE WAS GIVEN THE DETAILS OF THE CASE. FOLLOWINGS ARE THE REPORT CHART OR ALLOPATHIC MEDICINES**		
5-12-23	CONSULTED PHYSICIAN – CHOL – 288 TRIG – 85.7 HDL – 49 LDL 222 VLD – 17.1 TELMISARTAN – 40 MG AND ATORVASTATIN – 20MG BETWEEN SEPTEMBER 2023 TILL FEBRUARY – 2026 PT IS MANAGED WITH HOMEOPATHIC MEDICINES AS WELL		
17-7-24	CONUSLTED PHYSCIAN □NO COMPALIN □ BP 116-80□ TELMIKIND – 40 AND ATORVA – 20		
30-5-25 '	CHOL 270 HDL – 49 LDL – 188 TRIG 102 VLDL 20,3 ALK PHOS – 74.8 BILIRUBIN – 0.41 SGPT 22.5 SGOT 28.2 S PROTEIN – 6.97 ALB – 3.94 GLO- 3.03UREA – 20.14 CREAT – 0.55 CALCIUM – 8.85 URIC ACID 4.48 SODIUM – 139 CRP – 8.4 HB – 11.7 VIT B 12 – 145 VIT D – 42.99 TESTOSTERONE – 9.47S IRON 56.9 TIBC – 410 T3 – 80 T4 – 7.24 TSH – 3.44E GFR – 112 ABG – 114 HBA1C – 5.6 HB – 11.7 TC 5730 PC – 2.75 STRESS TEST (TMT) – IS NEGATIVE PRESCRIPTION – ATORVASTATIN 20 MG (STOPPED ANTI HT MEDICINES BY ALLOPATHIC PHYSICIAN)		

7-1-26	CONSULTED GYNECOLOGIST FOR USG – UTERUS IS BULKY, ENDOMATIRUM IS THIN, BILATERAL AXILLA IS NAD – AND BILATERAL BREAST IS NAD	
FEB 2026	CALLED UP PATIENT – SHE SAID – SHE DON'T HAVE ANY PROBLEM – NOW ONLY ANTI LIPID MEDICINES ARE GOING ON IF ANY COMPLAIN ARISE – THAN REFERRING DOCTOR USED TO GIVE ME DOSE OF HOMEOPATHIC MEDICINES SOS	