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ROLE OF HOMOEOPATHY IN MANAGEMENT OF TINEA CRURIS

Homeopathy

Dr. Pintu Srivastava Phd Scholar Tantia University, Sriganganagar. Associate Professor Department Of Anatomy LR Shah Homeopathic Medical College Under Smt. T.V. Mehta Charitable Foundation Rajkot, Saurashtra University Rajkot ,gujarat, India.

Dr. Ravinder Kochchar Phd Guide Emeritus Professor At Sriganganagar Homoeopathy Medical College Hospital And Research Centre, Tantia University, Sriganganagar, Rajasthan, India.

ABSTRACT

Jockey itch, or tinea cruris, is an infection of the vaginal, pubic, perineal, and perianal skin that is brought on by pathogenic fungus called dermatophytes. The etiology, diagnosis, and treatment of the most prevalent infectious causes of dermatophytes are the main topics of this article.

KEYWORDS

Tinea cruris, homoeopathy Medicine.

INTRODUCTION

Jockey itch, or tinea cruris, is an infection of the vaginal, pubic, perineal, and perianal skin that is brought on by pathogenic fungus called dermatophytes. These dermatophytes cause a distinctive rash by affecting keratinized tissues like hair and the stratum corneum of the epidermis. Fungi thrive in intertriginous spaces, and the groin's susceptibility to infection is caused by perspiration, maceration, and an alkaline pH.

Epidemiology

Tienea cruris is one of the cutaneous mycoses that afflict 20 to 25 percent of people worldwide. Due to high temperatures and higher humidity, dermatophyte diseases are more common in developing and tropical nations. Over 51 million doctor visits and an estimated 29.4 million cases of superficial fungal infections have been documented in the US. Male adolescents and adults make up the bulk of people with tinea cruris and are more likely to have the condition. Concern has been raised globally by the rise of dermatophytoses and the identification of resistant diseases.

Pathogenesis :

Dermatophytes often do not penetrate living tissues; instead, they grow only on the keratinized layers of the skin and its appendages. Local inflammation may be triggered by fungus-based products. The sterile vesicular lesions that are occasionally observed in remote form from ringworms are likely caused by hypersensitivity to fungal antigens, which may contribute to disease.

Dermatophytes invade peripherally in a centrifugal pattern after an incubation period of one to three weeks. The active border exhibits enhanced proliferation of epidermal cells in response to the infection, which leads to scaling. By removing the contaminated skin and exposing fresh, healthy skin in the middle of the developing lesion, this provides a partial defense. Cell-mediated immunity is used to eradicate dermatophytes.

Trichophyton rubrum is a common dermatophyte that is difficult to eradicate due to its cell wall. Mannan, which is present in this protective barrier, may reduce cell-mediated immunity, prevent keratinocytes from proliferating, and increase the organism's resistance to the skin's defenses.

Symptoms

Symptoms of skin diseases caused by fungi vary depending on the type and location of the disease.Typically, patients may experience persistent itching, which is a hallmark sign of these problems. The skin you touch often turns red and shows irritation and inflammation. Another typical symptom is a rash that can become a scale, peeled or foam, depending on the severity and nature of the condition. The skin might also feel dry and crack, especially around the edges of the rash. In some cases, there is discoloration, with the skin turning lighter or darker than the surrounding areas. Infections affecting the nails can cause changes such as thickening, brittleness and discoloration of the nail.

Investigation

Potassium hydroxide (KOH) scraping-Simple, inexpensive, quick, and sensitive test. Samples to be taken depend on the site of infection.

Homoeopathy Medicine

Antimonium Crudum

Skin Eczema with gastric derangements. Pimples, vesicles, and pustules. Sensitive to cold bathing. Thick, hard, honey-colored scabs. Urticaria; measle-like eruption. Itching when warm in bed. Dry skin. Warts. Dry gangrene. Scaly, pustular eruption with burning and itching, worse at night.

Arsenicum album

Skin Itching, burning, swellings; śdema, eruption, papular, dry, rough, scaly; worse cold and scratching. Malignant pustules. Ulcers with offensive discharge. Anthrax. Poisoned wounds. Urticaria, with burning and restlessness. Psoriasis. Scirrhus. Icy coldness of body. Epithelioma of the skin. Gangrenous inflammations.

Bacillinum

Skin Ringworm; pityriasis. Eczema of eyelids. Glands of neck enlarged and tender. Worse, night and early morning; cold air.

Calcarea Carbonicum

Skin Unhealthy; readily ulcerating; flaccid. Small wounds do not heal readily. Glands swollen. Nettle rash; better in cold air. Warts on face and hands. Petechial eruptions. Chilblains. Boils.

Calcarea Sulphurica

Skin Cuts, wounds, bruises, etc, unhealthy, discharging pus; they do not heal readily. Yellow, purulent crusts or discharge. Purulent exudations in or upon the skin. Skin affections with yellowish scabs. Many little matterless pimples under the hair, bleeding when scratched. Dry eczema in children.

Natrum Muriaticum

Skin Greasy, oily, especially on hairy parts. Dry eruptions, especially on margin of hairy scalp and bends of joints. Fever blisters. Urticaria; itch and burn. Crusty eruptions in bends of limbs, margin of scalp, behind ears (Caust). Warts on palms of hands. Eczema; raw, red, and inflamed; worse, eating salt, at seashore. Affects hair follicles. Alopecia. Hives, itching after exertion. Greasy skin.

Sepia Officinalis

Skin Herpes circinatus in isolated spots. Itching; not relieved by scratching; worse in bends of elbows and knees. Chloasma; herpetic eruption on lips, about mouth and nose. Ringworm-like eruption every spring. Urticaria on going in open air; better in warm room. Hyperidrosis and bromidrosis. Sweat on feet, worse on toes; intolerable odor. Lentigo in young women. Ichthyosis with offensive odor of skin.

Tellurium

Skin.Itching of hands and feet. Herpetic spots; ringworm (Tuberc). Ring-shape lesions, offensive odors from affected parts. Barber's itch.

Stinging in skin. Fetid exhalations (Sulph). Offensive foot-sweat. Eczema, back of ears and occiput. Circular patches of eczema.

Thuja Occidentalis

Skin Polypi, tubercles, warts epithelioma, nævi, carbuncles; ulcers, especially in ano-genital region. Freckles and blotches. Perspiration sweetish, and strong. Dry skin, with brown spots. Zona; herpetic eruptions. Tearing pains in glands. Glandular enlargement. Nails crippled; brittle and soft. Eruptions only on covered parts; worse after scratching. Very sensitive to touch. Coldness of one side. Sarcoma; polypi. Brown spots on hands and arms.

Graphites

Skin Rough, hard, persistent dryness of portions of skin unaffected by eczema. Early stage of keloid and fibroma. Pimples and acne. Eruptions, oozing out a sticky exudation. Rawness in bends of limbs, groins, neck, behind ears. Unhealthy skin; every little injury suppurates. Ulcers discharging a glutinous fluid, thin and sticky. Swelling and induration of glands.

Sulphur

Skin Dry, scaly, unhealthy; every little injury suppurates. Freckles. Itching, burning; worse scratching and washing. Pimply eruption, pustules, rhagades, hang-nails. Excoriation, especially in folds (Lyc). Feeling of a band around bones. Skin affections after local medication. Pruritus, especially from warmth, is evening, often recurs in spring-time, in damp weather.

REFERENCES;

1. Upta AK, Chaudhry M, Elewski B. Tinea corporis, tinea cruris, tinea nigra, and piedra. Dermatol Clin. 2003 Jul;21(3):395-400, v.
2. Ely JW, Rosenfeld S, Seabury Stone M. Diagnosis and management of tinea infections. Am Fam Physician. 2014 Nov 15;90(10):702-10.
3. Sahoo AK, Mahajan R. Management of tinea corporis, tinea cruris, and tinea pedis: A comprehensive review. Indian Dermatol Online J. 2016 Mar-Apr;7(2):77-86.
4. Khurana A, Sardana K, Chowdhary A. Antifungal resistance in dermatophytes: Recent trends and therapeutic implications. Fungal Genet Biol. 2019 Nov;132:103255.
5. Sardana K, Kaur R, Arora P, Goyal R, Ghunawat S. Is Antifungal Resistance a Cause for Treatment Failure in Dermatophytosis: A Study Focused on Tinea Corporis and Cruris from a Tertiary Centre? Indian Dermatol Online J. 2018 Mar-Apr;9(2):90-95.
6. Gupta AK, Foley KA, Versteeg SG. New Antifungal Agents and New Formulations Against Dermatophytes. Mycopathologia. 2017 Feb;182(1-2):127-141.
7. Ameen M. Epidemiology of superficial fungal infections. Clin Dermatol. 2010 Mar 04;28(2):197-201.
8. Vena GA, Chieco P, Posa F, Garofalo A, Bosco A, Cassano N. Epidemiology of dermatophytoses: retrospective analysis from 2005 to 2010 and comparison with previous data from 1975. New Microbiol. 2012 Apr;35(2):20713.
9. Panikar textbook of microbiology .7th edition
10. Lesher, J. (2017). TineaCorporis. [online] Medscape. Availableat:1.http://emedicine.medscape.com/article/1091473
11. Ibbotson S.H., Dawe R.S.; Davidson's Principles and Practice of Medicine; 22nd Edition; Churchill Living Stone Elsevier Ltd.;
12. Boericke W. Pocket Manual of Homoeopathic Materia Medica and Repertory. 9th Edition. New Delhi: B. Jain Publishers (P) Ltd; 2009.