

# An Alternative Approach in The Treatment of Methicillin-Resistant *Staphylococcus Aureus* (MRSA), using Classical Homeopathy.

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## Introduction

MRSA (Methicillin-resistant *Staphylococcus aureus*) is a bacteria that is resistant to most common antibiotics. Aside from methicillin the bacteria is also resistant to other more common antibiotics such as oxacillin, penicillin and amoxicillin.<sup>1</sup> Staph infections, including MRSA, occur most frequently in patients who have recently been hospitalised for long periods, who have had invasive medical procedures or who have weakened immune systems. Individuals treated in long term healthcare facilities such as nursing homes or dialysis centres have been considered most at risk. In a healthcare setting can cause serious and potentially life threatening infections such as bloodstream infection, infections at a surgical site, or pneumonia. However, MRSA infections also occur in otherwise healthy people who have not recently been hospitalised or undergone an invasive medical procedure. These infections usually present as skin infections, pimples, boils or other pus-filled lesions but can rapidly progress to more life threatening infections. In this otherwise healthy population they are known as community associated (CA)-MRSA infection; according to a recent study<sup>2</sup> MRSA has become the most frequent cause of skin

<sup>1</sup> Centres for Disease Control. Overview of healthcare related MRSA

<sup>2</sup> Invasive Methicillin-Resistant *Staphylococcus aureus* infections in the United States. R. Monina Klevens, DDS, MPH et al. [www.jama.com](http://www.jama.com) at CDC-Information Center.

and soft tissue infections presenting at emergency rooms in the USA. During the period from 1999 to 2005 the estimated number of hospitalizations involving *S. aureus*-related infections increased 62% from 294,570 to 477,927. In 2005, there were 11,406 *S. aureus*-related deaths of which 6,639 were MRSA-related<sup>3</sup>.

Current medical treatment for MRSA usually involves removing the infected person to an isolation ward and the use of the intravenous antibiotic vancomycin. The hospital stay can be several days. The patient is usually sent home with wound care instructions and a prescription for the ointment bactroban which is applied to the internal nasal passages. The infection can be controlled this way, but in many cases the patient will remain colonised. While vancomycin is currently effective against MRSA it is clear that increased resistance exists and some hospitals are already reporting strains that are less sensitive to vancomycin.<sup>4</sup>

## Homeopathy

In this light, it seems important to examine the potential of alternative therapies that do not make use of costly drugs or hospital stays, to combat such infections and prevent the risk of developing further antibiotic resistant bacterial strains. Homeopathy is widely practiced throughout Europe and Asia and is increasing in use in the US. In the UK the NHS (National Health Service) operates 5 dedicated homeopathic hospitals. According to a 2005 study, 70% of 6544 follow-up patients reported improvements in their health. Among the ailments most commonly treated were eczema, asthma, migraine, irritable bowel syndrome and

<sup>3</sup> Klein E, Smith DL, Laxminarayan R. Hospitalizations and deaths caused by methicillin-resistant *Staphylococcus aureus*, United States, 1999–2005. *Emerg Infect Dis* [serial on the Internet]. 2007 Dec [25 Sept 08]. Available from <http://www.cdc.gov/EID/content/13/12/1840.htm>

<sup>4</sup> <http://www.mayoclinic.com/health/mrsa/DS00735/DSECTION=treatments-and-drugs>

chronic fatigue.<sup>5</sup> In the modern day context there is unfortunately little data on the use of homeopathy in acute outbreaks of infectious disease but historically it has been effectively applied in outbreaks of cholera, influenza and scarlet fever. During the 1918 Spanish Influenza epidemic data collected by the Hahnemann College of Medicine in Philadelphia showed a mortality rate of only 1.05% amongst a group of 26,795 cases treated by homeopaths. The mortality rate in the general population treated medically was 30%.<sup>6</sup>

Homeopathy is symptom driven and based on careful observation of the individual signs and symptoms as exhibited by the patient. It is experiential and the homeopath pays extremely close attention to the use of language by the patient in relating how the ailment is affecting him. A remedy acts as a reversing trigger on the self-healing vital force of the body that is being challenged. It is described as working at a vitalistic level, similar to acupuncture. It is bio-dynamic in nature rather than bio-chemical, as western medicine is.

Homeopathy is very effective in chronic illnesses but as the case below illustrates, homeopathy can also be extremely effective in acute infections that require daily monitoring and frequent re-evaluation of remedy selection.

## **Case Presentation**

### **History**

James, an otherwise healthy 40 year old man entered our care in late November 2007. He had sustained a minor scratch on his finger at the end of September 2007 while clearing away vegetation in upstate New York. Despite thorough wound care at the time James' finger

began swelling up during the night of the scratch and within 3 days had progressed to a severe infection. James sought advice at a walk in clinic near his home and was prescribed antibiotics. He had no improvement over the next two days at which point he visited the Emergency Room at Columbia Presbyterian hospital in New York City. His finger was red, edematous and showed clear signs of infection. His wound was lanced in the ER and the exudates sent for analysis. As a precaution James was admitted to the hospital overnight and received an IV antibiotic and analgesics. On discharge the next day he was instructed about wound care and hoped the infection would clear. However, he received a message 2 days later informing him that the culture grown from his lab specimen was not responding to antibiotics and was confirmed as being MRSA.

James was immediately readmitted to the hospital, this time in an isolation ward to avoid exposure to any other patients. Vancomycin was prescribed and he was sent home with bactroban ointment for his nose 2 days later. He was advised that the infection could re-occur and to be vigilant about skin lesions.

Two months later, just after Thanksgiving, James noticed a large, fleshy bulge on the back of his thigh. He was concerned it might be a recurrent MRSA skin infection but as an uninsured patient was forced to seek an alternative to another costly hospitalisation. On the recommendation of a friend he sought homeopathic treatment.

## **Homeopathic findings**

When I first spoke with James he described how the wound on his middle finger in September "blew up" within a day to a hard swelling. His fever spiked to 102F. Now, two months later, the presenting symptom was a large swelling on the back of his right thigh just below his buttock. He described how it "came right out" close to 1 inch in thickness and then

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<sup>5</sup> Spence DS, Thompson EA, Barron SJ. Homeopathic treatment for chronic disease: a 6-year university-hospital outpatient observational study. *Journal of Alternative & Complementary Medicine* 2005; 11: 793-798. <http://www.trusthomeopathy.org/csArticles/articles/000001/000164.htm>

<sup>6</sup> Homeopathy for Epidemics. Eileen Nauman, DHM (UK). Pg

reverted to a very large “bite-like,” dark dot within a day. Light red discolouration of the skin was seen almost down to his knee. The lump was *sharply*<sup>7</sup> painful and causing him concern. It was *constricting* his leg and felt very *hard*. He felt as if *an iron band* was preventing movement. He was *concerned* because he thought it might be the same, *incurable* infection as the first one on his finger.



Based on the sensation of *constriction* that he repeated in many different ways and the other symptoms listed in italics I prescribed Cactus Grandiflora. I also stressed the importance of being seen by a medical doctor. James however steadfastly refused to return to the hospital.

At this stage about five dozen remedies were identified as being valid homeopathic remedies for this individual. Careful differentiation and research would clarify final remedy selection, according to homeopathic repertories and Materia Medicas.

#### **24 hours later (from initial consultation)**

After one day the sensation of constriction was significantly diminished. The pain had lessened but the infection was not improving. The central area of induration was growing

larger but he described marked improvement in the sensation of his most prevalent symptom, i.e. the swelling and the constricting. The discolouration that had spread to his knee was more localised. At this stage I repeated the same remedy.



#### **2 days later**

Though the infection seemed contained the central area now resembled a large boil and had grown rapidly to a *darker red* circle of about 4 inches. At this point he complained of severe “burning pains”, and the infection was described (and looked) as ‘angry’. He was also extremely *restless* with a constant *need for motion*. At this point I had several remedies in mind that might have fit the symptom picture, but the degree of *anger* and *burning* in the case led me to Cantharis.

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<sup>7</sup> Italicized words in this description of finding represent qualities specifically used in selecting the proper homeopathic remedy.



### 3 days later

James reported that the Cantharis had addressed the burning pains which now felt much better. He was happy that he did not have to take pain medication as he had with the first infection. The outward progression of the infection had clearly stopped and the boil turned even darker red with a *congested, shiny* appearance and blood seeping through the pores in the centre of the mass. According to these symptoms, Crotalus Horridus was given, as it is often used for dark, haemorrhagic wounds. I had previously researched this remedy in regards to Ebola type infections several years ago.



All along James was repeatedly advised to seek medical care and have the wound lanced. There was concern about a systemic blood infection. James pointed out that he had no fever at all and that the swelling had stopped.

His pain was manageable and was not requiring the high doses of narcotics he had needed during his first MRSA infection. He was confident that the lesion was healing and could not afford the high cost of another hospitalisation so he was not willing to seek medical attention.

During this time James did stay in his apartment to avoid any possibility of secondary infection.

### 4 days later

24 hours after the Crotalus the boil began changing colour. Yellow and light green pus could be seen in the border. His pain was manageable and he had no fever.

At this point James described *intense anxiety* over the possibility of MRSA occurring over and over and over again in his life. He felt he was *poisoned* for life. The increased anxiety along with the idea that his body was poisoned and that he had an incurable disease indicated the remedy Arsenicum Album.



### 6 days later

Clearly the infection was no longer spreading. James' anxiety was much diminished. The boil was filled with pus and began oozing but there was no way to know what was going on underneath the mass of pus and necrotic tissue. He felt very good about his

progress but I remained concerned about *systemic infection* and *necrosis* at the infection site. Secale was given as a prophylactic for blood poisoning. Within half a day his anxieties and restlessness came back. It was clear this remedy was not having an effect and I reverted to Arsenicum.

### Continuing Progress

On the 7<sup>th</sup> day the mass opened and began oozing. At this point James was able to manually squeeze the lesion and exude a large amount of dark green, almost black pus. At this stage James collected several of the cotton balls he had used to drain the exudate and on the 6<sup>th</sup> December 2007 he had them analysed at the same laboratory facility as his earlier sample. The exudate was confirmed as positive for MRSA.



Later on the wound stopped seeping and began to dry up. I continued to prescribe Arsenicum daily and James remained vigilant about cleaning the wound with hydrogen peroxide. I was encouraged that at the time the lesion burst there was already evidence of granulation on the borders. This was evidence to me that the infection had been fully isolated.

Over the next two weeks the wound continued to slowly heal from the outside edges towards the centre and from the bottom of the ulcer to the surface of the skin. Within 3 weeks

the lesion had healed over completely. James continued to take Arsenicum several times a day as he still had some level of anxiety regarding re-infection. We were gradually able to reduce the frequency of repetition as the wound continued to heal and his anxiety diminished.



### 5 months later

James continues to do well and on the 9<sup>th</sup> of April 2008 he returned to Columbia for another nasal swab analysis. Remarkably the tests came back negative for MRSA, meaning that not only was his local infection cured but his body was no longer colonised by the bacteria. In other words, his wound was completely healed and he is no longer a carrier of MRSA in the general population.



### **Conclusion**

Given the growing number of antibiotic resistant infectious agents, a treatment for MRSA that avoids all use of antibiotics has enormous potential in the general population. Furthermore, the treatment above is reproducible in a hospital setting using the basic five dozen remedies that fit the MRSA symptom picture. There is also the possibility of using other homeopathic remedies prophylactically. To that end we recommend and hope to undertake further research on this approach in a traditional medical facility.