PL TREATMENT IN THE ANKYLOSING SPONDYLITIS

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SUMMARY. We propose a new drug, PL and his third hahnemannian dilution, PL CH 3, or shorter PL 3, in the treatment of the ankylosing spondylitis. Since 1975 (till now) we treated 426 patients with AS, 225 in early stages and 201 in advanced stages of illness.

77 patients were treated with PL (till 1987), which *is* the initial drug, the others were treated with' PL 3. The treatment was administrated regional by infiltrating periarticular (peri and para spinal, the torax, the hip etc.) and intraarticular. We are looking for the local homeopathicity, a notion in discution.

The therapeutical results were significant for all the patients, good and very good for the early stages of illness, good and acceptable for the advanced stages of AS. Only a few cases were without any positive result. We succeded to reduce the dayly dose of NSAID and to withdrew the corticoid therapy.

These therapeutical results were obtained with PL-s Their effect were comparable for that we succeded to use at least only the PL 3 treatment. '

Key words: Ankylosing Spondylitis, polypeptidic solutions, local homeopathicity.

The therapeutical results we want to present in the treatment of the Ankylosing Spondylitis (AS) were performed since 1975 till 1992. Between 1975-1987 we used in treatment the PL a solution which is a proteic hydrolisates which is a polipeptidic solution in saline. It was the first medicine we used, the "mother" dilution. Since 1987 till now we begun and we succeeded using centesimal dilutions from PL. For this proceeding we had the help of Mr. George Dragan (physicist) with structural determinations and we started . the therapeutics with the 3-rd and the 9-th dilution. These two dilutions showed an increase of the water crystal phase. For the practicaly points of view we used the 3-rd centesimal dilution. Since 1988 we used only this dilution in the treatment of the rheumatic states, the PL CH3, shortly PL 3.

Material and method

We treated 426 cases of AS, 309 cases having less than 40 years, at the begining of the PL treatment. We treated 77 patients with PL (the "mother" dilution) between 1975-1988. The rest of the AS ill patients were treated with PL 3 (349 cases).

We injected PL (PL 3) in the ill region of the body. That means in all the regions with pain and swelling, with desmitis, myositis; paraspinal region, cervical, toracal, lumbar, sacral, and in any other places where inflammatory changing was produced, depending on the ill aspect (perypherical or axial).

We injected daily in hospital conditions, and at two or three days in clinical conditions. At each day of treatment we injected between 5 and 50m/ medicine in many places and in regard with the importance of the symptoms and the evolution of the ill state under the treatment. In gonitis or coxitis we injected *2ml* intraarticular twice a week.

The NSAID treatment the patient has come with was kept. In the evolution we noted the possible reduction of the daily dosis of the NSAID. The cortisone treatment the patient has come with was also kept and we noted the reduction of the daily dosis till we succeeded to withdraw it.

We administrated the PL treatment in series of 12 or 24 days treatment once or twice a year, depending of the severity of each ill state.

We treated 321 male (76%) and 105 female (24%). At the begining of the PL treatment 225 patients where in the early stages and 201 in the late stages of the illness. In early stages there are reduction in the spine mobility and radiological specifical findings (sacroileitic) but in the late stages we can find important ankylosing (sacroileal and spine — poker spine), and other joint ankylosis (ankylosing coxitis or gonitis).

Therapeutical results The therapeutical results in the early stages were better than in the late stages of the illness. In adition the time to reach improvements in the early cases were shorter than in the late stages. In the Ist table we are showing these results. We succeded to have good and excelent results in 291 cases, moderate in 108, none in 19, and 3 cases with a worse evolution.

Tab. I

Therapeutical results in early (I) and in late (II) stages

	I	II	Total
Very good	43	28	61
Good	137	98	235
Fair	42	66	108
Poor	2	17	19
Very poor	1	2	3

Important for this therapeutics is the fact that these therapeuticaly results are stabile in time, that means there are kept after the breaking off of the PL

treatment.

We succeded long term remision at the patients with early stages in aproximatively two years, two series in one year, of PL treatment. There was much difficult to obtain long term remisions to the patients in late stages, and if we succeded there was after 3-4 years of PL treatment. In 1992 we have in treatment the patients we started the treatment in the last two years (1990, 1991). Another important observation is that the daily AINS dosis is reducing during the PL treatment, eapecialy in the pause period. During the treatment there are slight local pain in the infiltration regions. In the pause the improvements are more visible because pain disappear. All the AS patients in the early stages have now a quite normal life.

We had three patients which came at the PL treatment with daily important dosis of cortisone. In all three cases we succeded, not easily, to withdraw the cortison treatment and they don't need it more.

I want to make a special mention related to the social conditions of these young ill people. Many of them are in the situation to give up their work and to loose their family. Of all the patients we treated, 68 (mainly young) were going to give up their work because their insuportable pains and their difficulty in walking. After one year of treatment only 3 gave up their job, 65 of them having an acceptable behaviour. From all the patients treated three of them succeded to take back their job after 2-3 years of interruption.

From the point of view of the clinical results we may say that the PL and the PL 3 medicine are strictely comparable. We had good results with both of them. We noted no important side effects.

Discutioas

A. First of all we may observe that there are not long term good results in the treatment of the AS in the medical literature, and especialy with such a number of cases and followed of such a long period of remision. We have patients in remission since 1976, with no rebond, with a normal life, which had, before we started the treatment, large daily dosis of NSAID and one of them with cortisone.

We think that the PL treatment can change the immage we have on the AS ill state, a severe ankylosing illness. The good and the excelent results and evolutions are better if we start the PL treatment as soon as possible, that means in the early stages of the illness.

B. The problem of the antiinflammatory effect of a polypeptidic solution is a preclinical finding (experiment) and not a theoretical point of view. The pre-clinical trial showed, even we are able to accept or not, such a clear antiinflammatory effect (2).

C. Another important problem is the administration of the treatment, in local injections periarticulary (subcutaneous, intramuscular) that means in the mesenchimal tissue. Our point of view is that the tissular disorders in AS illness began in the soft tissue. Only after a long evolution in the soft tissue the joints are affected and after the joints are involved, the soft tissue is suffering. That is why we are treating the soft periarticular tissue, the pathogenical theories we propose [3] can be or not near the pathological situation, but only the practical results led us, and lead us on.

D. The last but not the least problem we rise is the importance of the great dilutions we are using now.

PL, the "mother" dilution is a horse serum 1/32 diluted in saline. Adding the lose of proteins by precipitations in the technologi cal steps of the hydrolisis PL has not more than 0.15-0.20 miligrames polypeptides at one millilitre. PL 3 has not more than 0.0015-0.0020 milligrames polypeptides at 1 millilitre. Physical structural trials [1] have shown that some centesimal dilutions (PL CH3 and PL CH9) have different crystal frame, different density, according to the water we start. All the results led us to understand that the water is not a trivial unique substance, but a very complex one, with different kinds of waters which can have the same chemical compounds by different crystal frame.

E. PL and PL3, in the clinical aplication we succeded, have the same effects. PL 3 has some advantages: has less polypeptides, less possible side effects, and easier to produce

it that PL. It is important that the crystal frame in PL 3 has an important stability in time, as the physical cheks up have shown.

Conclusions

The PL ant iinflammatory treatment is using diluted and very diluted polypeptidic solutions with low molecular weight. This treatment is avoided of side effects (toxicity, pirogenity, antigenity, and others).

Pb, the "mother" dilution, has comparable effects in the clinical trial on the AS treatment.

The therapeutical results were good and excelent (student semnification< 0.001) for the early cases of AS.

The PL (as his centesimal dilutions) treatment is a possible new therapeutics with real effects in AS.

We may'change our point of view about the AS ill state as a severe, ankylosing one. The PL treatment may change the future of a lot of young people with AS illness