Authors' reply

Sir,

This has reference to your letter commenting[1] on our paper, "Current regimen for pulse therapy for pemphigus: Minor modifications, improved results".[2]

I find it strange that authors of the letter and some others like them use a different method for treating pemphigus which fails and they conclude that the DCP regimen used by us is 'faith-healing' and unacceptable. Is there anything that prevents my colleagues to visit my clinic and see the patients who are recovering/have recovered with the DCP regimen. Alternatively, they can depute their junior colleague whom we will be glad to train. Several dermatologists indeed have learnt the technique and produced similar results. A dermatologist can also send five to ten or even more of his patients for our treatment and see them recover. We have also been holding workshops/conferences on pulse therapy where we have often called our ex-patients so that the delegates can interact and see the results with their own eyes. We have also published books and described the parameters of the regimen in the internet. But if still a person decides to do nothing of this type and continues to call us faith healers, I can only pray, "May God bless him", and sympathize with his patients.

I have no intention of using placebo treatments for my patients at this stage because (1) I have used conventional methods for 22 years till 1982 and pulse therapy for 28 years after 1982 and there has been a tremendous difference in the outcome before and after 1982, (2) every patient who has taken treatment elsewhere before coming to us has acted as his/her own control, (3) the ultimate cure can be reproduced in every case who follows the protocol strictly, and (4) patients come to us for recovery and not experimentation, and therefore it will be unethical to deny or delay their recovery.

I hope the following case histories will illustrate my point.

A 25-year-old lady was having pemphigus vulgaris since January 1999, and taken conventional treatment with oral corticosteroids. In December 2000, when first seen by us, 50% of her skin was involved. With 2 mg betamethasone for one month and 1 mg for the next month, oral antibiotics and DCPs given at 28-day cycles along with 50 mg cyclophosphamide daily, the lesions healed in one month, but she became irregular in taking the DCPs. There was reactivation of the disease in May 2001. Another course of oral betamethasone 3 mg/day tapered over the next three months along with regular DCPs made her recover all over again. She took seven DCPs at regular 28-day cycles with us and seven more at irregular intervals at Ahmedabad along with 50 mg cyclophosphamide per day but remained alright. The DCPs were stopped in October 2002 and daily cyclophosphamide in March 2003. Her IIF titer came down from 1:80 in December 2000 to 1:10 in March 2003, and (negative) in October 2007. When last seen in September 2010, she had not developed a relapse ever again. Her only problems were the aseptic necrosis of the femur which she had developed before coming to us, and diabetes which was present before she had pemphigus.

The second patient was a 33-year-old homeopathic doctor who started developing pemphigus in November

2004. He was treated by two dermatologists one after the other with conventional methods, and also with mycophenolate in addition to dexamethasone 100 mg and cyclophosphamide 150 mg for four months, till December 2005. When first seen by us in January 2006, he had extensive ulcerations all over the body some of which were deep and looked like even bed sores. He also had myopathy and his condition was so bad that to examine him I had to go to the van in which he had been brought. He received irregular DCPs, oral corticosteroids, additional dexamethasone pulses, oral antibiotics, oral anticandida drugs, and cyclophosphamide, but kept having relapses. Regular DCPs with us were started in January 2007, along with 2 mg betamethasone, 50 mg cyclophosphamide, antibiotics and antifungal drugs. The DCPs were stopped in May 2008, and daily cyclophosphamide in January 2009. He now walks to my clinic for follow up. The IIF titer has become negative, while in March 2006, it was 1:80.

The third patient was a 47-year-old gentleman who developed pemphigus vulgaris in 2001 and had been on oral corticosteroids. He was first seen in February 2001 and asked to report for DCP treatment; but since he was afraid of the DCP, he continued the oral corticosteroid and immunosuppressive drugs. He reported again in January 2003 and January 2005, but still did not report for the DCP. In March 2007, he reported again after he had already received three doses of IVIG at monthly intervals apart from 20 mg prednisolone and 100 mg azathioprine per day. He was again advised to change over to the DCP, but once again he did not report. He took three more courses of IVIG at monthly intervals, but continued to have recurrences till the treating dermatologist told him to take DCP. The DCP was started in November 2007, along with 50 mg cyclophosphamide and 2 mg betamethasone every day, and antibiotics and antifungal drugs, the DCPs being given at 28-day cycles. The skin lesions healed in one month, oral lesions in two months, and betamethasone was tapered off in three months. He needed two more courses of oral betamethasone, antibiotics and antifungal drugs for chest infection, oral candidiasis and skin blisters and continued DCPs. In November 2008, he completed phase I of the DCP regimen, in August 2009 phase II and in May 2010 phase III of the regimen. Since May 2010, he is being followed up without any treatment.

All these three cases have been rather exceptional cases. The following patient represents what happens in most of the patients.

This patient was a 57-year-old gentleman from Nepal who developed pemphigus vulgaris in July 2000. He was initially treated with oral corticosteroids followed by 10 DCPs at Kathmandu but at irregular intervals. He was sent to me on 31st December 2001 when the treatment was started with the DCPs at 28-day cycles along with 2 mg betamethasone daily, 50 mg cyclophosphamide daily, antibiotics and anticandida drugs. All the lesions healed in one month. Betamethasone was tapered over the next month and other drugs were also stopped. He received three DCPs during phase I, 9 more DCPs along with 50 mg daily cyclophosphamide during phase II and only 50 mg cyclophosphamide a day during phase III and is free of the disease or any treatment for pemphigus since 12thAugust 2003.

We would also like to point out that there is a tremendous difference between a cure and a clinical remission. By “cure”, we mean that the patient will not develop a relapse of the disease for the rest of his/her life (most patients have now been followed up post-treatment for more than 5-10 years, the maximum being 25 years) without any maintenance treatment.

The clinical remission on the other hand means that the skin/mucosal lesions have healed, but the disease will recur when the drugs are tapered/ withdrawn.

The DCP regimen as used by us cures pemphigus, while if a patient continues to develop clinical lesions as in the case of Singh and Chaudhary, the dermatologist has obviously failed to induce even a clinical remission. The patient in such instances requires a better management of his disease.

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