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A study on the effectiveness of homoeopathic medicine in allergic rhinitis with an evaluation based on absolute eosinophilic count

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Abstract

Allergic rhinitis is an IgE immunologic response of nasal mucosa to air-borne allergens and is characterized by watery nasal discharge, nasal obstruction, sneezing and itching in the nose. This may also be associated with symptoms of itching in the eyes, palate and pharynx. Allergic rhinitis is triggered by allergens. Up to 20% of the population have symptoms of allergic rhinitis. This study is to know the Effectiveness Of constitutional Homoeopathic Medicine in Allergic Rhinitis.

Keywords: Homoeopathy, allergic rhinitis, seasonal rhinitis, perennial rhinitis, constitutional remedies

Introduction

It is an IgE mediated immunologic response of nasal mucosa to air-borne allergens and is characterized by watery nasal discharge, nasal obstruction, sneezing and itching in the nose. This may also be associated with symptoms of itching in the eyes, palate, and pharynx^[1].

Allergic rhinitis commonly known as hay fever, is caused by an IgE-mediated allergic response. During the early allergic phase, mast cells degranulate and release preformed chemical mediators, such as histamine and tryptase, and newly generated mediators, such as leukotrienes, prostaglandins, and platelet-activating factor. After a quiescent phase in which other cells are recruited, a late phase occurs approximately 4 to 8 hours later. Eosinophils, basophils, CD4 T cells, monocytes, and neutrophils release their chemical mediators, which leads to the development of chronic nasal inflammation. Allergic rhinitis can be seasonal, perennial, or episodic depending on the particular allergen and the exposure. Some children experience perennial symptoms with seasonal exacerbations^[2].

It can be accompanied by conjunctivitis and sore throat. Seasonal rhinitis usually occurs in the summer and is caused by allergy to pollens. Perennial rhinitis can occur at any time of the year and can be associated with exposure to extrinsic allergens such as animals (e.g. cats or dogs) or house dust mite^[3].

Epidemiology of Allergic Rhinitis

The prevalence of atopic disease varies greatly throughout the world, being much more common in the developed world with "Western" lifestyle. There has also been a dramatic increase in prevalence, particularly in the developed world over time. The rise in sensitisation to aeroallergens probably began in the 1920s, but the large increase in symptomatic disease started in the 1960-70s, with some evidence that the rates have now stabilised, with rates of asthma between 20% and 40%, depending on the criteria used, compared with 2-3% in the developing world^[4].

Allergic rhinitis is a global health problem affecting at least 10 to 25% of the population and its prevalence is increasing, our study in Bangalore on school children in the age group of 6-15 years indicates the incidence of 22.5%, in the year 1994 which increased to 27.5% in the year 1999. 75% of asthmatic children have allergic rhinitis. Although allergic rhinitis is not a serious disease, it has an impact on the social and quality of life of patients and affects school performance and work productivity and moreover, the economic burden by rhinitis is substantial. It has link with asthma, sinusitis and other comorbidities like conjunctivitis. The onset of allergic rhinitis is highest in school going children usually before the age of 5 years and is more prevalent in boys before the age of 10 years and in girls, between 10-18 years of age. It takes more than 3 years or more to develop allergic rhinitis after exposure to allergens to produce tissue sensitization and onset of symptoms. Seasonal pollen allergy, therefore, rarely occurs before the age of three years^[5].

Mechanism of Allergic Rhinitis

The understanding of the mechanism of the disease provides a way for rational treatment. Allergy is classically the result of IgE mediated response to allergens causing nasal inflammation. The response includes chemotaxis, selective recruitment and trans endothelial migration of cells, release of cytokines and chemokines, activation of eosinophils, T-cells, mast cells and epithelial cells and release of mediators by the activated cells predominantly histamine and cysteinyl-leukotrienes (Cyst LT). Non-specific nasal hyper-reactivity is an important feature of allergic rhinitis. Persistent allergic rhinitis is due to ongoing inflammatory late phase reaction. The minimal persistent inflammation is an important new concept where inflammation of the nose persists without symptoms and without exposure to seasonal allergens [5].

Types

Seasonal allergic rhinitis

It is caused by airborne pollens, which have seasonal patterns. Typically trees pollinate in the spring, grasses in late spring to summer, and weeds in the summer and fall. The pollen, microscopic in size, can travel airborne hundreds of miles and be inhaled easily into the respiratory tract [6].

Weed pollens and mould spores predominate in the latter part of the summer and early autumn. Grass pollen counts above 50/m³ are considered high and represent the threshold level at which most hay fever sufferers experience symptoms [7].

Perennial allergic rhinitis

It is primarily caused by indoor allergens, such as house dust mites, animal dander, mold, and cockroaches. These are found in every house and accumulate in carpets, bedding, fabric and furniture. Domestic pets, e.g. cats, dogs and even cockroaches cause rhinitis [8].

Objectives of the Study

To clinically assess Allergic Rhinitis in All age groups and to evaluate the efficacy of Homoeopathic medicines in the management of Allergic Rhinitis.

Materials and Methods

Source of Data

Patients will be collected from the In-patient and Out-patient Departments, Peripheral Centers, Rural Health Camps and Medical Camps conducted by Vinayaka Missions Homoeopathic Medical College Hospital. The literature will be collected from authentic text books and journals.

Method of collection of the Data

Inclusion criteria

- All age groups with both male and female.
- Detailed case history by interview as per the Performa prepared for the topic will be taken. Medication will be started on the basis of the Homoeopathic totality.
- The patient will be reviewed once in 7 days for a period of 3 months and once in 15 days for next 3 months basing on the particular case. Sample size will be 30 in number.

Exclusion criteria fixed for the study

Seasonal Type Allergic Rhinitis, Cases associated with other systemic illness will be excluded. Complications to lower respiratory tract infection will be excluded.

Treatment plan

The patients were assessed, analysed and evaluated according to Dr. J.T. Kent’s method. Repertorization was done using Kent repertory. Miasmatic interpretation was done by using the presenting complaints, past history, family history, mental and physical generals. Mental generals, physical generals and characteristic particulars were considered for the selection of the remedy. Criteria for follow up were mental generals, physical generals and characteristic particulars. Prognosis was evaluated according to the symptomatic relief and the reduction in the Absolute Eosinophilic count.

Observation & Results

Table 1: Age wise Distribution of Allergic Rhinitis Cases. (n = 30)

S.no	Age group (In Years)	Number of Patients	Percentage
1	10- 20	5	16.66%
2	21-30	12	40%
3	31- 40	8	26.66%
4	41-50	5	16.66%
5	51-60	0	0%

Commonly affected patients were between the ages of 21-30[40%] and 31- 40 [26.66%] .10-20 aged groups are affected by 16.66 and 41-50 age groups are also affected by 16.66%.

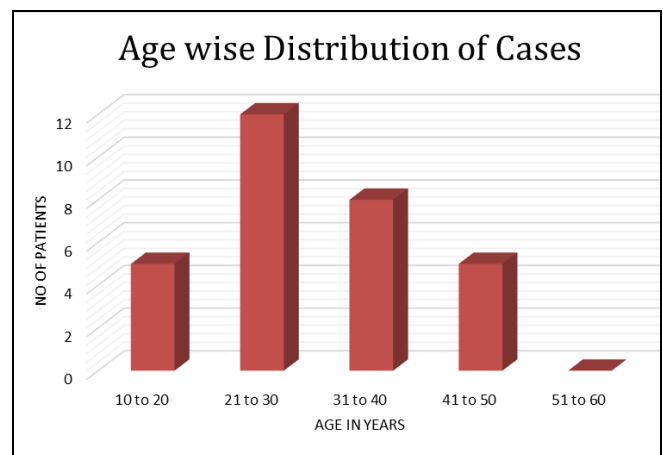


Chart 1: Age wise Distribution of Cases

Table 2: Sex wise Distributions of Cases (n = 30)

S. No.	Sex	Number of Patients	Percentage
1	Males	18	60%
2	Females	12	40%

Males (60%) are affected than Females (40%)

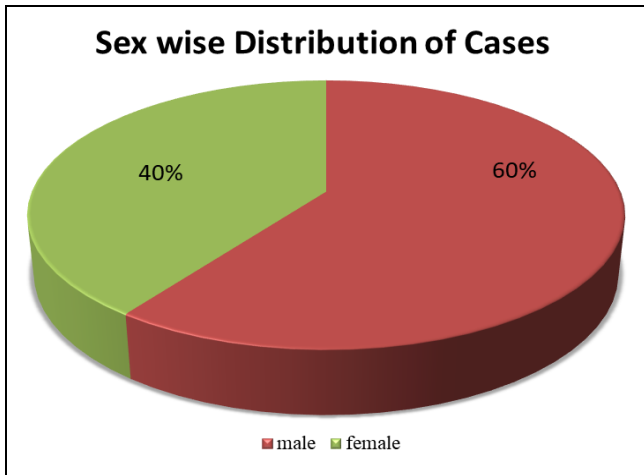


Chart 2: Distribution of Cases According to the Sex of the patient (n = 30)

Table 3: Distribution of Cases According to the occupation of the patient

S. No.	Occupation	Number of Cases	Percentage
1	Teacher	3	10%
2	Business	6	20%
3	House wife	6	20%
4	Students	7	23.3%
5	Nurses	2	6.6%
6	Sales man	2	6.6%
7	Driver	1	3.3%
8	Cooli	2	6.6%
9	Police	1	3.3%

Students are affected by 23.3% and hose wives and business doing patients are affected by 20% each. Teachers are affected by 10% and nurses ,sales mans ,coolies are affected by 6.6% each. Police and drivers are affected by 3.3% each.

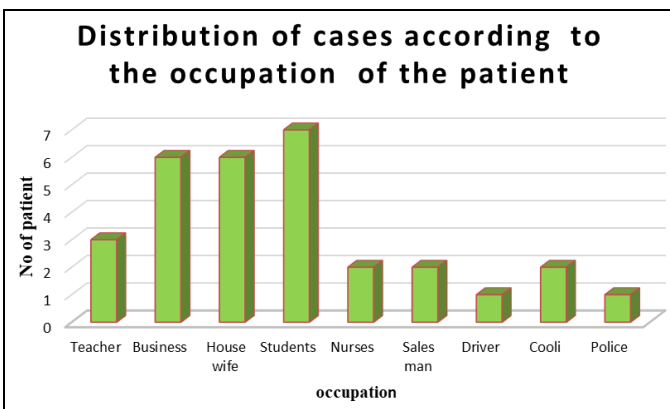


Chart 3: Distribution of Cases According to the occupation of the patient

Table 4: Distribution of Cases According To The fundamental miasm (n = 30)

S. No.	Fundamental miasm	Number of Cases	Percentage
1	Psora	17	56.66%
2	Sycosis	13	43.33%
3	Syphilis	0	0
4	Tubercular	0	0

Psora came for the fundamental miasm for 56.66% of patients and sycosis came for 43.33% of patients

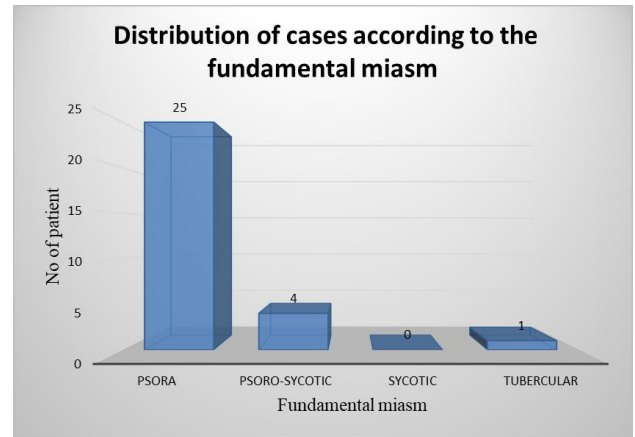


Chart 4: Distribution of cases according to the fundamental miasm

Table 5: Distribution of Cases according To the Dominant miasm (n = 30)

S. No.	Dominant miasm	Number of Cases	Percentage
1	Psora	25	83.33%
2	Psoro-Sycotic	4	13.33%
3	Sycotic	0	0
4	Tubercular	1	3.333%

Psora came as a dominant miasm in 83.33% of patients and Psoro-sycotic came for (13.33%), and tubercular for 3.33% of patients.

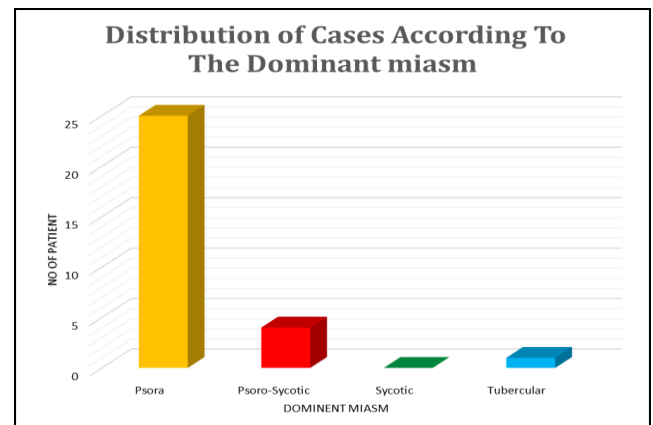


Chart 5: Distribution of Cases according To the Dominant miasm

Table 6: Distribution of Cases According to the Constitutional Remedy Used (n = 30)

S. No.	Remedies	Number of Patients	Percentage
1	Ars alb	2	6.66%
2	Bryonia	2	6.66%
3	Calcarea carb	4	13.33%
4	Kali carb	1	3.33%
5	Lycopodium	2	6.66%
6	Nat. mur	2	6.66%
7	Nitric acid	2	6.66%
8	Phosphorus	7	23.33%
9	Sulphur	8	26.66%

Sulphur is given as a constitutional remedy for 26.66% of patients and phosphorus for 23.33% of patients. Calcarea carb is given for 13.33% of patients and Ars. alb (6.66%), Bryonia (6.66%), Nat. mur (6.66%) Nitric acid (6.66%) Kali carb (3.33%) respectively.

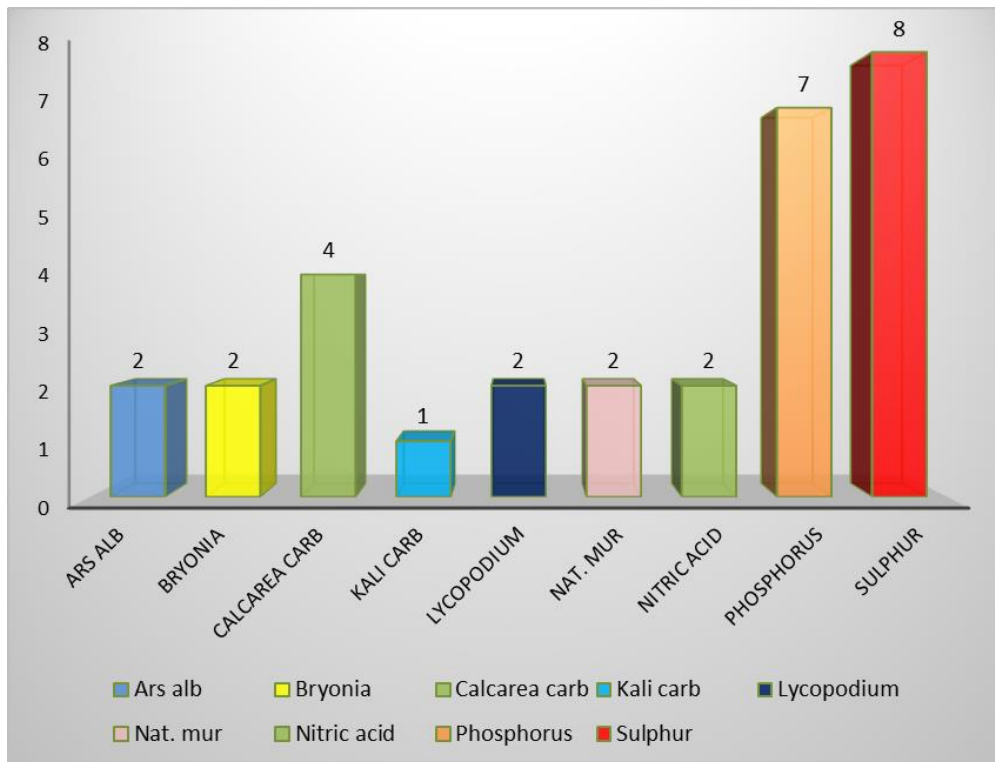


Chart 6: Distribution of Cases According To The constitutional Remedy Used

Table 7: Distributions of Cases According To the Treatment Outcome (n = 30)

S. No.	Treatment Outcome	Number of Cases	Percentage
1	Cured	20	66.66%
2	Moderate improvement	5	16.66%
3	Marked improvement	5	16.66%

66.66% of Patients are cured and 16.66% of patients are got moderate improvement and 16.66% got marked improvements.

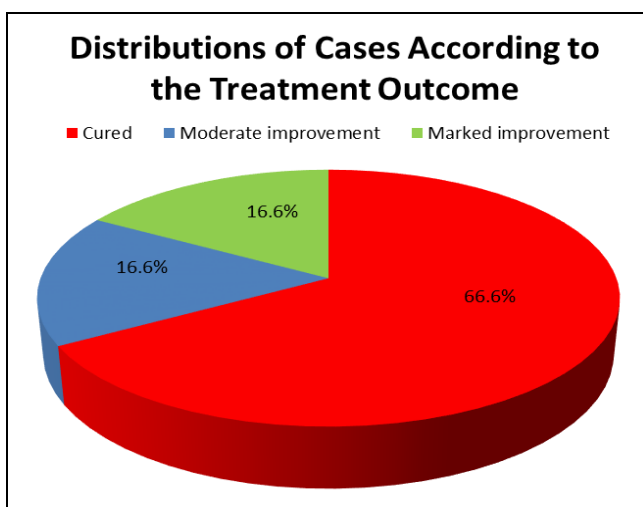


Chart 7: Distributions of Cases According to the Treatment Outcome

Summary and Conclusion

Thirty clinically diagnosed cases of Allergic Rhinitis were taken into consideration for the study. The patients were between the age group of 10-60 years. Patients of both sexes were treated. A detailed case history with the proper clinical

examination was done in all the patients.

The commonly affected age group according to my study were 21-30 (40%) and 31 – 40 (26.66%) years. Males are most commonly affected, which was evidenced by this study which shows presence on 63.00% of cases. Most of the affected persons were Students which were evidenced by this study which shows presence on 23.3 of cases. Psoric miasm background and Psoro-sycotic predominance played a dominant role in the occurrence of Allergic rhinitis in this study. Sulphur, Phosphorus and Calcarea carb were found to be most frequently indicated constitutional remedies in this Study. Most of the patients got complet cure (66.66%) and Remaining got Moderate to Marked Improvement (33.34%), indicating a need of longer time of treatment.

My study evidently shows that Allergic Rhinitis can be effectively treated with Homoeopathic medicines.

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