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Tonsillitis and homeopathic management

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Abstract
Inflammation usually occurs in children or adolescents. Tonsils may be involved in either inflammation of the pharynx or the tonsil alone may involved [5]. Because of the large number of upper respiratory infections that affect children, especially young children, infectious and inflammatory processes of the pharynx play a significant role in their health.

Keywords: Tonsillitis, homeopathic management, pharynx

1. Introduction

Sore throat is a common complaint and is usually associated with upper respiratory tract infections. Although it is largely a self- limiting problem, it causes significant morbidity and absence from school and high consultation rate in general practice [2].

All children will complain of sore throat at some time. Viral pharyngitis is by far the most common culprit. Viral pharyngitis is caused by a number of different pathogens including adenovirus, enterovirus, coxackievirus, and parainfluenza virus. It typically presents with nonexudative pharyngeal erythema and tender cervical adenopathy. It is frequently associated with other upper respiratory complaints such as rhinorrhea, nasal obstruction, cough, and fever [3].

2. Aetiology

Most sore throats have a viral etiology, especially in children under the age of 3 years. Viral pathogens include adenovirus, influenza and parainfluenza, Coxsackie A and Epstein-Barr virus (EBV), which are the causes of her angina and of glandular fever respectively. The primary bacterial etiology is group Abeta-hemolytic streptococcus [2].

3. Classification

3.1 Acute Tonsillitis

Maybe classified according to the depth of the inflammation, as follows:

- **Catarrhal:** This is the early stage of upper respiratory infections (UR1) and of acute infectious fevers like measles, infectious mononucleosis, etc. This is the least severe form, the tonsils appearing red. Transitory catarrhal sore throat ('red throat'), often the precursor of coryza, is not to be confused with acute tonsillitis.
- **Follicular:** The crypts become involved with discrete yellow patches of exudate and enlargement of regional glands.
- **Parenchymatous:** There is congestion and swelling of the entire organ.
- **Peri-tonsillar** abscess (quinsy) [11].

Beta hemolytic Streptococcus is the most important and common organism.

H. influenzae type B is occasionally responsible. Nursery, schoolrooms and dormitories favour spread.

3.2 Symptoms: Usually the onset is abrupt with shivering and pain in the throat which may radiate to the ears. Swallowing is painful, solid food being refused but drinks tolerated. Fever is 'sometimes high (39-40°), and convulsions may occur in the younger child. In the early stages, uniform injection of the throat is seen. Later, the tonsils look markedly red and congested as also the anterior pillars. In follicular tonsillitis, yellow beads of exudate at the mouths of the crypts which may coalesce to form a false membrane are seen. The anterior cervicalglands are tender and enlarged [11].

3.3 Chronic Tonsillitis

Complete resolution after a single attack of tonsillitis is usual. But if there are repeated attacks, the crypts retain the purulent material and the regional glands remain enlarged. At a later stage, the tonsil has a spongy enlarged appearance. Finally, after several attacks, the tonsil is bound down to its bed with fibrous tissues. This results in scars over the mouths of the crypts leading to retention within the tonsil of the infected material. This stage is found more frequently in adults but can also occur in children. Predisposing factors include post-nasal drip and breathing through the mouth [11].

3.4 Symptoms: Symptoms of chronic tonsillitis are more of a general rather than of a local nature.

History of frequent attacks of sore throat, some of which may be mild, can be elicited on questioning. The general symptoms are that the child tires easily, shows no eagerness to play and lacks pep. There may be disinclination for food and cyclical vomiting, there may be bad smell in the breath before break-fast (halitosis) and occasional attacks of abdominal pain, each attack being preceded by tonsillitis. The voice may become thick and episodes of recurrent bronchitis and obits media may ensue. In some cases nocturnal enuresis and night terrors can be attributed to chronic tonsillitis [11].

4. Physical Examination

1. General signs that maybe encountered are a thin pale child without the usual healthy sparkle, and the presence of dark circles under the eyes.
2. Local signs in the throat are a band of congestion down the free margins of anterior facial pillars, ‘flush of the anterior pillars’ and tonsils whose crypts appear spongy; purulent material cane expressed from the crypts on pressure, as distinct from the cheesy food debris which normally comes out on suitable application of pressure. The size of the tonsils is of much less importance; often it is small and buried in chronic infection, due to fibrosis, even in children. The cervical glands at the angle of the mandible become persistently enlarged [11]

5. Pathology

5.1 Acute Infection

Most episodes of acute pharyngo-tonsillitisare viral. Group A P-hemolytic Streptococcus (GABHS] is the most common cause of bacterial infection in the pharynx. Additional bacterial organisms may include other p-hemolytic streptococcal species (i.e., group C), Staphylococcus aurous, gram-negative organisms, Mycoplasma pneumoniae, and, rarely. Neisseriagonorrhoeae and Corynebacterium diphtheriae. Oral candidiasis may occur in immuno compromised patients or children who have been treated chronically with antibiotics [6].

5.2 Chronic Infection

The tonsils and adenoid may be infected chronically in a polymicrobial manner that may include a high incidence of p-lactamase-producing organisms. Both aerobic species, such as streptococci and Haemophilus influenzae, and anaerobic species, such as Peptostreptococcus, Prevotella, and Fusobacterium, predominate. The tonsillar crypts may accumulate desquamated epithelial cells, lymphocytes, bacteria, and other debris, causing cryptic tonsillitis. With time, these cryptic plugs may calcify into tonsillar concretions or tonsillolith [6].

5.3 Airway Obstruction

Both the tonsils and adenoid are a major cause of upper airway obstruction in children. Airway obstruction in children is typically manifested in sleep-disordered breathing, including obstructive sleep apnea, obstructive sleep hypopnea. And upper airway resistance syndrome [6].

5.4 Tonsillar Neoplasm

Rapid enlargement of one tonsil is highly suggestive of a tonsillar malignancy, typically lymphomain children [6].

6. Clinical Feature

Adenoidal hypertrophy may interfere with the passage of air through the nose, resulting in mouth-breathing (more so when the child lies supine during sleep).With development of gross adenoidal hypertrophy, the child tends to keep the mouth open during day time as well [10].

Accompanying manifestations include dryness of mouth and lips, persistent rhinitis, pharyngitis, snoring, nasal voice, offensive breath, impaired taste, bad smell, harassing cough, impaired hearing and chronic otitis media. Eventually, the child develops dull expression with open mouth and maloccluded teeth (adenoid facies). School performance suffers [10].

In a few cases, respiratory insufficiency may cause apneic spells, leading to arterial hypertension and, eventually, cor pulmonale [10]

6.1 Acute Infection

Symptoms of GABHS infection include dry throat, malaise, fever and chills, odynophagia, dysphagia, referred otalgia, headache, muscular aches, and enlarged cervical nodes. Signs include dry tongue, erythematous enlarged tonsils, tonsillar or pharyngeal exudate, and enlargement and tenderness of the jugulodigastric lymph nodes [6].

6.2 Chronic Infection

Children with chronic or cryptic tonsillitis frequently present with halitosis, chronic sore throats, foreign body sensation, or a history of expelling foul-tasting and smelling cheesy lumps. Examination may reveal tonsils of almost any size and frequently they contain copious debris within the crypts. Because the offending organism is not usually GABHS, streptococcal culture is usually negative [6].

6.3 Airway Obstruction

In many children the diagnosis of airway obstruction maybe made by history and physical examination. Daytime symptoms of airway obstruction, secondary to adenotonsillar hypertrophy, include chronic mouth breathing, nasal obstruction, hyponasal speech, hyposmia, decreased appetite, poor school performance, and, rarely, symptoms of right-sided heart failure. Nighttime symptoms consist of loud snoring, choking, gasping, frank apneas, restless sleep, abnormal sleep positions, somnambulism, night terrors, diaphoresis, enuresis, and sleep talking. Large tonsils are typically seen on examination, although the absolute size may not be indicative of the degree of obstruction. The size of the adenoid tissue may be

demonstrated on a lateral neck radiograph or with flexible endoscopy. Other signs that may contribute to airway obstruction include the presence of a craniofacial syndrome or hypotonia [6]

6.5 Tonsillar Neoplasm
The rapid unilateral enlargement of a tonsil, especially if accompanied by systemic signs of fever, weight loss, and lymphadenopathy, is highly suggestive of a tonsillar malignancy. The diagnosis of a tonsillar malignancy should also be entertained if the tonsil appears grossly abnormal [6].

7. Investigation
- Clinical impression ofadenosis needs to be confirmed by ' digital palpation during the first few years of life.
- Later, indirect visualization with a pharyngeal mirror or fiberoptic bronchoscope, or a lateral pharyngeal X-ray may help in confirming the diagnosis [10].

8. General Management
8.1 Medical Management
The treatment of acute pharyngotonsillitis. For antibiotic treatment of GABHS.Because co-pathogens such as staphylococci or anaerobes may produce p-lactamase that may inactivate pencillin, the use of cephalosporins or clindamycin may be more efficacious in the treatment of chronic throat infections. children with cryptic tonsillitis may be able to manually express tonsillolith or debris with either a cotton tipped applicator or a water jet. Chronically infected tonsillar crypts may be cauterized using silver nitrate [6].
- Tonsillectomy
- Adenoidectomy
- Tonsillectomy And Adenoidectomy

9. Complication
- Acute Pharyngotonsillitis
- Perironsillar Abscess
- Retropharyngeal Space Infection
- Parapharyngeal Space Infection
- Chronic Pharyngotonsillitis
- Chronic Airway Obstruction

10. Homeopathic Repertory
Tonsilitis has been found to be represented with certains remedies in the following repertory.

10.1 Kent's Repertory
Throat Internal - PAIN - Tonsils
Alum.am-c. Benz-ac.calc-p.Caust.crot-t. graph. Hep.kali-bi. kali-p. lach. Merc-i-f.najaraph. Tarent [4].

Throat Internal - Swelling - Tonsils
Acon.alumn. alum. Am-c.ant-t. Apis arum-t.Aur. BAPT. BAR-C.BAR-M. BELL. berb. brom. bufoCALC.Calc-p.Calc-s.canth. Carb-ac.carbn-s.cedr. CHAM.Chel.coc-c. Colch.cop. Crot-t. Dulc.fago. ferr-p. Fl-ac.Gels.Graph.Guaj.guare. ham. HEP.hippoz. ign. Iod.Kali-bi.kali-c. Kali-chl.Kali-i.kali-p. kali-s. LAC-C.LACH.led. LYC.Manc.Merc.Merc-c.Merc-cy.Merc-i-f.Merc-i-r.Mur-ac.nat-act.nat-s. nicc. NIT-AC.nux-v.PHOS.PHYT.plat. Plb.puls.Ran-s.raph. Sabad.sep. SIL.sol-ni. stann. Staph.SULPH.tarent. tep. thuj. verat. Zinc [4].

10.2 Murphy repertory
Throat - Tonsillitis, infection, tonsils
Acon.aesc. Ail. ALUMN. aml-ns. anan. ant-t. anthraci. ApisArs.bad. Bapt.BAR-C.Bar-m.BELL.benz-ac. berb. bufoCanth.Caps.cedr. Cham.chel. Chen-a.Colch.Crot-h.Cupr.cur. Dulc.ferr-p. Fl-ac.Gels.GUAJ.ham. HEP. Ign.Iod.Kali-bi.Kali-chl. kali-p.LAC-C.LACH.Lyc.MERC.Merc-cy.MERC-D.Merc-i-f.Merc-i-r.najaNat-s.NIT-AC.Phyt.Plb.Psor.puls. Sabad.Sang.sep.SIL.Staph.still. Sulph.tarent. ust. verat. vesp. Zinc [7]

10.3 Boger Boenninghausen's Characterstic materia medica and repertory
Mouth - Throat (and gullet) - inflamed - tonsils
ACON.alum. AM-C.Apisarg-n. Arn.arum-t. aur. Bapt. bar-c.BELL. brom. calc. CANTH. caps. CHAM. colch. crot-h. Dulc. Ferr-p.gels. Guaj. HEP. IGN. iod.kali-i. LACH.LYC. Mang. MERC. Merc-c.Merc-i-r.mez. NIT-AC.NUX-V. PHOS. Phyt.plb. PULS.sang. sep.STAPH. sulph. thuj.

11. Homeopathic management
11.1 Mercurius
- Parenchymatous tonsillitis, throbbing type of pain, tonsils and fauces yellowish-red, often covered with a thin false membrane;
- Tongue pale, flabby and indented by the teeth; pain on deglutition and speaking; pain on empty swallowing; salivation increased
- Throat sore externally when pressed upon; tonsils dark-red,studded with ulcers.
- Quincy with stinging pain in fauces; when pus has formed it hastens maturation [8].

11.2 Lachesis
- Throat purplish, patient very nervous, least touch unbearable; tonsils swollen, lefts<with tendency to right; inability to swallow, threatening suffocation.
- Liquids escape by the nose when swallowing is at tempted and are more difficult to swallow than solids.
- <from hot drinks; on swallowing burning pains shoot in left ear; pus from tonsils unhealthy, with tendency to degenerate into ulcers; excessive dryness, particularly if it appears in spots, <by inhaling cold air.
- It may break up the disease in its conception or promote resolution in later stages [8].

11.3 Baryta Carb
- Liability to quincy after every cold or suppressed sweat of feet; tonsils tend to suppurate, especially the right.
- Throat feels worse from empty swallowing; pricking sensation when swallowing; general malaise; palate swollen; chronic induration of tonsils.
- Sensation as of a plug in throat, worse when swallowing solids; paresis of muscular structure of throat.
- Scrofulosis, enlargement of glands in neck, under jaws and behind ears [8].

11.4 Baryta Muriaticum
- Chronic hoarseness from enlarged tonsils, which may also be indurated; difficulty of swallowing.
- Mercurial odor from mouth, unnoticed by himself, whole mouth full of vesicles, especially inside of

mouth.
- Great salivation; elongation of uvula with hyperaemia and blennorrhoea; catarrh extends over tonsils, epiglottis, glottis into tubes.
- Disposition to tonsillitis with suppuration each time, after every cold or checking foot-sweat [8].

11.5 Lac Caninum
- Tonsils inflamed, shining and very sore, swollen so as almost to close the throat.
- Suppuration from left to right, or changing from side to side, or both tonsils equally affected.
- Whole posterior portion of throat oedematous; tonsils enlarged; pricking, cutting pains from empty swallowing ;great dryness of tonsils at night; throat sensitive to touch externally; ashy-gray exudation [8]

11.6 Phytolacca
- Chills alternating with fever; great weakness.
- Tonsils large, ulcerated; intense dryness of throat
- Rough, burning, smarting fauces; pain in throat extends to ears when swallowing.
- Aching in back, neck, head and limbs; ulceration on tonsils and fauces; with grayish-white sloughs and little or no foetor; cannot drink hot fluids; great prostration.[8]

11.7 Hepar Sulph
- Chronic tonsillitis, especially when accompanied by hardness of hearing, with sensation like splinter or fishbone in throat when swallowing.
- Sharp, lancinating pains, throbbing, rigors and chills, with stitches in throat, extending to ears, worse when swallowing; cannot bear cold air. [8]

11.8 Cantharis
- Apthous ulcers on right tonsil and atback part of fauces, covered with a whitish, adherent crust; throat inflamed, with intense burning, and covered with plastic lymph.
- Swallowing very difficult,< at night, when drinking,>when lying down [8]

11.9 APIS Mellifica
- Stinging-burning pain when swallowing.
- Red and highly inflamed tonsils; deep ulcers on tonsils and palate, with erysipelatous or oedematous appearance around ulcers.
- Oedema glottides, tenacious mucus in throat.
- <heat or hot drinks,> from cold or cool drinks. [8]

11.10 Belladonna
- Tonsillitis, worse right side, parts bright-red, worse swallowing liquids; during deglutition.
- Sensation as if throat were too narrow and as if nothing would pass properly.
- Rapidly forming aphthous ulcers on tonsils.
- Intense congestion, throbbing of carotids; swelling of neck.
- Externally painful to touch and motion [8]

11.11 Kali Bichrom
- Tonsillitis herpetica with membranous exudations.
- Inflammation of uvula and pharynx, foul, yellow tongue, fauces covered with ropy mucus.
- Eustachian tubes blocked up; pain shoots from ear down throat [8]

11.12 Phosphorus
- Tonsils and uvula much swollen.
- Dry, shining, polished, glistening, stinging and raw feeling< towards evening and when talking; hawking of heavy mucus morning and forenoon with horrible taste.
- Often feels quite cold in mouth [8].

11.13 Mercurius Iod. Flav
- Hypertrophy of tonsils with enlargement of cervical and salivary glands.
- Inflammation of the mucous membrane of mouth and pharynx, which is succulent and freely secreting [8].

11.14 Lycopodium
- Tonsils enlarged, indurated and studded with many small ulcers.
- Swelling and suppuration of tonsils, going from right to left.
- Chronic enlargement of tonsils;< from cold drinks, and smarting in throat from hot drinks [8]

11.15 Rhux Toxicodendron
- Erysipelatous swelling of throat.
- Tonsils covered with yellow membrane.
- Intense pain on swallowing
- Constant aching and bruised feeling; sticking or stinging pain on tonsils.
- < when beginning to swallow and at night [8]

12. Conclusion
Homeopathy is a system of medicine which is approach the sick by not considering the single disease entity but its holistic approach. Homeopathy having much efficacy in treating tonsillitis because of its individualistic approach to treat the sick with dynamic and potentised medicine.

13. References
1. Boger CM. M.D. Boger Boenninghausen's Characteristics and Repertory with corrected and abbreviations and word index; B, jain publishers, 457.
2. Forfar and Arneil's Text Book of Pediatrics. 6th edition, 775.
3. Ghai OP, FIAP, FAAP, Former Professor and Head, Department of Paediatrics and Dean, All India Institute of Medical Sciences, New Delhi; Essential Paediatrics;6th Edition; DrGhai Published, 338.
4. Kent JT, AM, Repertory of the Homoeopathic MateriaMedica B, jain publishers, 460, 469.
5. Ramalingam KK, MB, FRCS, DLO A Short Practice of Otolaryngology Second edition.All India Publishers, 291.
6. Richard E, Behrman MD, Nelson Text Book of Pediatrics- 17 thedition, 138, 139.
7. Robin Murphy MD, Homoeopathic Medical Repertory A Modern Alphabetical and Practical Repertory. 3rd revised edition, B. Jain publishers, 472.
8. Samuel Lilienthal. Homoeopathic Therapeutics, B, jain publishers page no 1035,1036,1037, 1038.
9. Surajgupte MD. FIAP Director children's health center professor and head, pediatric unit government medical college and associated hospitals jammu, india. The Short Text Book of Pediatrics 10th edition

jaypeebrothers medical publishers, 676.
10. Viswanathan J. formerly professor of pediatrics, madurai medical college Achar's Text Book of Pediatrics 3th edition. 498, 499, 500.