



International Journal of Homoeopathic Sciences

E-ISSN: 2616-4493
P-ISSN: 2616-4485
www.homoeopathicjournal.com
IJHS 2023; 7(4): 82-93
Received: 05-08-2023
Accepted: 13-09-2023

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Management strategy of various types of hypertensions amid scientific substantiations for practice of Homoeopathy

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DOI: <https://doi.org/10.33545/26164485.2023.v7.i4b.961>

Abstract

Management of various types of hypertension in Homoeopathy is an immense skill through repertorial process in Homoeopathy. In this article, not only management of essential hypertension with its diverse features described but also management of portal hypertension and pulmonary hypertension is described. The management of pulmonary hypertension is described through a novelty in post-repertorial result analysis by 'Bridging Technology in Repertorisation', a model discovered by me is described with model cases of pulmonary hypertension.

Keywords: Essential hypertension, portal hypertension, pulmonary hypertension, bridging technology in repertorisation

Introduction

Arterial blood pressure refers to 'the force of circulating blood on the walls of the arteries' [1]. "Systolic blood pressure refers to the maximum pressure within the large arteries when the heart muscle contract to propel blood through the body" [2]. "Diastolic pressure denotes the lowest pressure within the large arteries during the heart muscle relaxation during diastole" [3].

Haemodynamics of essential hypertension: The systemic arterial blood pressure is the lateral pressure of blood upon vessels through which it flows. The equation of arterial blood pressure is derived by the formula of Ohm's law ($V = IR$, where V is potential difference measured by voltage, I is the current flowing through the conductor and R is the resistance of conductor at a constant temperature) [4] i.e. $\Delta P = F \times R$ where ΔP is the pressure gradient between two ends i.e. $P_1 - P_2$, F is the blood flow which is directly proportional to cardiac output, and R is denoted for resistance here it is peripheral resistance of vessel through which blood is flowing [5]. So in other words, B.P. = Cardiac output (CO) for blood flow $F \times$ Peripheral resistance (PR) for Resistance of vessel through it blood is flowing. So arterial blood pressure is directly proportional to the cardiac output, so when cardiac output increases due to intake of excess salty food, or salty drink or physical exercise or mental tension, the Blood pressure also rises. Similarly the arterial blood pressure is directly proportional to peripheral resistance. So when more the peripheral resistance due to arteriosclerosis or atherosclerosis, more the increase of blood pressure. The sympathetic tension due to grief, anger, tearfulness etc. also causes constriction of blood vessels, palpitation and high rise of B.P. The normal arterial blood pressure is $120 \pm 20 / 80 \pm 10$ mmHg [6]. The systolic blood pressure represents brain function i.e. the sympathetic tension and diastolic blood pressure represents heart and blood vessels conditions and function i.e. it rises in atherosclerosis, arteriosclerosis and due to water retention by excess mineral corticoids secretion by which the blood vessels retains sodium and water and thus B.P. rises.

For example, intake of salt if increases it retains more water, as a result blood volume increases. So, in high blood pressure (hypertension) less salt and in low blood pressure (hypotension) more salt intake should be prescribed. Force of pumping action of heart is regulated by mental and physical tension. In mental tension sympathetic nerves are activated and blood vessel constriction occurs. Blood vessels constriction also occurs due to secretion of adrenalin in mental tension. Similarly in physical tension like pain and exercise the blood pressure increases. In pain blood pressure increases due to adrenalin secretion and in exercise blood pressure increases due to forceful pumping of heart and simultaneous venous return.

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‘Cardiac output increases in more salt intake, weight gain, mental tension due to sympathetic nerve activation’^[7] and adrenalin secretion and in physical pain due to more adrenalin secretion causing vasoconstriction is the cause of essential hypertension and cardiac output increases in exercise due to forceful contraction of heart and simultaneous venous return.

Peripheral resistance increases also in mental tension due to activation of sympathetic tone and adrenalin secretion. Permanent increase in peripheral resistance occurs in atherosclerosis due to hyperlipidaemia in obesity and hyperlipidaemia of thin people due to diabetes or genetic predisposition for hyperlipidemia. Taking oil or fat – rich food also contribute to high blood pressure. “Atherosclerotic plaque can also break off or damage a blood vessel, possibly leading to a heart attack or stroke. Blood pressure higher than 130/80 is seen in 69% of the people who have their first heart attack, 77% of the people who have their first stroke and 74% of the people who have congestive heart failure”⁸. Arteriosclerosis occurs in sclerotic changes in vessels due to old age and diabetes.

Another two types of high blood pressure (hypertension) also occur in human body. Those are (i) Portal hypertension and (ii) Pulmonary hypertension.

Portal hypertension occur in case of liver fibrosis due to cirrhosis of liver where the vessels are constricted resulting pressure in portal vein. Portal hypertension also occur in congestive cardiac failure where the liver is the vulnerable to systemic back pressure. “Portal hypertension is increased pressure within in the portal venous system. A pressure gradient of 6 mmHg or more between the portal and hepatic veins (or inferior venacava) suggests the presence of portal hypertension in many cases”^[9]. In portal hypertension, collateral circulation is established and piles is the result of collateral circulation. So, in piles if it is due to portal hypertension or congestive cardiac failure, bleeding piles should not be surgically or medicinally intervened as bleeding from piles act as a safety valve for reducing excess pressure preventing catastrophe.

Pulmonary hypertension occurs in cor pulmonale where pressure in Pulmonary aorta increases due to dilatation and subsequent hypertrophy of right ventricle due to damage of alveoli in chronic bronchial asthma, chronic bronchitis and cystic fibrosis of lungs.

“Pulmonary hypertension is a type of high blood pressure that affects the arteries in the lungs and right side of the heart. In one form of pulmonary hypertension, called pulmonary arterial hypertension (PAH), blood vessels in the lungs are narrowed, blocked or destroyed. The damage slows blood flow through the lungs, and blood pressure in the lung arteries rises”^[10]. Occurs in congenital heart diseases such as aortic stenosis and acquired heart disease due to rheumatic fever in childhood where the mitral stenosis and aortic stenosis generally occur. “A value of 35 – 50 mmHg. At pulmonary aorta considered as mild pulmonary hypertension, value of 50-70 mmHg. At pulmonary aorta considered as moderate pulmonary hypertension and value 70 mmHg. And above at pulmonary aorta, is considered as severe pulmonary hypertension. Normally we all work with pulmonary aorta pressure of 20 mmHg.”^[11] “A mean pulmonary arterial pressure greater than 25mmHg at rest or greater than 30 mmHg at exercise considered as pulmonary hypertension.

The World Health Organisation (WHO) has divided

pulmonary hypertension into five groups on the basis of similarities in pathophysiology, clinical presentation, and therapeutic options. These group include the following: Group 1 – Pulmonary arterial hypertension (PAH), Group 2 – Pulmonary hypertension due to left sided heart diseases, Group 3 – Pulmonary hypertension due to lung diseases and/or hypoxia, Group 4 – Chronic thromboembolic pulmonary hypertension (CTEPH) and Group 5 – Pulmonary hypertension with unclear or multifactorial etiologies, including haematological disorders, systemic disorders (e.g., Sarcoidosis, Pulmonary Langerhans cell histiocytosis, neurofibromatosis, vasculitis and lymphangioliomyomatosis), metabolic disorders (e.g., Glycogen storage disease, Gaucher disease, thyroid disorders), and miscellaneous conditions (e.g., tumor obstruction, mediastinal fibrosis, chronic renal failure on dialysis)”^[12].

Management of various types of blood pressure related problems

1. Management for arterial low blood pressure or hypotension: Hypotension is not the disease in true sense, it is the low blood pressure below 110/70 mmHg due to anaemia, protein energy malnutrition, and in adolescence due to demand of body. There is no medicine for it but patient should be given natural juices which are richer in iron and electrolytes such as cane sugar juice, pome granate juice, apple juice, Carrot – tomato-beet root mixed juice, coconut water etc. More protein foods like sprouted grams, peanuts, walnuts, almonds, are to be taken. In lunch soyabean curry, beet root – carrot curry is more to be taken. For non veg people liver and fish are the best. *The table salt is to be little increased i.e., with in 3 grams / day* as American heart Association recommends no more than 2,300milligrams /day^[13].

2. Management of high primary arterial blood pressure or essential hypertension: The primary / essential hypertension is due to sympathetic overtone and oilier and saltier dietic habit. So in this case when blood pressure is more than 140/90 mmHg. The first management is *Nidanasyabar janam* which means the cause is to be eradicated first. The oilier and saltier food first is to be restricted. The salt is to be limited to no more than 1,500 miligrams/day in essential hypertension as per American Heart Association^[13]. In pregnancy salt should not be restricted as the foetal circulation is restricted. Daily walking for 2 kilometers advised. Kapal vati and Vastrik pranayama is advised which has creates parasympathetic stimulation for nullification of sympathetic stimulation acquired through mental tension. More fruit juice especially citrus fruits such as lemon, orange, and grapes are advised as vitamin C relieves mental tension. After all this endeavor, if high blood pressure is not reduced, then medication is to be given.

Homoeopathic medication

1) In mild hypertension blood pressure between 140/90 – 160/90, if it is due to sympathetic overtone due to excess pressure in office, Kali phosphoricum or Nux vomica acts well as per indication. Kaliphosphoricum at morning and evening Nux vomica while going to bed can relieve the blood pressure in much social tension

causing hypertension. Later constitutional medication is to be advised as intercurrent medication. I had success of hundreds of cases when I find the systematic essential hypertension is due to mental tension or work load tension.

- 2) In severe hypertension blood pressure above 160/100 mmHg., 'Rawlofia serpentina mother tincture' [14, 15] (Q) 10 – 15 drops, thrice daily with water should be taken in empty stomach. Reserpine alkaloid derived from Rawlofia serpentina has been banned in modern medicine due to its side – effect but in extract form it has no side effect and working well in severe hypertension because its side effect is neutralized due to another two alkaloids Rawlofin and Rowlofinin.
- 3) In old age where both atherosclerosis and arteriosclerosis occur, so pathological approach is to be made. The Glonine is the drug which dilates the arteries as it is coronary vasodilator in crude state, that same happens in potentized state. In arteriosclerosis rubric of Murphy's repertory [16] Glonine is the 2nd grade remedy. I treated a 76 year old person with Glonine 30CH every 6 hourly when all medicine failed to control severe hypertension of 180/110 mmHg. If hypertension with cardiomyopathy or with already heart disease 'Craetegus mother tincture'¹⁷ can be taken.
- 4) **Repertorial approach in Management of Essential Hypertension**
 - a) If we are using Kent's repertory, there is no hypertension rubric. So we can take the rubric 'Orgasm of blood from Generalities chapter of Kent's repertory' [18]. The particular annoying rubric such as throbbing headache or heaviness of head and/or dizziness can be taken. Head, pain, pulsating for Hypertension or tension headache. Headache due to hypertension or mental tension rubric in Kent's repertory is Head, pain, Excitement for the emotion after. If tension headache is due to excess heat, then rubric head, pain, heated from becoming etc.
 - b) Similarly, if we are using BCCR, there is no hypertension rubric in BCCR. We can take 'Circulation, Ebullition, surging or rush of blood, orgasm of blood' [19] is indicated from subchapter circulation. Then we can take the particular annoying rubric e.g., headache, dizziness, heaviness of head etc.

Management of portal hypertension: Portal hypertension is due to cirrhosis of liver [20]. Cirrhosis of liver is due to alcohol consumption called alcoholic type and due to viral hepatitis particularly due to Hepatitis B, Hepatitis C and Hepatitis D viruses. If due to alcohol patient has to quit alcohol immediately. Nux vomica 30CH is the best medicine for tackling withdrawal syndrome and also it is best medicine for cirrhosis of liver. In hepatitis B, C, or D infection and subsequent cirrhosis of liver 'Myrica cerifera mother tincture to 3CH' [21] may be needed. The constitutional medicines are for hot patient Bryonia, Lycopodium, Natrum mur., Pulsatilla and Sulphur; and for chilly patient Nux vomica, Phosphorous, Phosphoric acid, and Sepia.

Management of pulmonary hypertension: A value of 35 – 50 mmHg. at pulmonary aorta considered as mild pulmonary hypertension, value of 50 – 70 mmHg. at

pulmonary aorta considered as moderate pulmonary hypertension and value 70 mmHg. Above at pulmonary aorta is considered as severe pulmonary hypertension. Normally we all work with pulmonary aorta pressure of 20 mmHg. The pulmonary aorta pressure increases in Congenital or acquired Aortic stenosis, Mitral stenosis, and in Cor pulmonale. The patient is suffering from pulmonary hypertension with right ventricular and right atrial hypertrophy can be understood by P pulmonale [22] feature of ECG i.e., peak P waves. Then the echo-cardiography reveals the value of pulmonary blood pressure.

Management of pulmonary hypertension is possible when we have to manage the cause. For example, pulmonary hypertension causes lung bed congestion and later pulmonary oedema. Due to lung bed congestion, there is repeated cough. So, if we can relieve the cough think of causative anomalies, may be lung bed congestion or pulmonary oedema due to aortic stenosis or mitral stenosis. For both aortic stenosis and mitral stenosis both are may be congenital diseases or acquired from rheumatic fever both being state of syphilitic miasm state. So, *Aurum metallicum* is the drug of choice. In repertorial approach, we have to consider both cause and effect. Here I have utilized the Bridging technology of repertorisation in a congenital aortic case to bridge between cause and effect.

Case of Congenital aortic stenosis with pulmonary hypertension [23]: Master 'X' of 3 years 1 month old had on dated 26-7-2001. In Echocardiogram it was revealed that the patient was suffering from the Congenital Aortic Stenosis with mild left ventricular hypertrophy but having the normal biventricular function done on dated 14-07-2001.

He used to suffer the cough with asthmatic symptoms every month for 10-12 days in spite of taking allopathic bronchodilator and expectorant syrup. When he came to me, he had course crepitations all over lungs and no ronchi probably due to action of allopathic remedies. Haemoglobin was 8 gm%, Total W.B.C. count was 16,850/cmm. Of blood signifying the infection. In Differential Leucocyte Count, Polymorphs. -53%, Lymphocytes-42%, Eosinophils-4%, Monocytes-1%, and Basophils-0%. His ESR was 25 mm. at 1st hour in Westerngreen method. PPG: 50mmHg. All these pathological tests was done on dated 23-07-2001. His cough was aggravating at night, in cold weather. He had always blockage of nose.

Evaluation of symptoms

Congenital cause: Aortic stenosis.

Left ventricular hypertrophy: Effect of cause.

Heart disease causing path. General: Anaemia.

Which again acting as a cause for susceptibility to infection and cold suffering.

Difficulty in breathing due to heart problem.

The causative modality of difficulty in breathing

Cold temperature & Aggravation in night

The susceptibility-tendency to catch cold, developed due to heart problem, chronic lungs affection, and anaemia. The obstruction of nose, due to tendency to catch cold. The delayed mile-stone-slow in learning to walk, developed due to heart disease, anemia and prolong respiratory illness.

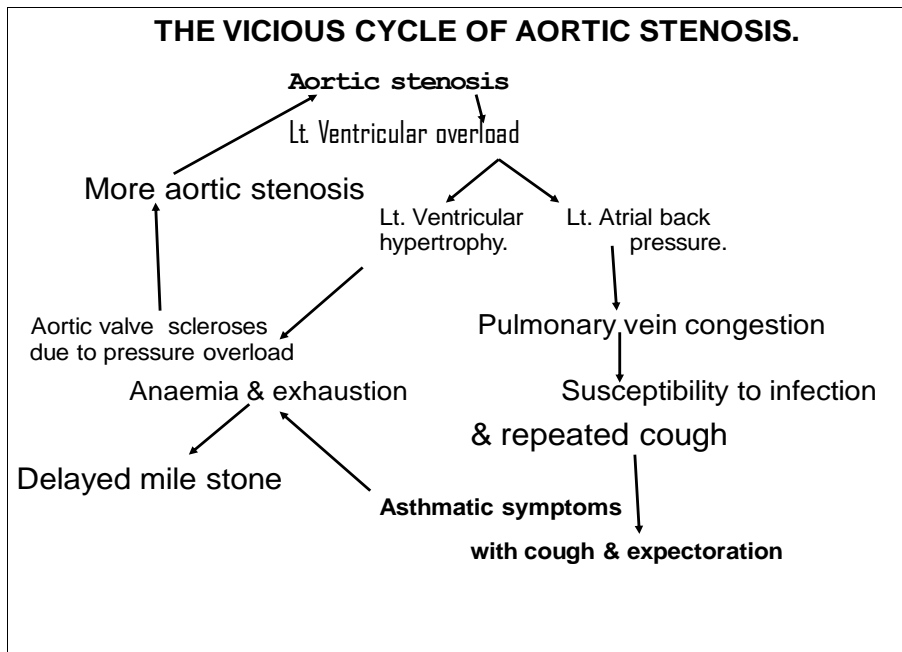


Fig 1: Vicious cycle of Aortic stenosis causing repeated cough and asthma

Repertorisation by 2nd Edition of Murphy’s repertory

Table 1: Repertorisation table of Aortic stenosis case

Medicine	Blood, arterio-sclerosis	Heart, Hypertrophy of	Anaemia, Heart disease from	Breathing, Difficult, Heart problem with	Cough, cold, temp. becoming on	Generals, Cold Tendency To take	Time, in general, night	Obstruction, nose
Ars. Alb.	1	2	1	1	3	2	3	2
Aur.	2	3	---	1	---	---	2	1
Glonine	2	2	---	2	---	---	---	---
Cactus	1	3	---	2	---	---	1	---

Arsenicum album: 17/8, *Aurum metallicum*: 9/5, Glonine: 6/3, Cactus.: 8/4

Method of Analysis: Mean of Pathological rubrics as cause-Mean of Clinical rubrics as effect i.e. (Blood, arteriosclerosis + Heart, hypertrophy + Anaemia, heart disease from + Breathing difficult heart disease from / 4) – (Cough cold temperature becoming on + Cold, tendency to take + Nights + Nose obstruction children)/4

In case of *Arsenicum album*

$$(1 + 2 + 1 + 1/4) - (3 + 2 + 3 + 2 / 4) = 1.25 - 2.5 = 1.3$$

In case of *Aurum mettalicum*

$$(2 + 3 + 0 + 1/4) - (0 + 0 + 2 + 1/4) = 1.5 - 0.75 = 1.25$$

In case of Glonine

$$(2 + 2 + 0 + 2/4) - (0 + 0 + 0 + 0)/4 = 1.5 - 0 = 1.5$$

In case of Cactus

$$(1 + 3 + 0 + 2/4) - (0 + 0 + 1 + 0/4) = 1.5 - 0.25 = 1.25$$

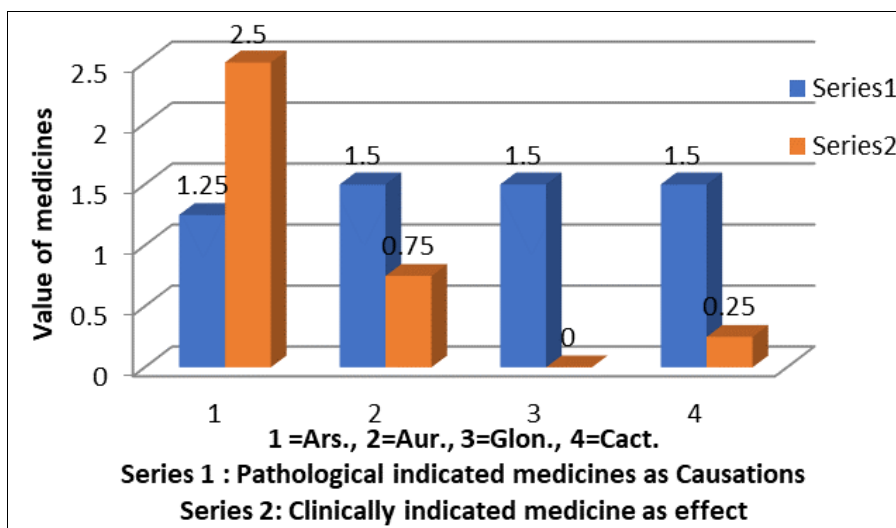


Fig 2: Comparative study of pathologically indicated medicines (Series 1) & Clinically indicated medicines (Series 2)

Evaluation: *Aurum metallicum* is selected as it has highest value in Pathological causation indicated medicines i.e. 1.5 and 0.75 value in Clinically indicated medicines compared to Glonine (0 value) and Cactus (0.25 value) in clinically

indicated medicines. In 50 milisimal scale of *Aurum metallicum* was given once daily. Patient was alright for six years and at the age of nine he was operated and now he is well and doing job.

Eccocardiogram Report

REGIONAL DIAGNOSTIC CENTRE
(Hubli Regional Medical Imaging Centre Pvt. Ltd.)

360333
261216
Fax : 360253

Ref. No. _____ Date: _____

2-D ECHO-CONVENTIONAL - COLOUR DOPPLER REPORT

Name - [REDACTED]	Age - 4YRS/M
Clinical Diagnosis - C.H.D.	Date - 14-06-01
Referred By - Dr. JOSHI M.D.	Case No. - 21569

IMAGING

Imaging in various views revealed -

- * SDS.
- * Normal venous connections
- * Intact cardiac septae.
- **The Left Ventricle shows concentric L.V.H.**
- **The Aortic Valve is thickened, bicuspid and domine.**
- * The Mitral, Tricuspid, and Pulmonary valves are normal.
- * Left aortic arch / No coarctation
- * No PDA.
- * No clots / vegetation's
- * Good biventricular function.

CONCLUSIONS

- ★ **MODERATE CONGENITAL BICUSPID AORTIC STENOSIS. PPG - 50mmHg.**
- ★ **L.V.H.**
- ★ **GOOD BIVENTRICULAR FUNCTION.**

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Fig 3: Echo cardiogram report of Aortic stenosis case before treatment

Pathology Report after treatment

Lab.: 352503
Res.: 251183

PATIENT'S NAME [REDACTED]	AGE / SEX 31 M	Dr. H. B. KOTBAGI M.D.(PATH) PODJA DIAGNOSTIC LABORATORY 10 A, EUREKA TOWERS, 1ST FLOOR, TRAFFIC ISLAND, HUBLI - 580 029.	PATIENT'S NAME [REDACTED]	AGE / SEX 31 M	Dr. H. B. KOTBAGI M.D.(PATH) PODJA DIAGNOSTIC LABORATORY 10 A, EUREKA TOWERS, 1ST FLOOR, TRAFFIC ISLAND, HUBLI - 580 029.
REF. By <i>Dr. Mahasana</i>	DATE 11.2.2007	LAB. NO.	REF. By	DATE 14.13.07	LAB. NO.

INVESTIGATIONS			INVESTIGATIONS		
HAEMATOLOGY			HAEMATOLOGY		
Haemoglobin % :	10.4 g/dl	NORMAL VALUES Male : 14.0-17.0 G/dl. Female : 13.5-16.5 G/dl.	Haemoglobin % :	11.4 g/dl	NORMAL VALUES Male : 14.0-17.0 G/dl. Female : 13.5-16.5 G/dl.
Total W. B. C. Count :	4520/cu. mm.	4000-11000/cu. mm.	Total W. B. C. Count :	5,300 cu/mm.	4000-11000/cu. mm.
Differential Count :			Differential Count :		
Neutrophils :	59%	40-75%	Neutrophils :	64%	40-75%
Lymphocytes :	38%	20-45%	Lymphocytes :	34%	20-45%
Eosinophils :	02%	01-06%	Eosinophils :	02%	01-06%
Monocytes :	02%	02-10%	Monocytes :	00%	02-10%
E. S. R. :	20	Male : 0-5 mm. Female : 0-10 mm.	E. S. R. :	35 mm / 1st hour	Male : 0-5 mm. Female : 0-10 mm.
Peripheral Smear Examination :			Peripheral Smear Examination :		

weight - 12 kg

Dr. H. B. KOTBAGI
M.D. (Path.)

Fig 4: Pathological report of Aortic stenosis case after treatment by Homoeopathy

Discussion: In this case infection subsided as evident from reduction of WBC, symptoms of cough and asthmatic attack subsided but Pulmonary hypertension remain as fixed because it was congenital heart disease. When pulmonary hypertension is due to cor pulmonale, the causation is lungs. So we can give more importance to lungs symptoms with additional importance to heart. Here is an example of the cor pulmonale treatment where more importance is given to lungs with additional importance to heart.

A Case of right ventricular failure (My Dr. B. D. Jatti Homoeopathic Medical College and Hospital experience)
[24]

Where pulmonary hypertension due to *cor pulmonale* [*Cor pulmonale* can be defined as alteration in structure (e.g., hypertrophy or dilatation) and function of the right ventricle (RV) of the heart caused by a primary disorder of the respiratory system resulting in pulmonary hypertension]²⁵, the lungs affection is the cause. So cause and effects are to be bridged using the Bridging technology in Repertorisation. Miss “Y” of 15 years old girl was admitted in Dr. B. D. Jatti Homoeopathic Medical College Hospital on 11th Day of March, 2002, by Dr. P. B. Patil with I.P.

No.756 and I was entrusted to take case and prescribe. During admission she had the complaints of Breathlessness since 10 days with cough which was aggravated by lying down, night and cold, and cold weather. There was swelling of lower limbs with occasional pain since three days. Patient had history of occasional fever. On examination, central cyanosis was found. Ronchi with crepitations all over the chest. Liver was enlarged little (two fingers). Her physical generals revealed that her appetite was less as little excess of food causes the more difficulty in breathing. Perspiration during eating. Bowel movement was two times a day. There was occasional burning urination. Sleep was disturbed due to cough and breathlessness. She was aggravated by cold and rainy weather. Mense was once in 2-3 month intervals, flow for 3-4 days. Her growth was retarded. Respiration rate 18/minute. Pulse rate 76/minute, regular. Temperature 97^oF. B.P. 110/78 mmHg. Rontgenogram of Chest done on 13th Day of March 2002 revealed accentuated lung markings with nodular opacities of both the lungs field. Trachea central. Both hilar shadows are enlarged and prominent. Transverse diameter of the cardia increased with prominent pulmonary artery. Both domes low placed and flat. Costo and cardiophrenic angle clear.

HUBLI SCAN CENTRE
6-13, LGF, Eureka Junction, Travellers Bungalow Road, HUBLI - 580 029. ☎ : 257828, 257838, 257848. Fax : 353949

2-D ECHO-CONVENTIONAL - COLOUR DOPPLER REPORT

Name- [REDACTED] Echo No. - 0571
Age - 15years / Female Date - 16/03/2002
Referred By Dr. DR. S.S. MAHARANA
Clinical Diagnosis - L.V. Function

PROCEDURES - M-MODE/2D/DOPPLER/COLOUR/CONTRAST B.S.A. M2

MEASUREMENTS	OBSERVED	NORMALS
- Aortic Root Diameter	2.1	2.0-3.7cm<2.2cm/ M2.
- Aortic Valve Opening	1.8	1.5-2.6cm.
- Right Ventricular Dimension	3.9	0.7-2.6cm<1.4cm/ M2.
- Left Atrial Dimension	2.7	1.9-4.0cm<2.2cm/ M2.
- Left Ventricular ED Dimension	3.4	3.7-5.6cm<3.2cm/ M2.
- Left Ventricular ES Dimension	1.8	2.2-4.0cm.
- Interventricular Septal Thickness	0.8	0.6-1.2cm.
- Left Vent. PW Thickness	ED-0.7	0.5-1.0cm.
- IVS/ LVPW		1.5<

INDICES OF LEFT VENTRICULAR FUNCTION:

- Mitral E-Septal separation.	0.4	< 0.9cm.
- Minor Axis Shortening	40%	24-42%
- LV Ejection Fraction	70%	60 +6.2%

DOPPLER (PW)

MV	-	0.8m/sec.	MR	-	NIL
AoV	-	1.0m./sec.	AR	-	NIL
TV	-	0.6m/sec.	TR	-	III
PV	-	0.8m/sec.	PR	-	II

IMAGING
Imaging in various views revealed -

- SDS.
- Normal venous connections.
- Intact Cardiac septae.
- The Aortic, Mitral, Tricuspid, and Pulmonary valves are normal.
- The Left Ventricle is normal in size and function.
- Enlarged PA/RV/RA/IVC/HV.
- There are no Intra cardiac clots or vegetation.
- The pericardium is normal.
- No coarctation / PDA.

COLOUR FLOW

- SEVERE TR / MILD PR.

CONCLUSIONS

- SEVERE PULMONARY HYPERTENSION P5P AP 100mmHg.
- STRUCTURALLY NORMAL CARDIA.
- RV DYSFUNCTION.

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MD, DM (Card) (Hon)
CARDIOLOGIST

Fig 5: Echo cardiography report of cor pulmonale case before treatment

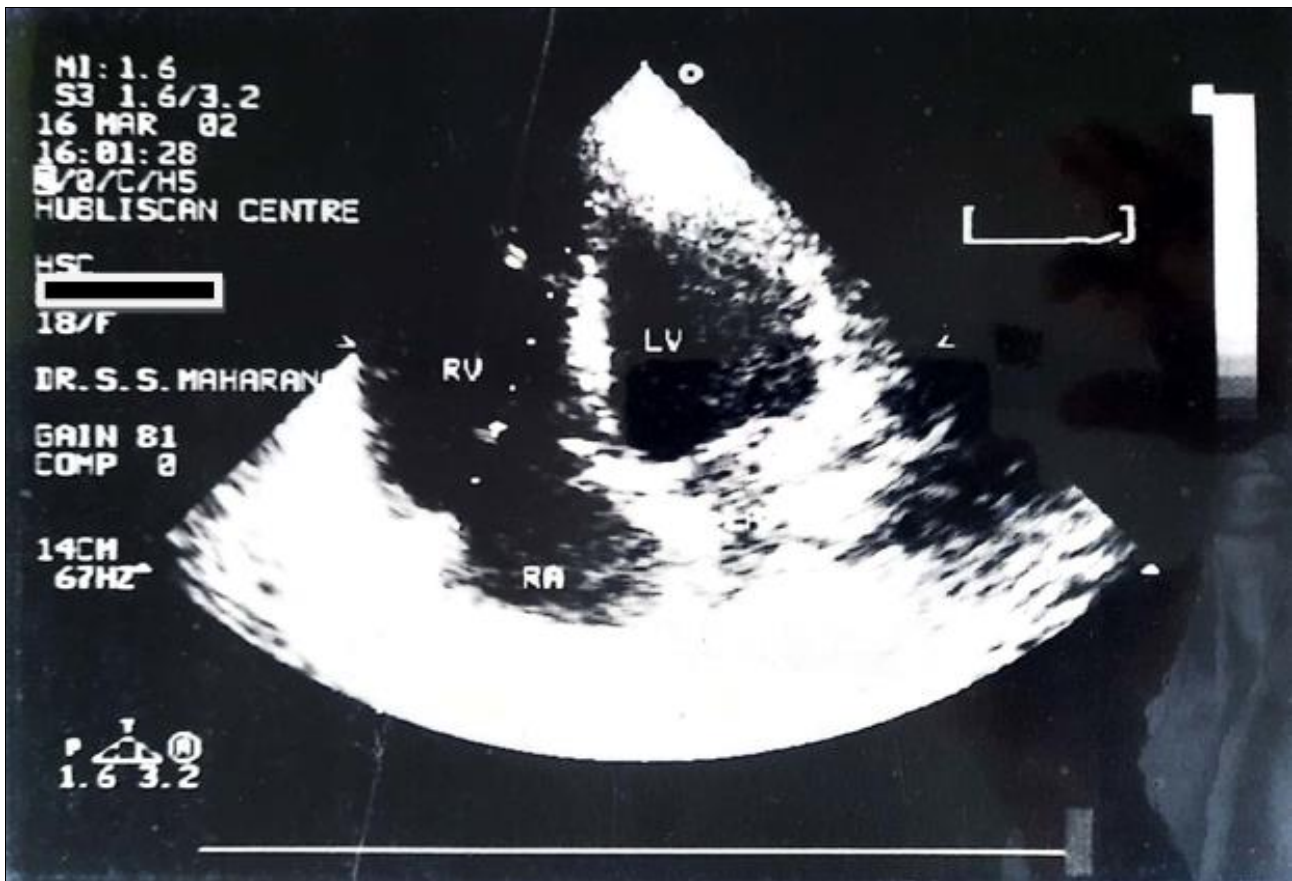


Fig 6: Echocardiogram of pulmonary hypertension of cor pulmonale case before treatment

So Echocardiogram was done suspecting the right ventricular failure (Cor Pulmonale). The Echocardiogram revealed that there are enlarged Pulmonary Aorta, enlarged Right Ventricle, enlarged Right Atrium, enlarged Inferior Venacava. Colour flow showed severe tricuspid regurgitation and mild pulmonary regurgitation. The conclusion was severe pulmonary hypertension PSP AP 100mmHg. Right Ventricular dysfunction.

On 14th Day of March Haemoglobin was 10gm%, ESR=60 mm at 1st hour by Westerngreen method. Total leucocyte count was 9,400cells/Cu.mm. Differential Leucocyte Count revealed Neutrophils-56%, Lymphocyte - 34%, Eosinophils-10%.

So she was on Spongia 3x, 6 hourly in due course which has the symptoms of cough aggravated at night, breathlessness. Saw like respiratory sound (ronchi) crepitations along with right ventricular hypertrophy. By spongia 3X, cough, breathlessness and cyanosis decreased but heart rate remain in between 120/minute to 140/minute. So we had to give vagal stimulation by rubbing the both the carotid tringle slowly. When pulse rate comes to 80/minute we stopped. In this way three times a day I had to give every 8 hourly. On 9th day of April 2002 the Differential Leucocyte Count revealed Neutrophils - 52%, Lymphocytes-40%, Eosinophils-6%, Monocytes-2% and ESR-25mm at 1st hour by Westerngreen method.

On 28th April 2002 in night 3 PM she vomited a big elongated cylindrical clot of 10 centimetes length and of 1 centimeter diameter. I was called and found that patient had hurried respiration but no ronchi or crepitations. Then I gave a dose of Carbo veg. 30CH and open fan with full speed and below fan she sat in an armed chair. Dr. Patil that day gave me full responsibility of case in writing. Then I thought we

have to repertories the case because patient had come to us with full hope from Orthodox Govt. Hospital. I took case again and repertorised with Murphy's repertory which is as follows:

Analysis & Evaluation of Symptoms:

Constitutal Causation: Tendency to take cold.

Causative Modalities

1. Breathing aggravated during night
2. Breathing aggravated during sleep
3. Breathing aggravated after eating

Pathological Genererals

1. Hypertrophy ofHeart
2. Congestive Heart failure
3. Cyanosis
4. Oedema, dropsy heart disease
5. Anaemia

Physical Generals: 1. Mense too late 2. Perspiration eating while 3. Bleeding from lungs and chest.

Here by analysis of the case, we find that the constitutional cause and causative modalities are the precipitating factor for the bronchial asthma and in long run the bronchial asthma lead to the cor pulmonale. The cor pulmonale is responsible for the portal hypertension by hypertrophy of heart which give rise to the pulmonary edema and a wet lungs field give rise to the frequent susceptibility to suffer from bronchial asthma in a vicious cycle as follows:

Causative Modalities →Frequent Bronchial Asthma→Emphysma → Cor Pulmonale → Pulmonary Hypertension → Congestive Heart Failure → Pulmonary Edema→Congested Lung Field→More Suceptibility Tobe

Affected By Causative Modalities → Frequent Attacks Of Bronchial Asthma. Figure - 6

technology was done between Pathological Generals and the Causative Modalities with physical generals.

Thus the pathological generals as well as causative modalities and physical generals are here are both important. Therefore, the comparative study by the bridging

Repertorisation by Murphy’s repertory with Repertorial Totality ^[15]

Table 2: Repertorisation table of Cor pulmonale case no. 2

Medicines	Heart, hypertrophy of(A)	Cyanosis(B)	Edema, dropsy, from heart d(C) heartdisease (C)	Pulmonary Edema(D)	Congestive heart failure(E)	Anaemia(F)	Cold tendency to take(G)	Colds, go to Chest(H)	mense late too(I)	Perspiration, eating while(J)	Difficult, breathing Night dur.(K)	Breathing difficult lying while(L)	Breathing difficult eating after (M)	Bleeding from Lungs & chest (N)
Acon.	3	0	0	0	3	0	3	0	2	0	1	0	0	3
Ars	2	2	3	3	0	3	2	1	1	1	3	3	1	3
Aur	3	1	0	0	0	0	0	0	2	0	2	2	2	0
Ant-t	0	2	0	3	0	2	1	1	0	1	2	2	0	2
Carb.v	0	3	0	2	0	2	2	1	1	3	2	3	2	1
Cact.	3	0	2	0	0	0	0	0	0	0	0	0	0	3
Dig.	2	3	2	2	1	1	1	0	1	0	2	2	1	2
Lach.	2	3	3	3	1	2	1	0	3	0	3	1	3	2
Lyc.	2	0	3	3	0	1	3	0	3	0	2	2	2	1
Phos.	2	1	1	2	1	3	3	2	2	1	3	2	3	3
Puls.	2	1	0	1	2	3	2	0	3	2	2	2	3	2
Spig.	2	0	0	2	0	1	1	0	0	0	0	2	0	0
Spong.	3	1	0	0	0	0	0(3)*	0(3)**	0	0	2	2	0	0
Sulph.	0	1	0	2	1	3	2	0	3	0	3	2	2	1

*The symptom taken from Hering’s Guiding Symptoms i.e.,IIAsthma; from taking cold.

** The symptom taken from Hering’s Guiding Symptoms i.e.,IIWet Weather,< Cough.

Then we find the remedies as per their values:

Acon.-15/6, Ars.alb.-28/13, Aur.-12/6, Ant.t-16/9, Carbo.v-22/11, Cactus-8/3

Digitalis-20/12, Lachesis-27/12, Lyc.-22/10, Pulsatilla-25/12, Phosp.-29/14, Spigellia-8/5

Sulphur-20/10, ***Spongia-14/6

***By including the values from Hering’s Guiding Symptoms in repertorisation.

By using the Bridging Technology in Repertorisation, we consider

$$\frac{\text{Pathological general rubrics}}{\text{No. of rubrics}} \quad \frac{\text{Clinical \& Constitutional rubrics}}{\text{No. of rubrics}}$$

$$\frac{\text{Heart, Hypertrophy} + \text{Breathing, cyanosis} + \text{Edema, from heart disease} + \text{Pulmo. edema} + \text{Congest. heart failure} + \text{Blood, anaemia}}{6}$$

$$\frac{\text{Cold, tendency to take} + \text{Cold, go to chest} + \text{Mense, late too} + \text{Perspira. eating while} + \text{Difficult breathing night during} + \text{Difficult breathing lying while} + \text{Difficult breathing eating while} + \text{Bleeding from lungs \& chest}}{8}$$

In case of Arsenic album

$$\frac{2 + 2 + 3 + 3 + 0 + 3}{6} \quad \frac{2 + 1 + 1 + 1 + 3 + 3 + 1 + 3}{8} = 2.16 - 1.87 = .29$$

In case of Lachesis

$$\frac{2+3+3+3+1+2}{6} - \frac{1+0+3+0+3+1+3+2}{8} = 2.3 - 1.62 = .7$$

In case of Phosphorous

$$\frac{2+1+1+2+1+3}{6} - \frac{3+2+2+1+3+2+3+3}{8} = 1.66 - 2.37 = -.7$$

In case of Pulsatilla

$$\frac{2+1+0+1+2+3}{6} - \frac{2+0+3+2+2+2+3+2}{8} = 1.5 - 2 = -.5$$

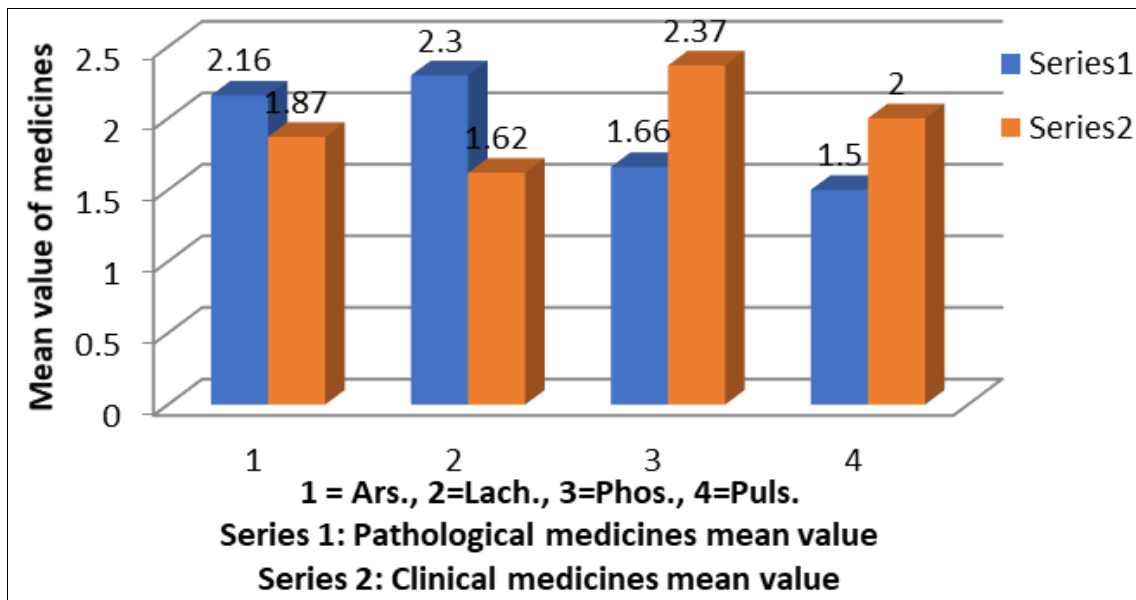


Fig 7: Comparative study of Pathologically medicines mean value & Clinically indicated medicines mean value

Multiple Bar Diagram – 2

So for finer differentiation in bridging technology, we have to consider the clinical and constitutional symptoms more, the causative modalities and general modalities of which gave rise to precipitation of bronchial asthma leading to cor pulmonale and till now are stimuli for asthmatic attack. Then the selection should be in the basis of high mean valued clinical and constitutional rubrics keeping them as constant, the higher mean value in pathological general rubrics should be chosen amongst high mean value constants. Here Phosphorous had secured highest mean value in clinical and constitutional rubrics (2.37) and simultaneously had third highest value in Pathological general rubrics (1.66) over Pulsatilla. Hence Phosphorous LM 1, once daily was started on 29th day of April 2002. Then till 13th May 2002, patient did not suffer frequently breathlessness in cold and rainy weather. When occasionally suffered little breathlessness Spongia 3x was given one dose

s.o.s. as phosphorous cannot be repeated so often even in 50millisimal scale. The pulse rate remained between 80 - 90/minute. Aspidosperma mother tincture 10 drops thrice daily was given as it was better remedy for pulmonary hypertension and known as Digitalis of Lungs. Now on 18th Day of May 2002, the Haemoglobin revealed of 12gm%, ESR-05mm at 1st hour by westerngreen method, Total Leucocyte count was 8,800cells/Cu.mm, Differential Leucocyte Count revealed Neutrophils-64%, Lymphocytes-28%, Eosinophils-6%, Monocytes-2% which shows sign of prognosis. In this case PPG decreases from 100 mmHg. to 75mmHg.

After remaining another month patient was discharged for home with advice of continuing Phosphorous LM 2 once in a month. In this schedule she survived another 5 years.

Thus in this case the bridging technology in repertorisation helped me in managing the acute phase of right ventricular failure.

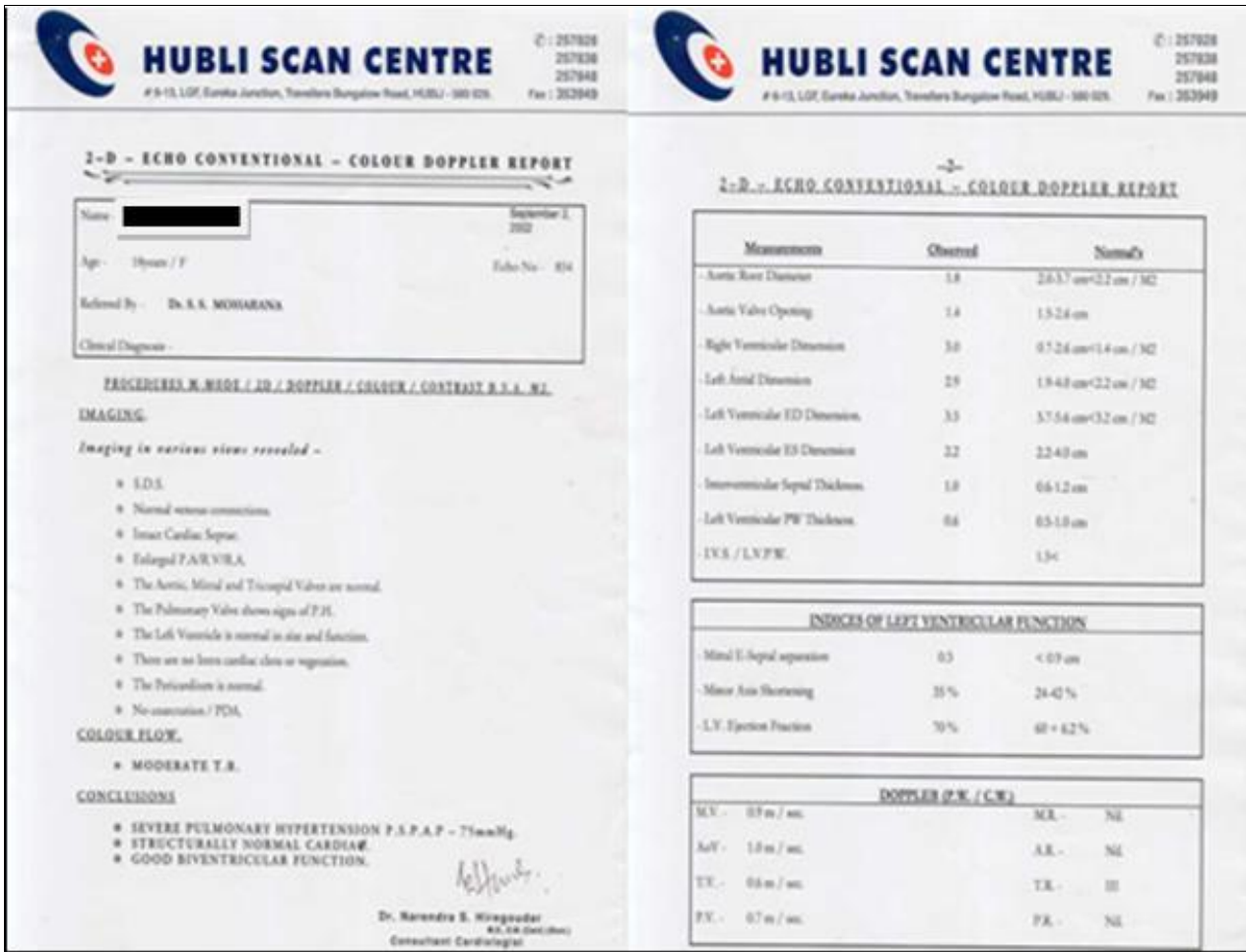


Fig 7: Echocardiogram report of pulmonary hypertension due to cor pulmonale after treatment

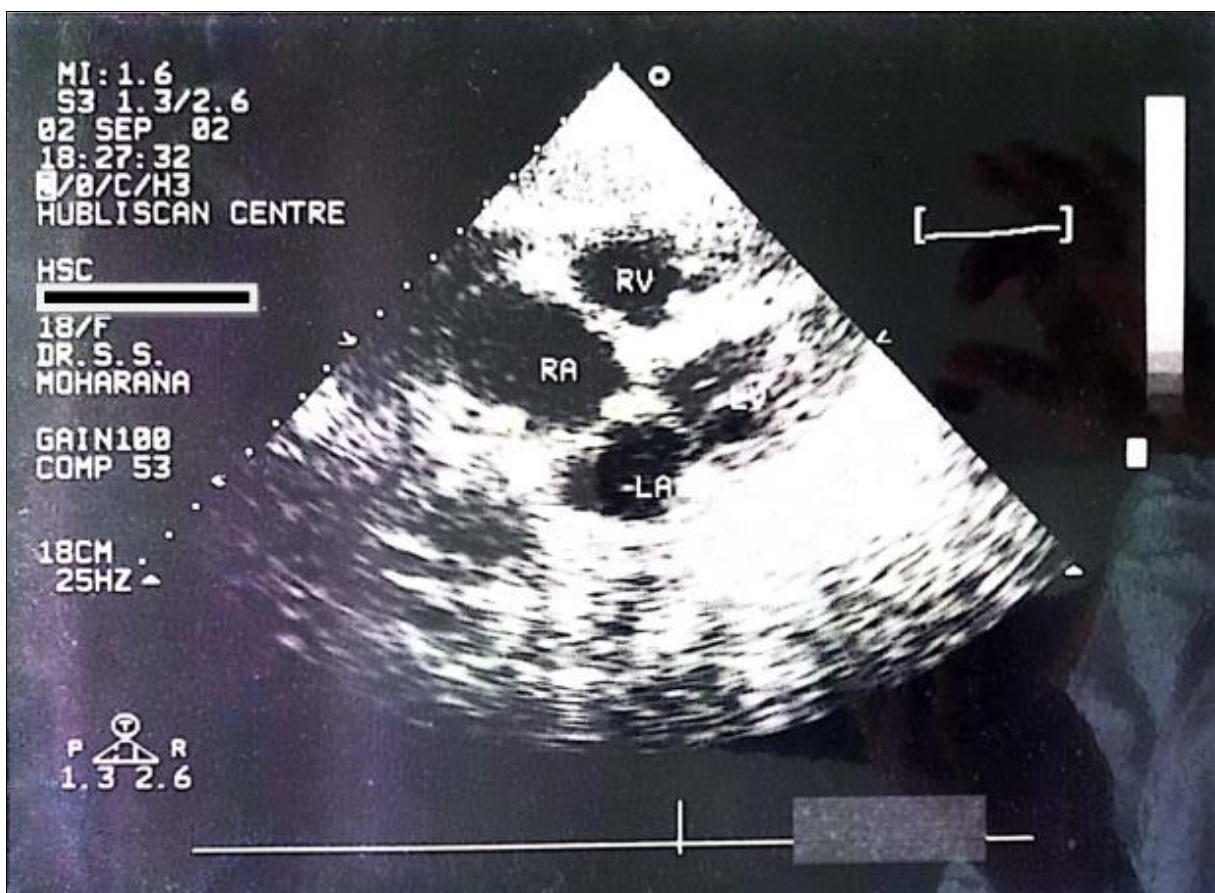


Fig 8: Pulmonary hypertension features of cor pulmonale after treatment

Conclusion

Hypertension in general is the life style disorder except pulmonary hypertension. Regular brisk walking, kapal vati and vastrik pranayam, restricted salt intake except in pregnancy, tension free social life keeps the person free from essential hypertension. The portal hypertension can be treated by changing lifestyle disorder also. Alcohol consumption, tobacco and pan consumption or any intoxicant consumption should be banned. Taking Sattvic food such as fruits and roots without cooking, bland cooking food without spices, Kapalvati pranayam, Vastrik pranayam, and daily walking minimum 2 kilometers twice daily (morning and evening) is the prevention of portal hypertension and also cure of mild liver affection. In moderate and severe portal hypertension along with these practices medication is necessary.

In Pulmonary hypertension, if it is due to congenital causes homoeopathic treatment is the best treatment (example, 1st case). Additional Homoeopathic Mother tincture like aspidosperma, creatus, etc. is helpful. If pulmonary hypertension is due to cor pulmonale, the lungs symptoms are treated with high importance along with heart problems (example, 2nd case).

Thus we conclude that in all the three types of hypertensions lifestyle change to simple, aesthetic manner and homoeopathic medication is the best treatment as first line of management.

Acknowledgement

I, Dr. Sudhansu Sekhar Moharana, author of this article sincerely showing my gratitude to the staff, management and Principal of Dr. B. D. Jatti Homoeopathic Medical College and Hospital for providing opportunity for managing such case of *cor pulmonale* with pulmonary hypertension during my tenure as staff there and presented in International Conference conducted by Malaysia chapter of Asian Homoeopathic Medical League (AHML) at Kota Bharu on 9th September 2002. Now I am sincerely showing my gratitude to Staff, Management, Principal of Dr. B. D. Jatti Homoeopathic Medical College and Hospital and Editorial board of LIGA Internationalis 2012 (Case no. 1) and Editorial board of AHML Malayasia Chapter of 2002 (Case No. 1 and 2) for publishing this article in 'International Journal of Homoeopathic Sciences' for better understanding in Homoeopathy and for further development and research in Homoeopathy.

Conflict of Interest

Not available

Financial Support

Not available

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How to Cite This Article

Moharana SS. Management strategy of various types of hypertension amid scientific substantiations for practice of Homoeopathy. International Journal of Homoeopathic Sciences. 2023;7(4):82-93.

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