Homotoxicology and treatment of the ENT (Ear, Nose and Throat) sphere

By the Medical Writer

SINUSITIS

Sinusitis affects one in three people at some point in their lives. In the US it is estimated that 32 million persons each year get chronic sinusitis, and it is also a common disease worldwide. It is more common in areas where there is high atmospheric pollution. A damp, temperate climate with higher concentrations of pollen also contributes to the disease.

Pathophysiology

Key factors involved in the development of sinusitis are the size of the osteomeatal complex, the movement of the cilia and the accumulation of mucus. When the ostia are blocked, mucus accumulates, the ciliary action is lost and the mucous membrane becomes hyperplastic. This comprises a breeding ground for bacteria and viruses. Initially only one type of aerobic bacteria is seen, but as the disease progresses anaerobes, mixed flora and also increasingly fungi will colonize the sinuses, especially in immune-compromised patients.

Classification

Many classifications have been proposed, both clinical and radiological. In general acute sinusitis is seen as a disease which resolves completely in four weeks, subacute sinusitis progresses for 4-12 weeks and chronic sinusitis extends beyond 12 weeks.

Diagnosis

The diagnosis of sinusitis is mostly made on clinical grounds. The patient presents with a variety of symptoms including nasal discharge, stuffy nose, postnasal drip, facial pain and headache, stuffy ears, unproductive cough and often an exacerbation of asthma. Radiological diagnosis is made from CT scan. X-ray evidence is poor and MRI scanning is not advised.

Antihomotoxic Therapy

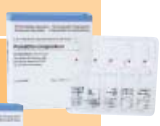
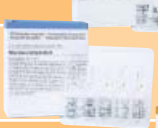
The homotoxicological treatment is aimed at several points, namely, the swelling of the mucus membrane and patency of the osteomeatal complex, drainage of the mucus and restoration of the milieu of the sinus cavity. In chronic recurrent sinusitis it is especially important to address the problem of chronic intoxication, immune dysregulation and also the integrity of the mucous membrane. As sinusitis becomes more chronic, the three pillars of homotoxicology, namely detoxification and drainage, immunomodulation, and organ strengthening are needed to restore the patient to health. It is also important to remember that if a mucous membrane is affected, then all of the mucous membranes of the body may be affected, and therefore mucosal resuscitation with Mucosa compositum or Endoteel as well as a good probiotic is imperative in the treatment of sinusitis.

Acute Sinusitis

Symptomatic remedy	Action	Dose
Euphorbium compositum/ Euphorbium Sinus Relief	Symptomatic remedy, antiviral	2 sprays four times per day in each nostril or 1 oral vial per day or 10 drops 3x/day
Naso-Heel/Nareel	Symptomatic remedy, especially for thick mucus	Initially 10 drops every half hour for 12 doses then 10 drops 3x/day
Traumeel	Immunomodulation, anti-inflammatory	10 drops or 1 tablet 3x/day or 1 oral vial per day
Lymphomyosot/Lyphosot	Drainage	10 drops or 1 tablet 3x/day or 1 oral vial per day
Echinacea compositum	"Antibacterial", may increase neutrophils	1 oral vial per day for five days or 1 tablet 3x/day for five days


Chronic Sinusitis

Symptomatic remedy	Action	Dose
Euphorbium compositum/ Euphorbium Sinus Relief	Symptomatic remedy, antiviral	2 sprays four times per day in each nostril
Pulsatilla compositum	Reactivation of the connective tissue, symptomatic in sinusitis	1 oral vial 3x/week
Mucosa compositum/Endoteel	Support of the mucous membrane, possible immunomodulation	1 tablet or 10 drops 3x/day or 1 oral vial 3x/week
Coenzyme compositum and Ubichinon compositum or Ubicoenzyme	Organ strengthening, deep detoxification	1 tablet of each 3x/day or 1 oral vial 3x/week or 10 drops 3x/day
A good probiotic should be added to help restore the mucous membrane	Restoration of the mucosal milieu, immunomodulation	As per manufacturer's instructions


Practical tip: The oral vials can be mixed together with a few milliliters of saline and given as an inhalation, through a standard nebulizer (a device, pressurized by an oxygen tank, for the purpose of converting a liquid medication into a fine mist to be administered into the nose).

OTITIS EXTERNA

This is defined as an inflammation of the outer ear canal, which also may include the auricle. A number of factors contribute to the development of otitis externa. The disease is especially common in athletes participating in water sports, and it is also more common in tropical, humid countries. People wearing hearing aids (and constantly wearing earphones) are also more prone to the condition, as well as patients suffering from eczema, allergic rhinitis or asthma.

Pathophysiology

There is normally a reduction in the cerumen in patients prone to this condition. Cerumen protects the skin and inhibits bacterial growth. A reduction in cerumen leads to the drying of the skin of the outer ear, which often causes itching with scratching as a natural result. If the external canal is obstructed with excessive cerumen or debris, or if the canal is particularly tortuous, water may be trapped, also leading to infection.

Signs of infection

The symptoms may include earache, itching, puslike discharge, hearing impairment. On examination there is tenderness on pulling the earlobe, discharge, which may be purulent, and in some patients even cervical lymphadenopathy. Fever is an uncommon symptom.

Antihomotoxic treatment

Symptomatic remedy	Action	Dose
Mercurius-Heel S	Antibacterial action	Acute: 1 tablet every 30 minutes (max. 12x/day) then 1 tablet 3x/day
Graphites-Homaccord	Especially good in eczema	10 drops 3x/day
Abropernol	Symptomatic remedy	1 tablet 3x/day
Cutis compositum/Cutisitum	Supportive of skin function	1 tablet or 10 drops 3x/day

The external ear canal should be kept clean and dry. In severe cases Traumeel ear drops (also known as Oteel in certain countries) can be inserted several times a day and a cotton swab can be inserted to drain the discharge of pus.

ALLERGIC RHINITIS

Symptomatic remedy	Action	Dose
Luffa comp.-Heel/Luffeel/BHI Allergy	Symptomatic for allergy	The following treatment schedules are suggested. A) For patients with symptoms recurring annually: start treating 1-3 months before the allergy season; 1 tablet 3x/day. B) For patients with less pronounced symptoms (i.e. from experience of the previous year), application of the nasal spray alone may be tried. Even so, treatment should start at least 3 weeks before the critical season. In all instances, treatment should continue for 3 weeks after the critical season. During this period, the dose can be reduced to 1 tablet per day.
Regulatory treatment		
Detox-Kit	Detoxification	10 drops of each 3x/day
Coenzyme compositum and Ubichinon compositum or Ubicoenzyme	Cellular activation and deep detoxification	1 tablet or 10 drops 3x/day or 1 oral vial per day
Mucosa compositum/Endoteel and Glandula suprarenalis suis-Injeel	Organ support	1 oral vial 3x/week or 10 drops 3x/day
Cortison-Injeel or Pulsatilla compositum	Detoxification of the matrix after cortisone use	1 oral vial 3x/week

Further points to consider:

When treating allergic rhinitis from an antihomotoxic point of view a few important aspects should be observed:

- Allergic rhinitis is classified in the impregnation phase of the six-phase table. It is thus a relatively difficult condition to treat.
- Allergic rhinitis always starts gradually, over years, and will also regress (regressive vicariation) gradually over years. The therapist and the patient thus need to have patience in this matter. The typical way allergy regresses is that it improves every year. This is better observed in patients with seasonal allergies than in patients with perennial allergies.
- The allergen is mostly not the culprit; it is the patient's aberrant immune system which will tend to have predominant Th2 response of the T cells in response to an innocuous protein. Through sensitization over several exposures, Ig E is produced by the B cells which will then bind to the mast cells on repeated exposure. The mast cells will then degranulate to release a host of inflammatory mediators, notably histamine and bradykinin, among others.
- Patients with Th2 predominance often have inherited this tendency. It is known that if both parents are allergic, 50% of their offspring will be allergic, and if one parent is allergic, 25% of their offspring will be allergic.
- The aim of treatment is thus not to avoid the allergen or treat the symptoms, but to achieve a so-called Th1/Th2 switch.
- Antihomotoxic medicine may be ideally suited to do this, as it has the potential to induce the so-called Th3 cells, which will then modulate the Th1, Th2 response (see Medical Summaries).
- Due to the fact that the Th3 cells are most abundant in the mucosal membranes, when one treats allergies, the medications are best given orally, nasally or in the case of eye drops on the conjunctiva. Inhalation with a nebulizer is often a very efficient way to deliver the medication, as are devices such as the Adapplicator®. Oral vials, tablets and drops are also better suited than injection therapy, as one wants to increase the oral tolerance.
- This method is also now widely adopted by allergists, who give diluted amounts of an antigen by mouth in order to induce tolerance. This method is called SLIT (sublingual immune therapy)
- It is important though to remember that the whole immune system is the problem, and not only one or two antigens.
- Due to the fact that this condition is in the impregnation phase, all three pillars of homotoxicology are employed in the treatment: detoxification and drainage, immunomodulation/organ strengthening and cellular activation.