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The Therapy of Chronic Bronchitis

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by H. Winterberg, M.D.

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Summary:

This presentation summarizes standpoints concerning the etiology, pathology, and therapy of chronic bronchitis as held by conventional medicine. Elaboration follows within the framework of biological medicine, especially from the viewpoint of homotoxicology.

The etiology of chronic bronchitis is extraordinarily intricate, influenced as it is by a host of complicated endogenous and exogenous factors. The pathologic-anatomic alterations involved, which are irreversible in obstructive bronchitis, present the attending physician — even one skilled and experienced in biological medicine — with great difficulties. The therapy of chronic bronchitis proceeds more simply and offers greater prospects of success if the disease is treated in a stage of development on the left side of the *biological section* of Hans Heinrich Reckeweg's Table of Homotoxicosis. Once bronchitis has developed into a phase on the right side of the *biological section*, the situation becomes considerably more problematic.

In the therapy of chronic bronchitis, the practitioner of holistic medicine must naturally also direct his or her special attention to the functioning of the patient's other organs. The liver with its detoxifying functions plays an especially important role here. The physician who places insufficient importance on the biological significance of an inflammation of the liver, for example, has only a slight chance of truly successfully treating chronic bronchitis.

In most cases of chronic bronchitis among children, successful therapy is possible very quickly through administration of Tartephedreel, Husteel, and Drosera-Homaccord. Treatment of this disorder among older patients, however, requires more extensive and more complex efforts, since the accompanying alterations in the organism, especially in the vascular system, play an increasingly important role as the patient grows older. In such cases, the above-stated medications Tartephedreel, Husteel, and Drosera-Homaccord can be effectively complemented by administration of the preparations Traumeel, Euphorbium compositum, Naso-Heel, Cruroheel, and Arsuraneel.

Effective treatment of spastic bronchitis is possible with Gripp-Heel, Engystol, Hepar sulfuris-Injeel, Tartephedreel, Husteel, and Drosera-Homaccord.

In therapy of cases of chronic spastic bronchitis and bronchial asthma, detoxification of histamines in the impregnation phase is necessary. Galium-Heel, Traumeel, Lymphomyosot, and Psorinoheel can be successfully administered here to initiate the regressive vicariation required in such cases. Other effective possibilities are alternating treatment with Gripp-Heel, Engystol, Baptisia-Injeel, Lachesis-Injeel, and Spongia-Injeel — interspersed with administration of Hepeel, Hepar sulfuris-Injeel, and Ubichinon compositum. For elderly patients, Coenzyme compositum has also proved highly reliable.

Although healing is not possible for bronchiectasis or for emphysemic bronchitis, dextoxification therapy can provide the patient great relief. In addition, Gripp-Heel and Engystol can favorably influence the course of feverish episodes.

The following preparations can also beneficially affect the course of chronic bronchitis: Traumeel, Arnica-Heel, Glyoxal-Injeel, and Echinacea compositum.

All the preparations stated above are manufactured by the Heel company of Baden-Baden.

Analytical medicine attempts to arrive at pathologic-anatomic differentiation and classification of the various mor-

ologic forms of chronic bronchitis. The beginning of the sorder is designated as uncomplicated chronic catarrhal bronitis with intensified secretion from the serous and mucous andular cells. This stage provides the basis for development intramural bronchitis, with exudation and edematous ucous-membrane swelling, accompanied by ulceration and filtration. The following are especially evident at this stage: stiocytes, as well as basophils and eosinophil cells with stamine enrichment. At this phase of the disease, there is exceptionally great tendency for bacterial development in e bronchi. If the chronic inflammation of the bronchus wall oes not subside, it may further lead to destruction and loss elasticity in the large and medium-sized bronchi.

The next stage of chronic bronchitis entails fibrosis and broblast proliferation. The further course of chronic bronitis involves pulmonary emphysema, as well as the possibili- of development of bronchiectasis. Previous illnesses (such s pneumonia) can also develop into chronic bronchitis or emhysemic bronchitis. Secondary bronchitis is especially pericious, exacerbated as it may be by sinusitis (sino-bronchial ndrome).

Collagen diseases such as Wegener's granulomatosis, lupus rythematosus, scleroderma, and often periarteriitis nodosa an all frequently lead to fibrotic alveolitis. In addition, tuberulosis, silicosis, and sarcoidosis can bring about disseminated broses, with subesequent tendency to chronic bronchitis.

As shown by the above summary, the etiology of chronic ronchitis is exceedingly complex and is influenced by enogenous and, to an even greater degree, by an extremely great umber of exogenous factors. One very frequent complicaion involves cases triggered by allergy which later develop nto spastic bronchitis and bronchial asthma. The disease can ecome considerably more complex, the longer the symptom icture is allowed to remain, with frequent development oward cases in which the pathologic-anatomic syndrome lemonstrates irreversible alterations which lead to further omplications demonstrating respiratory and cardiac insuffiiency in the clinical picture.

The World Health Organization defines the chronicbstructive syndrome as an incurable, irreversible, and progressively worsening disease. It will not be possible within his context, however, to elaborate on the most important stages involved here.

This extremely brief summary was necessary to indicate the herapeutic measures available to conventional modern medicine. Causal therapy of course plays a major role here, in such efforts as the encouragement of smokers who suffer from bronchitis to discard their habit. In cases of congestive bronchitis, in addition, cardiac therapy is also often pursued.

Now as before, however, conventional medicine primarily avails of the use of antibiotics for the therapy of chronic bronchitis, with long-term administration very frequently extending over years. In Germany, catecholamines have traditionally been prescribed for spastic bronchitis, and secretolytics have enjoyed wide use for the treatment of secretion congestion. Therapy in such cases is therefore symptomatic in nature whereby the long-term use of antibiotics promotes chronic lingering of the disease, with uncontrollable iatrogenic damage.

I have attempted to sketch out the background for one of the fundamental paradoxes in modern medicine: by means of antibiotic therapy, as well as many other conventionally administered measures, it is in fact not possible to provide causal therapy of diseases such as chronic bronchitis. Traditional pathology, as it views and describes the illness being considered here, cannot properly recognize the purposes of inflammation as the point of departure for chronic bronchitis. It cannot therefore properly provide the therapy necessary to aid the patient in passing through this illness.

A completely different assessment results from the consideration of chronic bronchitis from the standpoints of homotoxicology.

Let us go back to the early stage of uncomplicated chronic catarrhal bronchitis, characterized as it is by intensified secretion from the serous and mucous glandular cells. This early situation, of course, further develops toward the typical picture of inflammation, with formation of leukocytic cells. I would like to begin my consideration from the homotoxicological viewpoint by pointing out the effectively beneficial aspects of the inflammatory process.

As a result of the effects of histamine, and in conjunction with permeability dysfunctions, blood plasma with antigens extravasates from blood vessels. Connecting tissue, which lies between the blood vessels and parenchyma, subsequently produces a tissue gel in response to the following processes which act on it: the enrichment of acids and the diminution of oxygen which occur here, the production of hyaluronidase among the bacteria present, and the presence of toxic products of metabolism (so-called homotoxins). In this phase of inflammation, leukocytic cells are produced in the manner which has been very impressively demonstrated in the well-known experiment by Busse-Grawitz. Now, at this point, the toxic products of metabolism can, together with the pus formed, be properly eliminated from the organism, in the sense of a biologically effective detoxification reaction. Any measure taken to impede this process of detoxification signifies a corresponding hindrance of the process of healing.

The cause and the beginning of chronic bronchitis is to be found at this point. All other influences, such as environmental factors with their exogenous noxae, are of secondary significance. The therapeutic consequence of such a standpoint is simply thus: that beneficial treatment of the illness can lie only in promotion of inflammation as a highly effective process of detoxification, and in enhancement and acceleration of the healing of the organism by mobilization of the patient's resistance in what Reckeweg calls the Greater Defensive System. In the implementation of homotoxicology, this means supporting the organism in moving from the reaction phase into the excretion phase of illness.

The physician who does not understand or properly consider the effective biological function of inflammation cannot

take therapeutic steps which properly enable his or her patient to speedily return to a state of good health. This is indeed the most critical insight toward comprehending the etiology of chronic bronchitis, an insight which could well prevent the occurrence of many cases of iatrogenic damage, and could consequently prevent the development of many cases of chronic bronchitis. I therefore would like to emphasize again as strongly as possible: inflammation, including inflammation as encountered in bronchitis, is a biologically effective process of detoxification.

Chemotherapeutic measures taken to suppress the inflammatory process impede this cleansing function and trigger processes of damage to the enzymatic system. These processes subsequently produce allergic syndromes in cases of bronchitis.

The physician should, furthermore, not allow himself to be deceived if symptoms of chronic bronchitis quickly disappear after antibiotic therapy. They will reliably reappear later, once the organism again attempts to eliminate the responsible homotoxins, in many cases, through a different symptom picture.

The causal interrelationships of such phenomena become quite clear when biological homeopathic therapy is employed to initiate the process of desired regressive vicariation. In such a process, earlier (usually suppressed or otherwise not properly experienced) symptom pictures will appear and be repeated. One prime example here, often experienced in the practice of homotoxicology, is the suppression of tonsillar angina by antibiotics, with subsequent development of bronchitis. If another, homeopathically oriented physician properly treats the bronchitis, the angina will reappear. If the revived angina is biologically and effectively treated the second time, the patient can experience genuine healing.

In accordance with homotoxicology, therefore, the antibiotic treatment of tonsillar angina results in harmful consequences for the patient. The same applies to the common cold and even to pneumonia.

It has become disturbingly apparent that chronic bronchitis now widely afflicts young patients, whereas its victims in past generations typically first encountered this disease in their forties. One reason for this development may lie in the fact that severe obstructive bronchitis syndromes appear in hospitals at a point in time later than we, outside in private practices, encounter them. And it may well be that iatrogenic damage occurs now at an increasingly earlier age, now often in childhood, owing to the widespread administration of antibiotics.

There are, of course, better prospects for therapeutic success among the younger victims of chronic bronchitis than among older patients. The therapy of chronic bronchitis proceeds more simply and offers greater prospects of success if the disease is treated in a stage of development on the left side of the *biological section* of Hans Heinrich Reckeweg's Table of Homotoxicosis. Once bronchitis has developed into a phase on the right side of the *biological section*, the situation becomes considerably more problematic. The pathologic-anatomic alterations involved, which are irreversible in obstructive bronchitis, present the attending physician, even one skilled and experienced in biological medicine, with great difficulties.

Nowadays, we unfortunately encounter illnesses more and more frequently among young patients whose disorders are already in the cellular phases of the Table of Homotoxicosis. As a result, the overall homotoxic situation, along with the duration of the disease, becomes increasingly unfavorable and requires the therapy of more and more secondary damages.

In any case, the physician employing biotherapeutic/antihomotoxic treatment will attempt to promote the self-cleansing processes of the organism and to stimulate its elimination functions. In addition, the physician practicing holistic medicine will, in our example of chronic bronchitis, pay special attention to the functions of all other organs. Among these, the liver with its detoxification functions plays an especially important role.

Unfortunately, older patients with chronic bronchitis are long-term patients. Nevertheless, differentiated and concerted homeopathic therapy will enable subjective improvement, even if the patient's expectorative function is not entirely successful. Continuous and long-term therapeutic measures of detoxification also relieve other organs, with subsequent enhancement of their functioning.

If the patient experiences fever during therapy, the physician should rightly view this process as the attempt by the organism to compensate for toxin damage which it has suffered. Successful biotherapeutic/antihomotoxic treatment is in fact intentionally associated with bouts of fever, which enable the organism to move from degeneration phases, via regressive vicariation, back to reaction phases.

Some of the very most successful therapeutic results of antihomotoxic therapy have been achieved among children who have been harmed by previous antibiotic treatment. "Harm" in this sense signifies blocking, or suppression, of the original disease. Once, in the course of biotherapeutic/antihomotoxic treatment, the organism makes another attempt to eliminate the homotoxins originally responsible, the earlier-repressed disorder will resurface. The following is a typical example:

A mother reported how her ten-year-old daughter was treated antibiotically for pneumonia five years earlier. The fever soon subsided, and the symptoms of pneumonia disappeared. The girl seemed to have been cured. Soon thereafter, the girl developed bronchitis, however, and was plagued regularly by bouts of varying intensity. My therapy was administration of Tartephedreel, Husteel, and Drosera-Homaccord, with dosage of ten drops each taken five times a day. I instructed the patient to allow the drops to remain in her mouth for 30 to 60 seconds before swallowing. At first, the bronchitis became more severe. She experienced slight fever, and expectoration increased. After eight days, however, these symptoms began to gradually subside, and after three weeks the child was entirely free of complaints.

In most cases, this therapy will very quickly heal chronic bronchitis among children. After the child is free of symptoms, however, I continue the above-stated therapy 6 to 8 weeks longer, in order to enhance the patient's powers of resistance.

At a medical convention in Freudenstadt, Germany, in the autumn of 1975, I reported in detail on numerous additional cases in which I employed this therapy for children. I cited many examples of complete cure as a result of this treatment.

In May of this year, a 41-year-old woman patient from Bad Ems, Germany, came to me and reported suffering from spastic bronchitis for years. X-rays provided no helpful information. I recommended the following therapy to her general practitioner:

- Intravenous injection twice a week of one ampule of Gripp-Heel and one ampule of Engystol
- Intramuscular injection twice a week of one ampule of Hepar compositum
- Oral administration of Tartephedreel, Husteel, and Drosera-Homaccord, with dosage of ten drops taken five times a day.

Not long ago, on a visit to my office with her son, the woman reported that she had had a terrible reaction to the above-stated therapy. Coughing and expectoration were so massive that she became fearful. Since she was convinced that the therapy would not harm her, however, she faithfully continued the prescribed dosages. After about two weeks she experienced no more symptoms, and signs of spastic bronchitis have not returned.

Although healing is not possible for bronchiectasis or for emphysemic bronchitis, detoxification therapy can provide the patient great relief. In addition, Gripp-Heel and Engystol can favorably influence the course of feverish episodes.

The following preparations can also beneficially affect the course of chronic bronchitis to such an extent that antibiotic therapy is not necessary: Traumeel, Arnica-Heel, Glyoxal-Injeel, and Echinacea compositum.

At this point I would like to emphasize once again that antibiotics suppress the biologically effective processes of detoxification which are associated with inflammation. Antibiotic therapy initiates the pathological process of progressive vicariation in which chronic bronchitis develops. Biological therapy with homeopathic medication, on the other hand, involves the activation or induction of antitoxin-specific enzymes which act against the original causal homotoxins, and which bring about their elimination from the organism. The administration of homeopathic medication introduces a similar toxin in attenuated and potentized form, as a result of which an additional toxin-defense mechanism is mobilized.

In therapy of cases of chronic spastic bronchitis and bronchial asthma, detoxification of histamines in the impregnation phase is necessary. Galium-Heel, Traumeel, Lymphomyosot, and Psorinoheel can be successfully administered here orally, to initiate the regressive vicariation required in such cases. Other effective possibilities include alternating treatment with Gripp-Heel, Engystol, Baptisia-Injeel, Lachesis Injeel, and Spongia-Injeel (intravenously), interspersed with administration of various combination preparations such as Hepar compositum and Ubichinon compositum. For elderly patients, Coenzyme compositum has also proved highly reliable.

In the therapy of chronic bronchitis with simultaneous occurrence of sinusitis, the physican can well consider the bronchitis to be of secondary nature, with initial emphasis placed on treatment of the sinusitis. In such cases, I prescribe Traumeel, Euphorbium compositum, Naso-Heel, Cruroheel, and Arsuraneel.

Treatment of chronic bronchitis among older patients, however, requires more extensive and more complex efforts, since the accompanying alterations in the organism, especially in the vascular system, play an increasingly important role as the patient grows older, and since cor pulmonale also develops as a terminal stage in cases of obstructive bronchitis. Cardiac therapy should therefore begin as soon as possible: Cralonin is one outstanding cardiocirculatory medication which may be applied here. Therapy with vitamin E is also important: alpha tocopherol plays an important role in lipometabolism disturbances. Recent research has determined relationships between alpha tocopherol and metabolic activities at the vascular wall. For pulmonary emphysema patients, I have for many years now regularly prescribed Rovigon (made by La Roche), which contains vitamins A and E, and which in all likelihood retards the progress of the disease.

In conclusion, I would like to make a very brief summary of the concept of illness as it is advocated by homotoxicology, and as it provides the basis of therapy for chronic bronchitis set forth in this presentation. The phenomena which we term "illness" represent biologically wise and effective defense measures taken by the organism against endogenous and exogenous homotoxins. Through the functions of disease, the organism attempts to compensate for homotoxin damages. As a highly effective mechanism for initiating and supporting the detoxification of homotoxins, the process of inflammation is of great significance for convalescence and maintenance of human health.

Address of the author
H. Winterberg, MD
Specialist for Internal Medicine and for Bronchial and Pulmonary Diseases
Haselnussweg 10
D-6900 Heidelberg 1
West Germany