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Review Article

Homoeopathic Magical Pills for Adenoid With- A Case Report

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ABSTRACT
Adenoids or nasopharyngeal tonsils are part of the Waldeyer's ring. They are masses of lymphoid tissues located at the junction of the roof and the posterior wall of the nasopharynx. The adenoids are present at birth. They enlarge throughout childhood. They reach peak size by age seven. In most individuals, they will regress in size during puberty. Adenoids play an important role in the development of the immune system, thereby serving as a defense against infections. They are the first organ that meets respiratory and digestive antigens. The causes of adenoid hypertrophy are varied. They are most likely associated with aberrant immune reactions, infections, environmental exposures and hormonal or genetic factors, but they all are being an apparent cause, main cause lies in the inherent emotional state or miasm of the individual when we investigate it from a homoeopathic point of view.The prevalence of adenoiditis is not completely known. In India, the prevalence is 2.3% in children reporting with adenoid related problems.

Keywords: Adenoiditis, homoeopathic medicines, lymphoid tissue, children, individualization, vital force, psychodynamic

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INTRODUCTION

ADENOID HYPERTROPHY- occurs mainly in children. The vegetations become hypertrophied, inflamed and produce nasal obstruction. The child has no choice but to breathe through the mouth. They manifest in very sensitive children who realize that the relationship between their parents is not going well and believe. It may be the cause of this happening they feel like a nuisance in the family.

Vegetations represent emotions and beliefs that the child represses for fear of not being understood. They can be manifested by having had difficulties to catch the bite, the prey, the objective, for not being able to get, possess or own something (real or symbolic). For example, for not being able to retain the mother's scent or something emotionally. Similarly, the child may be affected after having received a bite with a sub-tonality of attack or defense: "It is necessary to camouflage my face to protect myself" and "my words must have more weight" We have to look for the conflicting situation in the parents, possibly as a consequence of family quarrels and arguments. Recommendations to recover physical, emotional and spiritual health: The child needs to express to his parents what he feels and to clarify the conflict

Etiology

Many agents and pathogens can cause inflammation of the adenoid tissue. A viral upper respiratory tract infection (URI) often

precedes acute adenoiditis. In this state, bacterial pathogens can superinfect the tissues and proliferate. The most common bacterial pathogens cultured from adenoid specimens are: Hemophilus influenza, Streptococcus pneumoniae, Streptococcus pyogenes, Staphylococcus aureus

Chronic adenoiditis is more often a polymicrobial infection caused by anaerobic pathogens. In most cases of pediatric rhinosinusitis, adenoiditis is involved as well. Allergies are believed to play a role in adenoiditis and subsequent adenoid hypertrophy. Allergens inhaled through the nose meet the adenoid tissue -> the adenoids then proliferate to create a response to allergens -> produce IgA.

Chronic irritation from stomach acid in the setting of gastroesophageal reflux disease (GERD) may also play a role in adenoiditis and adenoid hypertrophy, particularly in infants and young children.

Epidemiology Exact incidence and prevalence statistics for adenoiditis alone are challenging to elucidate, as adenoiditis is usually addressed in the context of a regional disease process such as rhinosinusitis and adeno-tonsillar disease. Since adenoid tissue atrophies during puberty, adenoiditis is typically a disease in children.

Current literature does not suggest a predilection for gender, race, region, or socioeconomic class in this disease, though parental smoking has been positively correlated.

Adenoiditis can be challenging to differentiate from bacterial sinusitis in children. Therefore, statistics on sinusitis in children may give us some idea of the frequency of adenoiditis. Estimates are that children have 6 to 8 viral URIs per year. Five to 13 percent of these viral URIs result in bacterial superinfection, leading to sinusitis with adenoiditis as a potential component of the illness. The estimated prevalence of adenoid hypertrophy among children aged between 6 months to 15 years has been reported to be 19 to 58% worldwide.

Pathophysiology

Acute adenoiditis often occurs after a viral upper respiratory tract infection (URI). Bacterial agents proliferate-> infect the adenoids and surrounding tissue-> resulting in inflammation and increased production of exudates.

Symptoms: rhinorrhea, post-nasal drip, nasal obstruction, snoring, fever, and halitosis.

Chronic adenoiditis shows many of the same symptoms but persistently, lasting at least 90 days, and is often caused by polymicrobial infections and biofilm formation. Exudates are frequently absent in chronic adenoiditis.

Another cause of adenoiditis is environmental allergens or caustic irritation from stomach acid in the presence of GERD/LPR.

Chronic inflammation ->may lead to the proliferation of lymphoid tissue and subsequent adenoid hypertrophy. This hypertrophy-> can lead to nasal airway obstruction and obstruction of the Eustachian tubes-> leading to other problems such as obstructive sleep apnea (OSA) and otitis media.

Other causes of adenoid hypertrophy, though not necessarily adenoid inflammation, include primary sinonasal malignancies, lymphoma, and human immunodeficiency virus (HIV) infection.

Predisposing Factors:

Endogenous:

Preexisting URTI, pre-existing chronic tonsils, Postnasal discharge due to sinusitis, Residual tonsillar tissue after tonsillectomy, General lowering of resistance due diseases like agranulocytosis, leukemia, Exanthemata, Emotional Conflict-when a child perceives a threat to one's existence- may be due to quarrels between parents or fights among friends or scolding from school.

Exogenous:

Ingestion of cold drinks or cold foods may directly cause infection nasal constriction or lower the resistance by, Contagious – Infection may be contacted from other individuals having infection, Pollution and crowded ill-ventilated environment, Imbedded foreign body

Clinical features:

Symptoms due to hypertrophy are produced not from the actual size of the lymphoid mass but from the relative disproportion in size between the adenoids and the cavity of

the nasopharynx. This leads to nasal obstruction.

1. In Infants: Interference with feeding because the baby must stop sucking intermittently to take a breather. The infant tires easily, takes insufficient food and fails to thrive, Noisy respiration, wet bubbly nose.

2. In older children: Nasal obstruction leads to mouth breathing, Voice loses tone and become nasal and lifeless, Nasal discharge partly due to mechanical obstruction at the posterior nares and partly due to secondary chronic rhinitis, deafness due to the adenoid mass obstructing the openings of auditory tube. This diminishes the air entry into the middle ears

3. Adenoid facies: Chronic nasal obstruction and mouth breathing lead to characteristic facial appearance called adenoid facies. Child has elongated face, dull expression, open mouth, prominent and crowded upper tooth and hitched up upper lip. Nose gives a pinched appearance due to disuse atrophy of alae nasi. Hard palate is highly arched as the molding action of the tongue on palate is lost.

4. Pulmonary hypertension

5. Aprosexia: Lack of concentration.

Symptoms/Clinical Features due to infection

1. Purulent discharge from the nose due to rhinitis and sinusitis may occur.

2. Epistaxis due to infection.

3. Throat – Recurrent URTI is frequent. Patient may have post nasal discharge, pharyngitis, tonsillitis and cough.

4. Ear – recurrent eustachian catarrh, acute otitis media, chronic otitis media may occur

5. Lymphadenitis – Upper deep cervical node of the posterior triangle of neck is infected

6. Bronchial asthma and bronchitis if present may get aggravated.

7. General - Nocturnal enuresis and night terrors may occur due to suffocation.

8. Chest becomes flattened ff there is a combination of rickets and nasal obstruction, pigeon chest and Harrison's sulcus may develop because of inspiratory dyspnea and soft chest.

9. Voice becomes flat and toneless (Rhinolalia, clausa). Eustachian Tube Obstruction may occur which leads to middle ear diseases like Eustachian catarrh, serous otitis media, acute otitis media and chronic otitis media. This results in deafness or otorrhea.

10. Mental backwardness is not real, but the child may become backward in studies because of deafness or otorrhea.

11. General: Nocturnal Enuresis and night terrors may be present due to suffocation. Mental Backwardness is not real, but the child may become awkward in studies because of deafness.

DIAGNOSIS:

Clinical Features clinch the diagnosis in most of the cases.

Posterior Rhinoscopy may reveal adenoids in a cooperative child.

Digital Palpation of the nasopharynx may detect adenoids, but it is an unpleasant procedure which is better avoided.

Radiological Examination of the lateral view of the nasopharynx for soft tissue shadow may reveal adenoids.

Examination under General Anesthesia at the time of tonsillectomy can be easily carried out. and adenoidectomy may be performed, if necessary.

Adenoids hold a strategic position in the upper airway. They may obstruct the nasal respiration if they become swollen or hypertrophic, but take care not to equate all nasal obstruction with adenoid enlargement, for the nasal turbinate are far more often to blame. Adenoidal size may be assessed by laryngeal mirror, or lateral neck X-ray, but there is a simple clinical technique for determining if there is significant obstruction:

Using two tongue depressors held together, ask the patient to open his mouth and insert them to carefully touch the soft palate just above the uvula. The resting the lower tongue depressor on the lower incisor teeth, then ask the patient to open mouth and make a sound so that the soft palate is elevated towards the posterior nasopharyngeal wall. Carefully advance the upper tongue depressor to again touch the palate above the uvula. At this time the lower one remains in place against the lower teeth. The difference between the two tongue depressors gives the

mobility of the palate. It is conveniently measured (for the sake of hygiene) on the side which is not covered in saliva. Less than 5 mm is considered to be obstructive. (normal is 8-10mm)

DIFFERENTIAL DIAGNOSIS

(1) Nasal Obstruction may be due to other causes like rhinitis, sinusitis, Antro choanal polyp, deviated septum, hypertrophic turbinates and allergy. benign tumor is a rare cause of obstruction

(2) Orthodontic Abnormality: High arched palate with protruding teeth may also occur without nasal obstruction.

(3) Thornwaldt's Disease is a cyst in the midline in the nasopharynx in an adult which is thought to be the persistence of the median furrow of the adenoids.

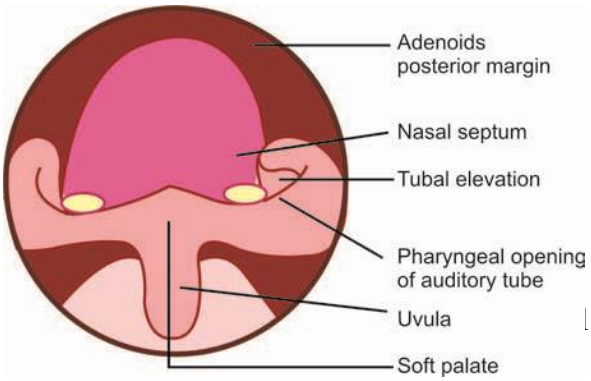


Fig.: Posterior rhinoscopy view o the nasopharynx showing adenoid

Complications of Adenoiditis- includ recurrent attacks of otitis media, secretor otitis media, maxillary sinusitis an orthodontic disturbances. Besides, suc patients are likely to encounter speec problems, like rhinolalia clausa (closed nos voice). Chronic infection may lead to th development of adenoid cysts.

TREATMENT:

(A) Conservative In mild cases, conservativ treatment may take care of adenoids. This i complemented by natural involution.

(1) Antibiotics are useful for acut inflammation

(2) Decongestants may be useful in re establishing breathing.

(3) General improvement in health an hygiene may help.

(4) Exercises: Breathing exercises should b advised.

(B) Surgical

(1) Adenoidectomy is advised to patients having persistent or recurrent problems

(2) Antral lavage may be required for concurrent sinusitis.

(3) Grommet may have to be inserted in the ear drum of a patient having secretory otitis media.

Therapeutics of Adenoiditis

Tuberculinum: It has enlarged tonsils and adenoids. It has mucus hawking after eating. It has all gone hungry sensation. It desires delicacies, meat esp. smoked meat, refreshing things, salty things. It is afraid of animals, especially dogs. It has irritability on waking. He wants to fight, throws anything at anyone, doesn't want to remain in one place long. They desire to break things. They are dissatisfied and always want a change, want to travel. Persons with a history of tuberculosis in the family. If Tuberculinum bovine are given in 10M, 50M and cm potencies, two doses of each potency at long intervals all children and young people who have inherited tuberculosis may be inherited from their and resiliency will be restored. It cures most cases of adenoids and tuberculosis glands of the neck.

1) Agraphis Nutans: It shows obstruction of the nostrils from adenoids. It has throat deafness, one of the leading remedies in Adenoids. Dr. Cooper gives "Adenoids with enlarged tonsils; frequently accompanying dentition". Their discharge is white mucus.

2) Calcarea Carb: Swelling of tonsils, difficulty swallowing. Stoppage of nose in morning on rising. It has offensive odor of the nose is from and eggs. It takes cold at every change of weather. They are obstinate children are self-willed. They are dull lethargic children who don't want to play. Complaints of teething children, fair plump children, big head and big belly. Great longing for boiled eggs, raw potatoes and flour great aversion to meat, defective dentition in children, very slow in teething, scrofulous children constant subject to sour diarrhea, profuse perspiration over the head, tendency to obesity with pot belly. A barometer indicating scrofulous diathesis. They are generally better when constipated.

3) Calcarea Phos: They are thin children wit large, pale tonsils.
4) Bacillinum: In children with consumptiv family history.
5) Baryta Carb: They exhibit scrofulou condition in children, dwarfish children aversion to strangers, deficient memor (children cannot remember and learn salivation, saliva runs out during sleep. The have a liability to get tonsilitis after ever slight cold or suppressed foot sweat. They have a disposition to acute tonsilitis with suppuration. They have inflammation of cellular membranes of fauces and tonsils with fever, difficult swallowing and speaking, throat is pale, inflamed and enlarged tonsils. They have inability to swallow anything but liquids.
6) Sulphur: Their children who are always hungry, have irritable skin, averse to be washed.
7) Thuja: They have swellings of tonsils and throat. They have painful swallowing and empty swallowing or that of saliva. They blow from the nose a large quantity of thick green mucus mixed with blood; later of dry brown scales with mucus which comes from the frontal sinuses which firmly adheres to the swollen upper portion of the nostrils. Accumulation of mucus in posterior nares

Rubrics in different Repertories with number of medicines indicated:

1. [Hearing]Impaired; Adenoids, from (see enlarged tonsils/ Enlarged tonsils, adenoids with)
2. [Hearing] Lost; Throat deafness (see nose, adenoids)
3. [Nose] Adenoids
4. [Nose] Obstruction; Breathes through mouth; Adenoids, removal after
5. [Throat] Adenoids
6. [Throat]; Swelling, Adenoids
7. [Respiration] Snoring; Adenoids removal after
8. [Generalities] Adenoids, complaints after removal of
9. [BR][Ear]Deafness, hardness of hearing; cause; adenoids and hypertrophied tonsils
10. [BR][Throat] Adenoid vegetations
11. [BG][Mouth and Throat] Adenoids
12. [Cl][Clinical]Adenoids
13. [Cl][Clinical] Post-nasal growth; see adenoids
14. [PH][Phatak A-Z]Adenoids
15. [PH][Phatak A-Z] Hearing; bad, deafness,impaired; Adenoids from
16. [PH][Phatak A-Z] Nose; obstructed; breathes through mouth; Adenoids, removal, after
17. [PH][Phatak A-Z]Respiration; Snoring; Adenoids, removal, after
18. [SP][Bio-chemic] Adenoids

A CASE REPORT

Name- Mr.ssd Age- 26 Yrs.

Sex- Male Occupation: - student. Diet: - Veg.
Religion: -Hindu. Date- 04/02/2024
Marital Status: -Unmarried.
Address: - MSW.
Chief complaints: -
1- cold and coryza 2- 3 weeks.
2- sleep apnea 1-2 weeks.
H/O chief complaints: -
1-cold and coryza
Duration- 2-3 weeks.
Onset- Gradual
Character- bland nasal discharges
Feels more when in open air
Agg- morning
2- sleep apnea
Duration- 1-2 weeks.
disturbed sleep
Agg- midnight.
Past history: -
No major illness in past
Family history: -
Mother -healthy, Father-HTN.
Personal history: -

- Habit: - Not Any.
- Thirst: - Thirsty, short quantity in large interval 3-4 glass per 2-3 hrs.
- Appetite: - Decreased.
- Desire:-NS.
- Aversion: - Spicy.
- Stool:-1 time in a day, satisfactory.
- Urine: - 3-5 times /day, no associated problem.
- Perspiration: - More on head, neck.
- Sleep:-Disturbed.
- Dreams:-Not remembered.

Constitution & generalities:-

- Thermal:-chilly.
- Whitish complexion, lean, thin.

Mental & Emotional State (with Life space situation):-

Patient is short tempered, get easily angry but cannot be express his anger therefore get irritable. He says that he Like to be alone don't want many people near him.

- He is timid, obstinate, silent and quiet, he has aversion to meet people. He gets uncomfortable in new people. He is
- Oversensitive to noise, can't bear loud noise
- he gets irritated by that.

General examinations: -

Physical examinations: -

Pulse: -86/Min. R.R.: - 28 C/Min

Temp: -99.0 F B.P.:- 110/70 mm Hg.

Pallor: -Absent. Edema: - absent.

Icterus: - Absent Cyanosis: - Absent.

Tongue: -Pink, moist. Nails: - Pale.

Systemic examinations: -

Resp. Sys: -A.E.E.B.S., Clear, No added Sound.

C.V.S: - H.S- S1 S2- NAD, No murmur.

C.N.S: - Conscious, Oriented, Reflexes- Normal.

- P/A: - Soft, no tenderness.

Miasmatic diagnosis: -

Psora

Symptoms	Psora	Sycosis	Syphilis
Irritability	✓		
< Consolation	✓		
Company aversion	✓		
Loquacity	✓		
Obstinate	✓	✓	✓
> Open air	✓		
> Cold air	✓		

Provisional diagnosis of case: -

- Acute adenoiditis
- sinusitis
- tonsilitis

Homoeopathic disease diagnosis: -

- acute disease.

Investigations: -

CBC: - HB-12.8 Gm. %, WBC-8900 c/mm, Plat- 234000 /UL.

Analysis of case: -

Mental generals: -

- Irritability, < consolation.
- Like to be alone.
- Company- aversion to.
- Silent, quiet, aversion to guest.

Physical generals: -

- Thermal-chilly/thirsty.

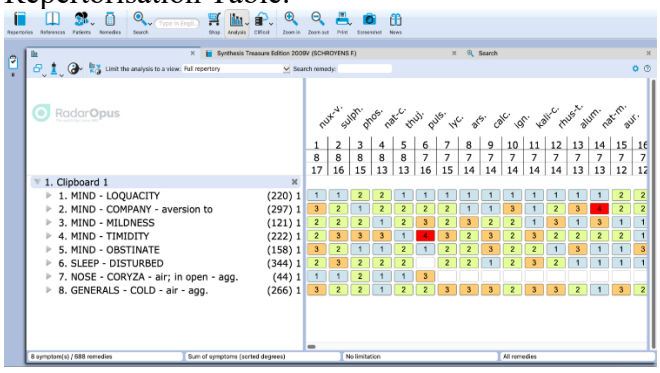
Particular generals: -

- snoring > midnight.
- Sneezing> open air.

Evaluation: -

1. MIND - LOQUACITY
2. MIND - COMPANY - aversion to
3. MIND - MILDNESS
4. MIND - TIMIDITY
5. MIND - OBSTINATE
6. SLEEP - DISTURBED
7. NOSE - CORYZA - air; in open - agg.
8. GENERALS - COLD - air - agg.

Repertorisation Table:



Probable remedies: -

1. Nux V. (8/17)
2. Sulph. (8/16)
3. Phos. (8/15)

Final diagnosis- Adenoiditis
Prescription: -
Nux Vomica 200 OD 3 DAYS, PL. 4GL / TDS. 15 DAYS.
Advice: -

- Avoid -cold drinks.
- Take- steam inhalation,
- Keep proper oral hygiene.
- Lukewarm water gargles.

Follow ups: -

- After 15 Days.

Reasons for selection of remedy: -

- Mentals, physicals and particular symptoms are matching.
- Constitution and individualization of the patient.

Reasons for potency selection: -

- Nature of disease- Acute.
- Nature of remedy-Vegetable kingdom.
- On the basis of miasm- psora.
- Susceptibility of the patient-medium.

Follow ups: -

Follow ups	Symptoms/observations	Remedy
1st 4/2/24	Treatment started	Nux Vom. 200 od 3 days Pl 4gls bd for 15 days
2nd 15/2/24	All Symptoms slightly reduced snoring +	Nux Vom. 200 stat Pl 4gls bd for 7 days
3rd 23/2/24	No further improvement	Nux v 200 stat Pl bd 10 days
4th 1/3/24	slightly improved snoring reduced	Nux v. 200 stat Pl 4 gls bd for 1 month
5th 28/3/24	Cold reduced No new symptoms appear	Nux Vom. 200 od 3 days Pl 4gls bd for 15 days
6th 15/4/24	Cold coryza reduced Sleep improved	Pl 4 gls bid for 15 days
6th 28/4/24	Asymptomatic, maintaining good vitals.	Pl 4 gls bid for 15 days

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