The Efficacy & Significance of Homeopathy in Chronic Tonsillitis

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Introduction

Homoeopathy signifies a system of treatment based on the similarity between symptoms of the patient and those obtained during proving of drugs on healthy human beings. The basic concept of disease is that, all natural diseases are due to derangement of the vital force of an individual resulting in abnormal sensations and functions manifested as signs and symptoms both in mental and physical plains. This image of the disease which we call as totality of symptoms is the sole guide for the physician to select the similimum - the curative remedy. Thus Homoeopathy is a system of medicine giving more importance to the diseased individual than the disease itself.

Chronic inflammatory changes in the tonsil are usually the result of recurrent acute infections treated inadequately. Recurrent infections lead to development of minute abscesses within the lymphoid follicles..These become walled off by fibrous tissue and surrounded by inflammatory cells.

The most common and the most important cause of recurrent infections of the tonsils is persistent or recurrent infection of the nose and paranasal sinuses.This leads to post nasal discharge which then infects the tonsils as well. Chronic And Recurrent Tonsillitis Are Much More Common As Causes Of Disability

Homoeopathy firmly believes in enhancing body's own defense mechanism to maintain the health y status. Tonsils are looked upon as immunological booths. The homoeopathic approach is to encourage the immunological activation of the tonsils, and to save them for body's own long term interest.

This is a humble effort made by me to show the homoeopathic fraternity and the whole suffering humanity, the efficacy and significance of homoeopathic medicines in the management of Chronic Tonsillitis.

Aims and Objectives

- To determine the efficacy and significance of homoeopathic medicines in the management of Chronic Tonsillitis.
- To determine the medicines and the corresponding potencies frequently indicated in the management of Chronic Tonsillitis

Review of literature

- TONSILS are organised lymphoid structures situated between the faucial pillars.

Five tonsils are usually present

- One **pharyngeal tonsil**, commonly called **adenoids**, lies on the posterior wall of the pharynx behind the nose.

- Two **palatine tonsils** are located on the lateral walls of the pharynx, these are the ones readily seen and most commonly referred to as tonsils.
- **Two linguals** are located on the base of the tongue.

Embryology

The palatine tonsils develop in relation to the lateral parts of the second pharyngeal pouch. The endoderm lining the pouch undergoes considerable proliferation .As a result, most of the pouch is obliterated. Lymphocytes collect in relation to the endodermal cells. It is not certain whether these lymphocytes differentiate in situ or are derived from blood. The intratonsillar cleft or tonsillar fossa is believed to represent a persisting part of the second p haryngeal pouch. Similar epithelial proliferations and aggregations of lymphoid tissue give rise to the tubal tonsils, t he lingual tonsils and the pharyngeal tonsils.

Anatomy

The palatine tonsil (tonsilla palatina) is a bilaterally paired mass of lymphoid tissue situated in the lateral wall of the oropharynx and forming part of a protective annulus of lymphoid tissue, the Waldeyer's ring.

The shape of the palatine tonsil is ovoid and its size is variable according to age, individuality and tissue changes leading to hypertrophy and/or inflammation. It is therefore difficult to define its normal appearance. For the first 5 or 6 years of life the tonsils increase rapidly in size, reaching a maximum at puberty when they average 20–25 mm in vertical and 10–15 mm in transverse diameter, projecting conspicuously into the oropharynx. Tonsillar involution begins at puberty when the reactive lymphoid tissue starts to undergo atrophic changes, and by old age only a little tonsillar lymphoid tissue remains.

The long axis of the tonsil is directed from above, downwards and backwards. Its medial or free surface usually presents a pitted appearance. These pits, 10–15 in number, lead to a system of blind-ending, often highly branching crypts, which extend through the whole thickness of the tonsil and almost reach the connective tissue hemicapsule. In a healthy tonsil the openings of the crypts are fissure-like and the walls of the crypt lumina are collapsed and in contact with each other. The human tonsil is a polycryptic structure, unlike the monocryptic tonsil of some other mammals, e.g. rabbit and sheep. The branching crypt system reaches its maximum size and complexity during childhood. In the upper part of the medial surface of the tonsil is the mouth of a deep intratonsillar cleft, or recessus palatinus, often erroneously termed the supratonsillar fossa. It is not situated above the tonsil but within its substance, and the mouth of the cleft is semilunar in shape, curving parallel to the convex dorsum of the tongue in the parasagittal plane. The upper wall of this recess contains lymphoid tissue extending into the soft palate as the pars palatina of the palatine tonsil. After the age of 5 years this embedded part of the tonsil diminishes in size; from the age of 14, there is a tendency for the whole tonsil to retrogress, and for the tonsillar bed to flatten out. During young adult life a mucosal fold termed the plica triangularis, stretching back from the palatoglossal arch down to the tongue, is infiltrated by lymphoid tissue and frequently represents the most prominent (antero-inferior) portion of the tonsil. However, it rarely persists into middle age.

The lateral or deep surface of the tonsil spreads downwards, upwards and forwards. Inferiorly, it invades the dorsum of the tongue, superiorly, the soft palate, and, anteriorly, it may extend for some distance under the palatoglossal arch. This deep, lateral aspect is covered by a layer of fibrous tissue, the tonsillar

hemicapsule, separable with ease for most of its extent from the underlying muscular walls of the pharynx which is formed here by the superior constrictor, with the styloglossus on its lateral side. Antero-inferiorly the hemicapsule adheres to the side of the tongue and to the palatoglossus and palatopharyngeus muscles. In this region the tonsillar artery, a branch of the facial, pierces the superior constrictor to enter the tonsil, accompanied by venae comitantes. An important and sometimes large vein (the external palatine or paratonsillar vein) descends from the soft palate lateral to the tonsillar hemicapsule before piercing the pharyngeal wall; haemorrhage from this vessel, from the upper angle of the tonsillar fossa, may complicate tonsillectomy. The muscular wall of the tonsillar fossa separates the tonsil from the ascending palatine artery, and, occasionally, from the tortuous facial artery itself which may be near the pharyngeal wall at the lower tonsillar level. The internal carotid artery lies about 25 mm behind and lateral to the tonsil.

Surface Anatomy:
The palatine tonsil is too deeply placed to be felt externally, even when enlarged. When the mouth is closed the medial surface of the tonsil touches the dorsum of the tongue. In this position the surface marking of the palatine tonsil on the exterior of the face corresponds to an oval area over the lower part of the masseter muscle, a little above and in front of the angle of the mandible and behind the third lower molar tooth.

Microstructure
The basic structure of the palatine tonsil is that of an accumulation of mucosa-associated lymphoid tissue covered by stratified squamous non-keratinizing epithelium on its oropharyngeal surface, and supported by connective tissue septa arising from the hemicapsule. On the medial, oropharyngeal surface the tonsillar epithelium is deeply invaginated to form 10–30 or more crypts. Like other neighbouring masses of mucosa-associated lymphoid tissue forming Waldeyer's ring, the palatine tonsil is a major source of T and B lymphocytes for local mucosal defence.

Blood Vessels:
The arterial blood supply to the palatine tonsil derives from branches of the external carotid artery. The principal artery is the tonsillar artery, which is a branch of the facial or sometimes the ascending palatine artery. The tonsillar artery and its venae comitantes often lie within the palatoglossal fold; hence a haemorrhage may be caused by interference with this fold during an operation. Additional small tonsillar branches may derive from the following: the ascending pharyngeal artery; the dorsales linguae, branches of the lingual artery, supplying the lower part of the palatine tonsil; the greater palatine artery (a branch of the maxillary artery) supplying the upper part of the tonsil; and the ascending palatine artery, a branch of the facial artery.

Vein:
The tonsillar ***veins*** are numerous and emerge from the deep, lateral surface of the tonsil as the paratonsillar veins. They pierce the superior constrictor either to join the pharyngeal venous plexus, or to unite to form a single vessel which enters the facial vein.

Lymphatics:
Unlike lymph nodes, the tonsils do not possess afferent lymphatics or lymph sinuses, but dense plexuses of fine lymphatic vessels surround each follicle, forming efferent lymphatics which pass towards the hemicapsule, pierce the superior constrictor and drain to the upper deep cervical lymph nodes, especially

the jugulodigastric nodes. Typically, the latter are enlarged in tonsillitis; they then project beyond the anterior border of the sternocleidomastoid muscle and are palpable superficially 1–2 cm below the angle of the mandible. They represent the most common swelling in the neck.

Nerves:

The tonsillar region receives its nerve supply through tonsillar branches of the trigeminal (maxillary) and the glossopharyngeal nerves. The maxillary nerve fibres passing through (though not synapsing in) the pterygopalatine ganglion and are distributed through the lesser palatine nerves, which, together with the tonsillar branches of the glossopharyngeal nerve, form a plexus around the tonsil. From this plexus, termed the 'circulus tonsillaris', nerve fibres are also distributed to the soft palate and the region of the oropharyngeal isthmus. The glossopharyngeal nerve additionally supplies, through its tympanic branch, the mucous membrane lining the tympanic cavity. Hence, tonsillitis may be accompanied by pain referred to the ear. The nerve supply to the tonsil is so diffuse that tonsillectomy under local anaesthesia is performed successfully by local infiltration rather than by blocking the main nerves.

Waldeyer's ring

The lymphatic tissues of the pharynx and oral cavity are arranged in a ring like manner around the oropharyngeal inlet. The inner ring consists mainly of the nasopharyngeal tonsil, peri-tubal lymphoid tissues, faucial tonsil and lingual tonsil.
The efferent from this ring drain to lymph nodes situated around the neck forming the outer ring. The lymphoid tissues have a protective function.

Function of tonsils

1. It plays a major role in body immunity mechanism and antibody reaction most probably i n children.
2. It is helpful in forming lymphocytes which protect our body as a defense mechanism
3. It traps the germs that enter the body by its antibodies and drains into the lymph node for elimination.
4. It is also supposed to kill bacteria that enter into the tonsil through the blood stream.
5. It monitors the quality of the air, food and water which enters our body.

Immunology of tonsils

The tonsils work as a filter which fights and protects the entire human system against the foreig n organism.
They also help preventing spread of infection from the nearby organisms such as mouth, sinuses, post nasal part etc.tonsils produce antibodies, which fight against the infection,
stopping its further spread to other parts of the body. when bacteria or virus attack the body, they initially have to face the tonsils.
In the process of fighting towards the germs and microbes the tonsils get inflamed[
called tonsillitis]which is simply a symbol of the local defence mechanism at work. In the process, they produce lymphocytes and antibodies to generate the required immune response.

Tonsillar Pathology:
While the palatine tonsil is a substantial part of the pharyngeal immune system, it may itself become infected; in particular, pathogenic bacteria, for example streptococci, may invade the tonsillar crypts and proliferate within them, causing an inflammatory reaction including the migration of leucocytes into the cryptal spaces. Various factors including the expansion of germinal centres cause swelling of the tonsillar mass, and the pus within the crypts is visible as yellowish spots on its inflamed surface. Tonsillectomy after repeated episodes of tonsillitis might be expected to cause considerable reduction of pharyngeal defence, but this usually does not appear to be the case, probably because other related lymphoid tissue masses, for example the lingual tonsil, increase their lymphocytic output.

CHRONIC TONSILLITIS

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The most common and the most important cause of recurrent infections of the tonsils is persistent or recurrent infection of the nose and paranasal sinuses. This leads to post nasal discharge which then infects the tonsils as well

CHRONIC AND RECURRENT TONSILLITIS ARE MUCH MORE COMMON AS CAUSES OF DISABILITY

Potential Problems Include

Multiple acute infections, each accompanied by pain and fever, causing frequent and prolonged absence from school or work

Chronically enlarged tonsils can cause upper airway obstruction and difficulty with difficulty with normal respiration

At night, airway obstruction can be manifested as loud snoring and may even lead to sleep apnoea syndrome, where the airway totally closes off for brief period leading to oxygen deprivation and heart failure

Swallowing problems due to tonsillar enlargement can lead especially in children, to failure to thrive or gain weight as expected

Voice changes are noted with partial upper airway obstruction

There may be a constant feeling of pain or fullness in the back of the throat

Persistent enlargement of lymph nodes in the neck can also be caused by c/c tonsillitis.

Symptoms

a. Sore throat :repeated attacks of sore throat with little remission in between attacks indicates chronic inflammation.

b. Odynophagia

c. Fever

d. Halitosis

e. Cough and irritation in the throat

f. In hypertrophic tonsillitis breathing problems and snoring are present

g. Unpleasant taste

On examination: three clinical types are seen

A. Chronic parenchymatous or hypertrophic tonsillitis

Tonsils are uniformly enlarged and congested; some times they meet in the midline and are called kissing tonsils

B. Chronic follicular tonsillitis

Beads of white discharge on surface of tonsils at the entrances to tonsil crypts. Often asymptomatic

C. C*hronic fibrotic tonsillitis*

Tonsils are small, and inflamed, occurs in adults.

Anterior pillars are hyperemic

The most reliable sign is enlarged tender, jugulo digastric lymphnodes at the angle of mandible

The most reliable indication of tonsil problem in children is a history of repeated acute attacks of tonsillitis

Clinical finding may be deceptive.

Diagnosis

History of repeated attacks of sore throat or acute tonsillitis, associated with symptoms of dysphagia and discomfort, rise o temperature[at least 3 0r 4 attacks per year]

These symptoms if seen with enlarged tonsils, hyperaemic pillars and enlarged jugulodigastric lymph nodes, a diagnosis of chronic tonsillitis is considered.

Investigation

Blood

Routine

E.S.R

A.S.O titer

Urine

Sugar

Albumin

Chronic lingual tonsillitis

Chronic inflammation of the lingual tonsils may be a problem after tonsillectomy when the lingual tonsils undergo compensatory hypertrophy.

The patient complains of discomfort in the throat, dysphagia and a thick plumy voice. Most patients respond to medical treatment of avoiding irritant foods.

Complication

Local

- Chronic rhino-sinusitis
- Intratonsillar abscess
- Peritonsillar abscess
- Para pharyngeal abscess
- Tonsillolith
- Tonsillar cyst
- Ear infections
- Middle ear effusion

General

- Rheumatic fever
- Acute nephritis
- Sleep apnoea syndrome

Causes of unilateral tonsillar enlargement

a. causes in the tonsils

- foreign bodies
- peritonsillar abscess
- gumma
- tuberculosis
- diphteria
- tonsillar calculi
- Vincent's angina
- intratonsillar abscess
- cysts
- tumors of tonsils like lymphomas, carcinomas
- aneurysm of tonsillar artery

B. ***causes outside the tonsil pushing the tonsil medially***

- carotid artery aneurysm
- unilateral cervical lymphadenitis
- parapharyngeal abscess
- parapharyngeal tumors
- deep lobe of parotid gland tumours

GENERAL MANAGEMENT

- Attention should be given to general health, nutritious diet, and well ventilated room
- Infections of the nose and paranasal sinuses forms the most important factor leading to chronic or recurrent infection of the tonsils, so treat these factors
- Avoid cold food and drinks
- Avoid sour food, curd, pickles
- Avoid fried and oily food

SURGICAL MANAGEMENT : Tonsillectomy

Indications for Tonsillectomy

Absolute:

- sleep apnoea
- suspected tonsillar malignancy

Relative:

- recurrent tonsillitis
- chronic tonsillitis
- quinsy
- diphtheria carriers
- systemic disease due to beta hemolytic streptococcus

Contra indications

- aneurysm or abnormal vasculature of tonsil
- epidemic of poliomyelitis
- in acute infective stage, unless airway of risk
- age below three years
- blood dyscrasias: leukaemia, purpura, aplastic anemia, haemophilia etc
- uncontrolled systemic diseases like diabetes and hypertension
- during menstruation and during pregnancy

Homoeopathic Management

Non surgical homoeopathic treatment
Homoeopathy firmly believes in enhancing body's own defence mechanism to maintain the health y status. Tonsils are looked upon as immunological booths.
The homoeopathic approach is to encourage the immunological activation of the tonsils, and to save them for body's own long term interest.

Enlarged tonsils are not the cause

Frequent infection of the tonsils simply suggests that the body's defence mechanism is low, leading to recurring infections. When the tonsils are infected again and again, they get enlarged. The tonsils thus enlarged is not the cause of infection. The enlargement of tonsils is the result of the poor immunological status of the body. The removal of the tonsils [tonsillectomy]cannot be the solution for it

Homoeopathic approach to treating recurrent tonsillitis

The homoeopathic approach may be summarized under

A, tonsils as a part of the whole system

B, treat the patient, not the diseased organs

C, save tonsils, enhances immunity.

A. *Tonsils as a part of whole system*

Homoeopathy doesn't look at individual organs as separate entities but as a part of the whole s ystem. any treatment of the single part,
should actually be aimed at treating the whole body system.
Our human body is not merely a mechanical conglomeration of spare parts.
It is an intricate and superbly designed wholesome totality.
every mode of treatment should essentially take into consideration the fundamental truth.
This applies to the treatment of tonsils as well.

B. Treat the patient, not the diseased organs.

Enlargement of the tonsils is not considered an indication for its removal. enlarged tonsils is an end result of the underlying feeble defense mechanisms. The 'constitutional treatment" in homoeopathy incorporates the study of the patient's entire constit ution in order to decide the treatment for tonsils. as a result, when the patient receives a course of homoeopathic treatment, he or she is not only relieved of frequent attacks of tonsillitis but also gets the immune mechani sms stronger. This is the real strength of homoeopathic treatment.

C. *save tonsils, enhance immunity*

With homoeopathic treatment of recurring tonsillitis, it is possible to save the tonsils and also to enhance the immunological st rength of the body at the same time. Wisdom lies in saving the tonsils

MEDICINAL MANAGEMENT

Literature by eminent homoeopaths reveals that polychrest remedies of deep acting nature have definite therapeutic indication in the treatment of chronic tonsillitis

According to the Lectures on Homoeopathic Materia Medica by *J.T.kent*, medicines are Alumina phosphorica, Cenchrix controtrix, Kali sulph, Kali silicum & Zincum phosphoricum

"The Prescriber" by *John Henry Clarke* Baryta mur, Baryta carb, Gun powder, Benzoic acid, Calcarea phos

Clinical Materia Medica by *E.A.Farrington* Baryta carb, Bromine, Cal-iod, Conium, Hepar, Ignatia, Lycopodium

Special pathology and diagnostic hints with homoeopathic therapeutics- D*r. raue* Baryta-carb, Baryta-mur, Cal-carb, Iodum, Ignatia, Lycopodium, Phos, Phytolacca, Psorinum, Sulph

Dictionary of homoeopathic Materia Medica by *O.A.Julian* V.A.B
Materia Medica of nosodes with repertory BY *O.A.JULIAN* B.morgan, Bacilli-7, Dysentery-co, Medorrhinum, Morg, Psorinum, Sterptococcinum, Syco-co, Syphillinum, Tubercullinum, Variolinum

A text book of material Medica and therapeutics by *A.C Cowper Waite* Baryta-carb, Cal-carb, Colch, Iod, Mer-iod, Sil, Sulph

Text book of homoeopathic Materia Medica by *Otto lesser* Alum, Baryta-carb, Hepar sulph, Silicea

The homoeopathic domestic physician by *Constantine hering* Apis, Bell, Hepar, Mercurius, Lachesis, Ignatia, Lyco, nux-vom, Puls, Capsicum, Sulph, Phos, Silicea

The abc manual of Materia Medica and therapeutics by *J.H. Clarke* Cal-carb, Cal-chloride, Iodine, Mercury

A synoptic key of the Materia Medica by *C.M Boger* Bar-carb, Baryta mur, Brom, Hep, Kali-iod, Lyc, Mez, Natrum- mur, Sulph-iod, Thuja, Phyt

A manual of pharmacodynamics by *Richard Hughes* Baryta, Cal phos

Twelve tissue remedies of schussler by *Boericke* Kali mur, Natrum phos, Cal-phos, Cal-sulph, Natrum-mur

A manual of homoeopathic therapeutics by *Neatby.E* Acid benzoicum, Brom, Caps, Phyt

A cyclopedia of drug pathogenesy vol: 1 BY *R.HUGHES* Aesculus hippocastnum, Antipyrin

Hand book of Materia Medica and homoeopathic therapeutics by *ALLEN.T.F* Arsenicum album

A primer of Materia Medica BY *T.F.ALLEN* Kali muriaticum

Materia Medica BY *PULFORD* Baryta carbonica

Thousand remedies BY *BOERICKE* Ammonium carbonicum, Eucal, Sulph-iod

Homoeopathic drug pictures BY *M.L.TYLER* Morbillinum

Leaders in homoeopathic therapeutics BY *E.B.NASH* Baryta carbonicum
v Pointers to the common remedies BY *DR.M.L.TYLER* Bell, Phyt, Nux, Apis, Hepar, Phos, Ign, Caps, Puls, Sulph, Bar-mur, Bar-carb, Sepia, Mercurius, Nit-acid, Aurum

Study on Materia Medica BY *N.M.CHOUDHARY* Bar-mur, Cal-carb, Cal-phos, Lac caninum, Mercurius, Mercy- cyan, Psorinum, Ustillago

Indications Of Some Important Remedies For Chronic Tonsillitis Are As Follows
ALUMEN
Enlarged and indurated tonsils
Sensation of dryness and constriction
Every cold settles in the throat
Constipation of most aggravated kind, marble like masses pass, but rectum still feels full
< Cold

AMMONIOUM CARB
Putrid sore throat
Tendency to gangrenous ulceration of tonsils
Glands enlarged

APIS
Oedema is the watch word of this remedy
Burning, stinging pains
Uvula swollen, sac like
Absence of thirst
Wants cool things
Worse from fire and radiated heat

ARSENICUM IODATUM
Scrofulous affections
Tonsils swollen, burning
Persistently irritating, corrosive discharges
Breath fetid and glandular involvement

AURUM
Tonsils red and swollen
Parotid gland on affected side feels sore
Ulceration of palate and throat
Aurum is especially where the patient is depressed to the verge of suicide
Loathing of life

BARYTA CARB
It is especially of use when the trouble is in the parenchyma of the glands, and suppuration rarely follows its use.
It suits comparatively mild cases, which have an attack from any exposure.it removes the predisposition to attack
Is very useful in cases where every cold settles in the tonsils, especially in children who have a chronic enlargement of those glands.
Like Belladonna it seems to have an affinity for the right side.
Inability to swallow anything but liquids
Children requiring Baryta are backward and bashful.
After baryta-c, psorinum will often eradicate the constitutional tendency to Quincy
Baryta iodide is preferred by Goodno and Tooker mentions Fucus vesiculosus in chronic cases.

BARYTA IODIDE

Quinsy
Indurated tonsil

BARYTA MUR
The same disposition to enlargement of glands, the same predisposition for tonsillitis like baryta carb

BELLADONNA
The acute paroxysms of chronic form, bell is very useful
Typical bell has congested' red, hot face and skin, big pupils, heat and dryness marked
Strawberry tongue
Right side is worse
Bell is the acute of calcarea, which is often required to complete a cure

BROMINE
Seems to especially affect scrofulous children with enlarged glands
Complaints from being over heated
Tonsils, pain on swallowing, deep red, with a network of dialated blood vessels
Better at sea

CALCAREA CARB
Calcarea patient is fat, fair, flabby, cold, sour, glandular enlargements
Takes cold easily
Head sweats profusely while sleeping, wetting pillow far around
Great longing for eggs, craves indigestible things, aversion to meat
Milestones delayed
Swelling of tonsils and sub maxillary glands, stitches on swallowing
<cold in any form >lying on painful side
In children it may be often repeated.

CALCAREA PHOSPHORICA
In chronic enlargement of the tonsils in strumous children this remedy stands well in typical Calcarea cases.
The tonsils are flabby, pale, there is a chronic follicular inflammation and impaired hearing
It efficacy in adenoid hypertrophy is well known and attested.
Can be used as an intercurrent with other remedies

CALCAREA IODATA
Scrofulous affections especially enlarged glands, tonsils.
Flabby children subject to colds
Enlarged tonsils with filled, little crypts, honey comb appearance

CAPSICUM
Tonsillitis, burning and smarting sensation as from cayenne pepper, not > by heat
Constriction of throat
Intense soreness
Inflamed, dark red, swollen
Chill or shuddering after every drink
Capsicum is flabby, red, fat and cold homesickness with red cheeks and sleeplessness
< Open air <uncovering <draughts

CINNABARIS

Throat swollen, tonsils enlarged and red
“Sensation of something pressing on nose, like a heavy pair of spectacle
Throat very dry, awakening from sleep
Tonsils swollen and inflamed
Ulcerated, deep ulcers, dropsical, shiny red, puffy discharges ropy and stringy
Exudate in throat looks like fine ashes sprinkled on the part

CANTHARIS
Inflammation of throat with severe burning and rawness
Great constriction of throat and larynx, with suffocation on any attempt to swallow water

FERRUM PHOSPHORICUM
Chronic enlarged hyperaemic tonsils, smooth swelling
Right sided
The typical ferr-phos subject is nervous, sensitive, anaemic with the false plethora and easy flushing
Prostration marked
< Night,4-6pm,touch,jar,motion
> Cold application

HEPAR SULPH
Where there are lancinating pains, splinter-like and much throbbing with rigors showing that abscess is on the point of forming and it is desired to hasten it Hepar will be well indicated
Parts extremely sensitive to touch.
Pain shoots into ears.
Suits especially the scrofulous and lymphatic constitutions who are inclined to eruptions and glandular swellings
Cough croupy, choking, strangling
Profuse sweating
< Eating or drinking cold, touch

IGNATIA
Raue says that ignatia is almost specific in follicular tonsillitis
Tonsils, inflamed, swollen, with small ulcers
Plug in throat sensation
Worse when not swallowing
Worse by liquids

KALI-IOD
Suited to pale, delicate, subjects with glandular swellings
Extreme sensitiveness of parts affected
Nocturnal aggravation
Discharges are ichorous, corrosive and green
Often brings about a favourable reaction in many chronic ailments even when not clearly, symptomatically indicated

LACHESIS
Left tonsils affected, tendency to go to right
Throat purplish
Sense of constriction, as if something was swollen which must be swallowed
External throat extremely sensitive to touch
Collar and neck band must be very loose
Liquids more painful

Pain radiates to ear
Prostration out of all proportion to appearance of throat
< Hot drinks <after sleep

LAC CANINUM
Begins on left side, changing from side to side every few hours or days
Sensitive to touch externally
Constant inclination to swallow, painful almost impossible
Pain extends to ears
Sore throat and cough are apt to begin and end with menses
Probably no remedy in the Materia Medica presents a more valuable pathogenesis in symptoms of the throat

LYCOPODIUM
Chronic enlargement of tonsils, which are covered with small ulcers
Affects right side, right to left
Children weak, emaciated, with well developed head, but puny, sickly bodies
< 4-8 pm, cold drinks, > warm drinks

MERCURIUS
More advanced stage than that calling for hepar
When pus has formed, great swelling, whole fauces deep red tonsils darker than any other parts, ulcers form
Profuse sweating without relief
Profuse salivation, breath offensive
Tongue large flabby with imprint of teeth
Moist tongue with thirst
< at night, damp, cold rainy weather

MERCURIUS IODATUS FLAVUS
Right sided
Throat affections with greatly swollen glands
Tongue coated thickly yellow at the base
Constant inclination to swallow
Better cold drinks

MERCURIUS IODATUS RUBER
Left sided with marked glandular swelling
Parenchymatous tonsillitis
Will often abort peritonsillitis if given frequently

NITRIC ACID
Suited to thin persons of rigid fibre, dark complexions, black hair and eyes
Catch cold easily
Sensation of splinter in throat, worse from touch
Extreme fetidity and corrosiveness of all discharges
Chilly, loves salt and fat
Depressed and anxious
< Evening and night, cold climate
> Riding in a carriage

KALI MURIATICUM

Valuable remedy in a/c or c/c tonsillitis with much swelling
Almost a specific in follicular tonsillitis
Throat has a gray look spotted with white
Hospital sore throat

NATRUM MURIATICUM

Especially for the anemic and cachetic
Great emaciation, losing flesh while eating well
Great liability to take cold
Craving for salt, aversion to bread
Consolation aggravates
< Heat of sun < sea shore
> Open air   >cold bathing

NUXVOMICA

Is irritable and oversensitive to external impression
Coryza dry at night, fluent by day < warm room, >cold air
Easily chilled, avoid open air
Frequent ineffectual urging for stool
< Morning,< cold air
< Damp wet weather

IODUM

Persons of a scrofulous diathesis, dark complexioned with enlarged lymphatic glands
Great emaciation, ravernous appetite
Acute exacerbation of chronic inflammation
Hot patient
< Warm room > walking in open air

PHOSPHOROUS

Adapted to tall slender persons of sanguine temperament
Great susceptibility to external impression
Thirst for very cold water
Burning sensation in throat
Hoarseness and aphonia, worse evening
Worse lying on left side
< Evening   < thunder storm < warm to cold air

PHYTOLACCA

Pre-eminently a glandular remedy
Right sided tonsillitis, dark red colour, uvula large dropsical, almost translucent
Burning as from a coal, of fire or red hot iron, dryness
Sensation of lump in the throat
Pain shoots from throat into ears on swallowing
Quinsy
< Hot drinks

PSORINUM

Especially adapted to psoric constitution
In chronic cases when well selected remedies fails to relieve or permanently improve
Great sensitiveness to cold
Tonsils greatly swollen, difficult painful swallowing

Profuse offensive saliva
Tough mucus in throat, must hawk continually
Eradicates tendency to quinsy
< Change of weather
Better by heat

PULSATILLA
Mild, gentle, yielding disposition
Symptoms ever changing
Discharges are thick, bland and yellowish green
Aversion to fatty, warm food and drinks
Thirstlessness with dry mouth
Desires open air
< Warm close room <evening
> Open air, cold air and room

SANGUNARIA CANADENSIS
Right sided tonsillitis
Burning sensation
Circumscribed red cheeks
Tongue white, feels scalded
Quinsy

SEPIA OFFICINALIS
Left side inflamed, much swelling with little redness
Sensation of lump in throat
Waked with sensation as if had swallowed something which has struck in the throat
Contraction of throat when swallowing
Sepia is chilly, indifferent White or gray coating at the base of tongue intolerant to cold and closed places

SILICEA
Cold, chilly, hugs the fire
Wants plenty of warm clothing, hates drafts, hands and feel cold,
Worse in winter
Want of grit, moral or physical
Scrofulous rachitic children, much sweating about the head
Ailments, caused by suppressed foot sweat
Periodical quinsy, pricking as of a pin in tonsil
Colds settle in throat
When the abscess has broken and refuses to heal children, fistulous cases
Bad effects of vaccination

SULPHUR
When carefully selected remedies fail to produce a favourable effect, especially in acute cases
Chronic sore throat
Burning and dryness in throat
Complaints that are continually relapsing
Scrofulous, psoric, chronic diseases that result from suppressed eruption
Ragged philosopher
For lean, stoop shouldered persons, standing is the worst position
Children dislike washing
< When standing

< Warmth of bed

TUBERCULINUM
Tubercular diathesis, tall, slim, flat, narrow chest
Active and precocious mentally, weak physically
When symptoms are constantly changing and well selected remedies fails to improve
Patient takes cold from the slightest exposure
Emaciation rapid and pronounced
Enlarged tonsil
Aversion to meat

THUJA
Swelling of tonsils and throat
Accumulation of a large quantity of tenacious mucus in mouth
Throat feels raw, dry, as from a plug, or as if it were constricted when swallowing
Hahnemann's chief anti sycotic
Hydrogenoid constitution
Ill effects of vaccination
Sweat only on uncovered parts or all over except head, stops when he wakes
Profuse sour smelling fetid at night
< Cold damp air
< Night,3.a.m and 3 p.m

<u>REPERTORIAL STUDY</u>
According to the repertory of "HOMOEOPATHIC MATERIA MEDICA" - BY J.T.KENT, the rubrics related to chronic tonsillitis are

Throat, enlargement of tonsils
3 marks:
BARC-C, BAR-M, LACH, LYC

2 marks:

Alum, calc, calc-iod, calc-phos, hep, kali-bic, kali-carb, kali-iod, merc, nat-mur, nit-acid, phy, sep, sil, staph ,sulph, syp.

<u>Throat, induration of tonsils</u>
2 Marks:

BAR-C, BAR-M

2 marks:
agar, ign, nit.acid, plb, staph.

Throat, inflammation, chronic
2 marks:
Alum, arg , calc, carb.s, carb.veg, cob, fl.acid, ham, hep, jug.c, kali.iod, lyc, merc, nat.mur, nit-acid, phos, phy, sep, sulph, thuja
Throat, Inflammation, Chronic, Follicular

Marks:

BELL, HEP, IGN, IOD, NAT-MUR

Throat, Inflammation, Tonsils, Recurrent

3marks:

BARYTA

2marks: *alumn ,bar.m, hep, psor, sang, sil*

Throat, Swelling,Tonsils

3 Marks:

BAP, BAR-C, BAR M, BELL, CALC, CHAM, HEP, LAC.C, LACH, LYC, NIT.AC, PHOS, PHY, SIL, SULPH.

2 Marks:

am.c, apis, aur, cal.p, cal.s, carb.acid, chel, dulc, colch, crot.t, flu.acid, gels, graph, guaj, iod, plb, ran.s, sab, staphy, kali.bic, kali.iod, manc, merc.

Right
2 marks:

bell, lyc, merc.i.f.

left

3 marks:

LACH

DR.BOENNINGHAUSEN'S "THERAPEUTIC POCKET BOOK"

Throat, Tonsils

5 MARKS:

BAR.C, MER, MER.I.F, NITRIC.ACID, PHYT

4 marks:

acon, amm.m, ars, bap, kali.bic, merc.i.fail, bar.m, calc.phos, crot.tig, iod, mer.cy, mur.acid, ran.s, sab, sulph, sulph.acid.

v Glands, Indurations

5 marks:

BELL, CLEM, CON

4 Marks**:**

bary, bry, carb.an, carb.veg, graph, lyc, mag.m

3 Marks:

agn, amb, am.carb, arn, calc.c, calc.f, cham, dig, dulc, fer, k.carb, merc, nat.c, nit.acid, phos, plb, rhus, sil, spo, squ, staph, sulph.

Glands, Swelling

5 MARKS:

BAR.C, BELL, LYC, MERC, NIT.ACID, PHOS, RHUS, SULPH

3 Marks

ars, ars.iod, bar.m, calc.c, can, carb.an, cham, graph, hep, kali.c, merc.i.r, nat.c, puls, sil, spo, thuja.

3 *Marks*

acon, ambr, am, calc.ph, carb.v, chin, cis, fer, dig, lac, phos.acid ,phy, plb ,psor, sep, spig, squ, staph, stram.

"BOENNINGHAUSEN'S CHARACTERISTICS AND REPERTORY"- BY DR.C.M.BOGER
THROAT AND GULLET,INDURATED TONSILS

3 mark:

BRO, IGN, PLB

2 Marks:

con, kali-bi, iod, nit.acid

sore throat, chronic

4marks:

LYC, ZIN

v Tonsils

PHYT.

Tonsils, affected Enlarged, swollen etc
4 marks:

KALI-BI, MERC, PHYT

3 marks*:*

bar.c, bell, nux-vom

v **Hypertrophy**

5 marks:

BELL, HEP, LACH, MERC

4 marks:

Bar-C, Cal-C, Cham, Ign, Nit.Acid, Nux.V, Stap, Sulph

3 marks:

bar.m, brom, canth, kali.iod, lyc, sep, thuja

"HOMOEOPATHIC MEDICAL REPERTORY"- BY ROBIN MURPHY,

Throat, inflammation chronic

3 marks:

MERC, PHOS

2 marks:

Alum, Am-Caus, Arg-Met, Arg-Nit, Bar-C, Carb-S, Carb-Veg, Calc, Cob, Fl.Acid, Ham, Hep, Hydr, Iod, Jug-C, Kali-Bic, Kali-Iod, Lac, Lyc, Nat-C, Nat-Mur, Nit-Acid, Nux, Phyt, Sang, Sep, Silicea, Sulph, Thuja, Wyethia

Throat, Induration, Tonsils

3 marks:

BAR-C, BAR-M

2 marks:

Agar, Bar-I, Calc.I, Cham, Graph, Ign, Iod, Kali-Bi, Merc-I-R, Nit-Acid, Plb, Staph, Staph, Sul-I

Throat, Swelling,Tonsils

3marks:

Bapt, Bar-C, Bar-M, Bell, Calc, Cham, Hep, Lac-C, Lach, Lyc, Nit-Ac, Phos, Phyt, Sulph, Tub

2marks:

Am.c, apis, aur, cal.p, cal-s, carb.acid, chel, colc, crot-t, dulc, fl.acid, gels, graph, guai, kali.iod, man, merc, merc-c, mer-cy, merc-i-f, merc-cy, mer-i-r, mur.ac, plb, ran-s, sabad, staph.

Sub rubrics

Hardness of hearing with-

3 marks: hep

left

3 marks: lach-c, mar-I-r

right:

3 marks: bell, lyc, mer-I-f, phyt

“CLINICAL REPERTORY”- BY J.H.CLARKE

Tonsillitis, concretions in enlarged Bar-C, Ben-Acid, Brom, Calc.P, Plum-Iod, Polyp-P

Hypertrophy of chronic sulph.iod

Swollen Am.M, Guare

“A CONCISE REPERTORY OF HOMOEOPATHIC MEDICINE”- BY DR.S.R.PHATAK

Tonsils-chronicity Bar.C, Bar.M, Bro, Hep, Kali.Iod, Lyc, Nat.M, Sulp.Iod, Thuja

Crypts, grayish, white cal.iod, ign

Tonsils, enlarged 3 marks:

Bar.C, Cal.F, Cal.Iod, Cal.P, Tub

2 marks: bar.m, lac, lyc

“SYNTHESIS” - BY DR.FREDERIK SCHROYENS

Throat, inflammation, chronic

3 marks:

ALUM, ARG,N, BAR.C, BAR.M, BELL, BROM, CALC, CARB.V, CARBN.S, COB, DULC, FLU-ACID, HAM, HEP, JUG.C, KALI-IOD, LACH, LYC, MERC, MEZ, PHOS, PHYT, SEP. SIL, STAPH, SUL-IOD, SULPH, THUJA, ZINC

Throat, inflammation, tonsils, chronic

4 marks: **BARC-C, BAR-M**

2 marks: *Cal-S, Carc, Hep, Streptococcin, Tub, V-A-B*

Generals, history, tonsillitis of recurrent

4 marks: **BAR-C, TUB**

3 marks: *alumn, bary-m, hep, psor, sang, sil, tub*

2 marks: aur-m-n, cal.p, carc, dys, guaj, lach, lyc, morg-g, morg-p, penci, sep, sulp, syc, syp, thymul

Indurations, tonsils of 4 marks:

BAR-C, BAR.M

3 marks:

agar, brom, cham, graph, ign, nit.ac, plb, staph

2 marks:

alumn, arg.n, cal.f, con, cupr, iod, kali.b, petr, sab

Throat, swelling, tonsils

4 marks:

BAR-C, BAR-M, BAP, BELL, CALC, CHAM, HEP, LAC-C, LACH, LYC, NIT.ACID, PHOS, PHY, SIL, SULPH, TUB

3 marks:

Alumn, Aur, Cal.Iod, Cal.P, Cal.C, Car.Ac, Ced, Chel, Chen, Colc, Crot.T, Dulc, Ferr, Fl.Acid, Gels, Graph, Guaj, Kali.B, Kali.C, Kali.Chl, Kali.Iod, Merc, Merc-C, Mer-Cy, Merc-I-F, Merc-I-R, Mur-Ac, Nat.M, Plb, Ran.S, Sabad, Sep, Staph, Syp

Right

3 marks:

Bell, Lyc, Mer-I-F

Left

4 marks: lach

3 marks: brucella melitensis

Children: cal.c, syc

COMPLETE REPERTORY”

Throat, inflammation, sore throat tonsils, chronic

3 marks: **BARC, NIT, PSOR, TUB**

2 marks: *Alumn, Bar-Iod, Bar-M, Hep, Ign, Sang, Sil, Staph*

Chronic-left

1 mark: calc

Throat, induration, tonsils of

3 marks: **Bary.C, Bar.M**

2 marks: *Agar, Bar.I, Cal.Iod, Ign, Mer.I.R, Plb, Nit.Ac, Staph, Sulph.Iod*

Throat, swelling, tonsils

4 Marks: **BAP, BAR-C, BAR-M, BELL, CHAM, HEP, LAC-C, LACH, LYC, NAT-ARS, PHOS, PHY, SIL, SULP**

3 marks: *Am.carb, aur, aur. Sulph, crot.t, dul, cal.p, calc.s, carb.an, chel, colc, fl.ac id, gels, graph, guac, iod, kali.bi, kali.ch, kali.io, manc, mer, mer-c, merc-cyn, mer-i-r, mur.acid, plb, ran. Secl, sab, staph, syco.co, tub*

Tonsils, left

3 marks: **LACH**

Right

2 marks: *Bell, Lyc, Mer-I-R*

Generals, Inflammation, chronic, chronic, tonsillitis

3 marks: **BAR, NIT.ACID, PSOR, TUB**

2 marks:*alum, bar-iod, bar-m, hep, ign, kali-iod, sang, silicea, staph, sulph.iod, thuja*

<u>"CLINICAL REPERTORY"- BY W.BOERICKE</u>
Throat, inflammation, catarrhal chronic

2 marks:*alum, caus, arg.met. arg.nit, hep, hyd,iod, kali-bi, lach, lyc, merc, nux-v, rumex, wye*

Throat, inflammation, follicular, chronic

2 marks: *alum, arum-t, hydr, kali.bic, lach, Mer.i.r, sang.n, wye*

Throat, hypertrophy, induration, inflammation, chronic tendency

2 marks: *bar-c*

MIASMATIC EXPRESSION

Miasms are the constitutional or diathesic states, which determine the modes of existence of the individual. It can be seen as the predisposition towards various chronic diseases. With this understanding of the miasm, we can easily see that it corresponds to the 'constitutional or hereditary influence' of the disease.

According to Dr. Hahnemann, there are 3 causes of diseases, psora, syphilis and sycosis. In any given patient, there could be the influence of one miasm, or any combination of them. An accurate miasmatic diagnosis depends on individual symptoms of the patient

TABLE: 1

MIASMATIC EXPRESSION OF SYMPTOMS AND RUBRICS OF TONSILLITIS

Psora	Sycosis	Syphilis	tubercular
	Induration of tonsils	Induration of tonsils	
Inflammation right			
Inflammation left		<night	
Inflammation forenoon			
Inflammation night	<change of weather	<cold	
Inflammation children			

Inflammation cold after			
Inflammation erysipelatous			
Inflammation follicular			
Inflammation painless			
Inflammation phlegmonous			
Suppuration,tonsils			
Suppuration,tonsils ,left			
Suppuration, tonsils, right			
>warmth		Enlargement of tonsils	
	Swelling tonsils		

MATERIALS AND METHODS

MATERIALS

Population: This study was conducted in the outpatient department of govt. homoeopathic medical college, Thiruvananthapuram, between the age group 3-15 years, irrespective of sex; from 1-5-2005 to 1-11-2005. keeping the aims and objectives in mind and to help in drawing valid conclusions from the study, the following inclusion and exclusion criteria were followed.

Medicines: *Prescription:*

Medicines are given on the basis of symptom totality in different potencies [based on susceptibility, age of the patient, stage of disease etc]

Placebo: sugar of milk, globules and blank tablets.

Dose: 1 pellet in sugar of milk

Pharmacy: Medicines and sundries supplied by m/s kerala state cooperative pharmacy, alapuzha.

Inclusion criteria:

Diagnosis of chronic tonsillitis-history, clinical features, examination and investigation are randomly selected.

Age group-patients within 3-15 years of age

Sex-both sexes are included

Exclusion criteria:

Acute tonsillitis unspecialized

Tonsillitis[acute]

Follicular

Gangrenous

Infective

Ulcerative

Cases below 3 and above 15 years

Cases with other systemic diseases.

Methods sample:

Cases of chronic tonsillitis are diagnosed first on the basis of clinical symptoms. Patients suffering from other systemic diseases were excluded, investigations which included routine blood and urine examination, were done.

The patients, who finally got through the inclusion and exclusion criteria formed the study sample, they were 30 in number, with males and females

Research technique

Sample:

Thirty cases of chronic tonsillitis were selected from the Out patient department of Govt. Homoeopathic Medical College Hospital, Thiruvananthapuram.

Data collection:

From 1-5-2005 to 1-11-2005.

Research Technique:

The selected cases were thoroughly examined on the basis of special proforma in which the complete symptomatology of patients and investigation reports were recorded.

The signs and symptoms of chronic tonsillitis were assessed subjectively and objectively and scored.

Nature of study: A prospective study was conducted and patients were followed upto a period of 6 months. All cases were treated as out patients and no controls were kept for study. The effectiveness of study was statistically analysed after 6 months.

Assessment criteria:

The symptoms and signs were graded on the basis of intensity and four scores were given-severe symptoms & signs as 3, moderate signs and symptoms as 2, mild symptoms and signs as 1, and absence of symptoms and signs as 0.the signs and symptoms considered are

History of repeated attacks of sore throat or acute tonsillitis, associated with symptoms of dysphasia and discomfort, rise o temperature[at least 3 or 4 attacks per year]

These symptoms if seen with enlarged tonsils, hyperaemic pillars and enlarged jugulodigastric lymph nodes.

Study design:

The study considered of subjecting patients with chronic tonsillitis to homoeopathic treatment and assessing the efficacy by comparing the clinical picture before and after the study. It was decided to conduct a clinical trial without placebo control, with the understanding that a placebo control trial may be attempted in future if the results of the current study are encouraging.

Treatment:

The cases were followed up for a period of twelve months, from the date of first prescription. The treatment period was fixed considering the importance of assessing the efficacy of treatment within a reasonable time frame.

Treatment intervention

Case taking and analysis:

Every patient included in the study was interrogated in detail and the history and examination findings are recorded in the case record. In all cases, a detailed analysis and evaluation were done for erecting the totality. The miasmatic basis of the symptoms was also considered to understand the miasmatic influence in each case.

Repertorisation

Kent's repertory was used for repertorisation

Remedy selection

Selection of medicine was made after considering the reportorial analysis and further differentiation with Materia Medica.

Potency selection and repetition of dose:

Potency selection depends on individual case presenting picture. The drugs were given in single dose [in sugar of milk] along with placebo in the form of blank tablets or globules.

Duration of treatment :Six months

Additional measures

Patients were given instructions regarding diet and regimen. They were advised to avoid cold food and drinks, cold exposure, to do gargling.

Assessment and follow up:

Periodical assessment and evaluating were done every two weeks. Outcome assessment done every twelve months. They were asked to report even before the scheduled date, in the event of experiencing any troublesome symptom or serious illness.

Each time changes were noted down regarding presenting complaints or new symptoms. Remedy repeated only if necessary and new remedy considered on the basis of change of symptoms if necessary.

RESULTS AND ANALYSIS

INTRODUCTION

Thirty cases coming under the age group of 3 - 15 years, were included in this study.

TABLE: 2

DISTRIBUTION OF CASES ACCORDING TO AGE

Age group	No: of cases
00 – 03	00
03 – 06	04
06 - 09	12
09 - 12	11
12 - 15	03

TABLE: 3

DISTRIBUTION OF CASES ACCORDING TO SEX

Sex	Number of cases
MALE	11
FEMALE	19

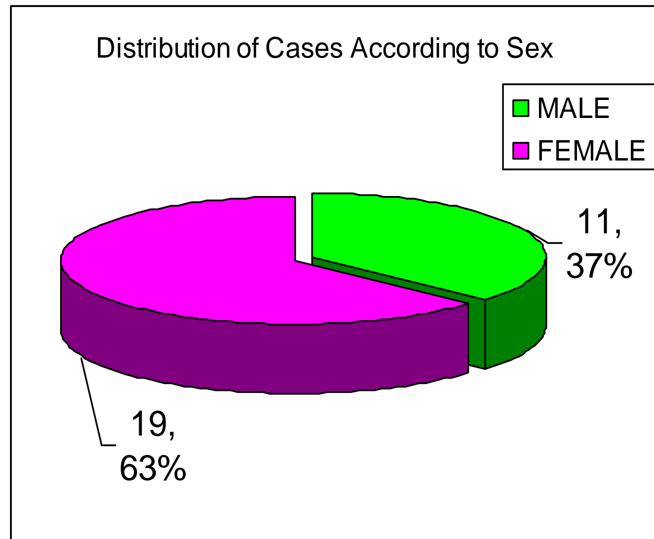


TABLE: 4

DISTRIBUTION OF PATIENTS ACCORDING TO FAMILY ILLNESS

Disease	Frequency	Percentage
Hypertension	12	40
Diabetes mellitus	08	26.7
Asthma	5	16.7
Cancer	01	3.3
Tuberculosis	01	3.3

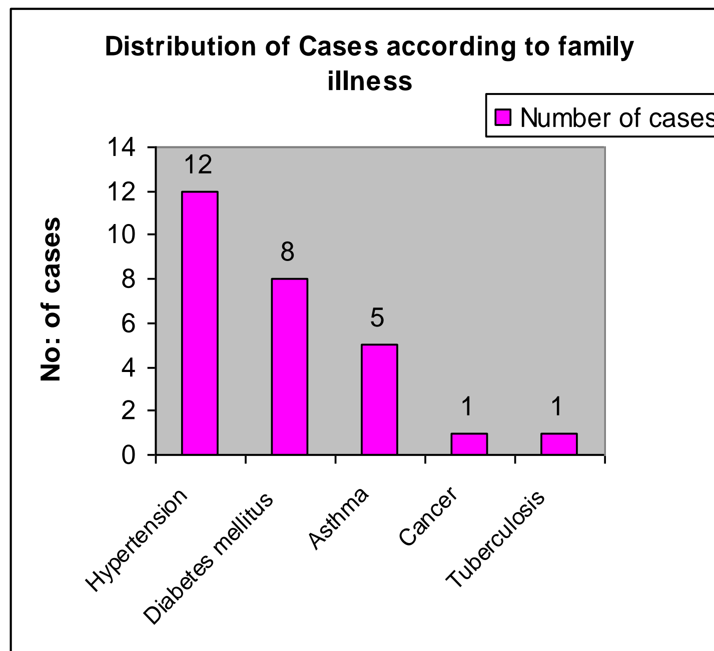


TABLE: 5

DISTRIBUTION OF PATIENTS ACCORDING TO THE TREATMENT HISTORY

System of treatment adopted	Frequency	Percentage
Allopathy	20	66.7
Ayurveda	6	20
Homoeopathy	4	13.3

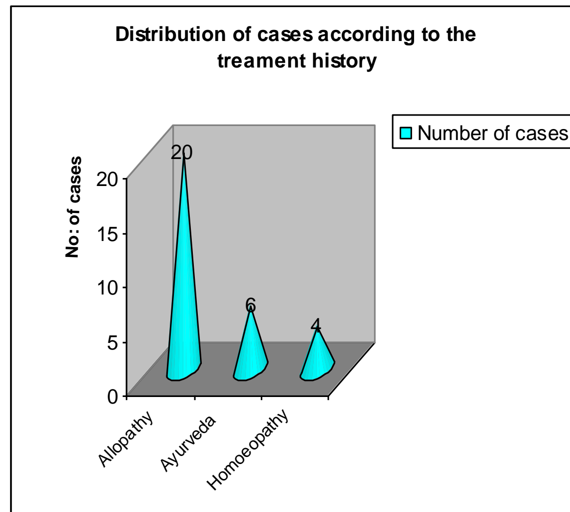


TABLE: 6
DISTRIBUTION OF PATIENTS ACCORDING TO THE PREDOMINANT MIASM

Miasm	Frequency	Percentage
Psora	30	100
Syphilis	09	30
Sycosis	30	100
Pseudo psora	30	100

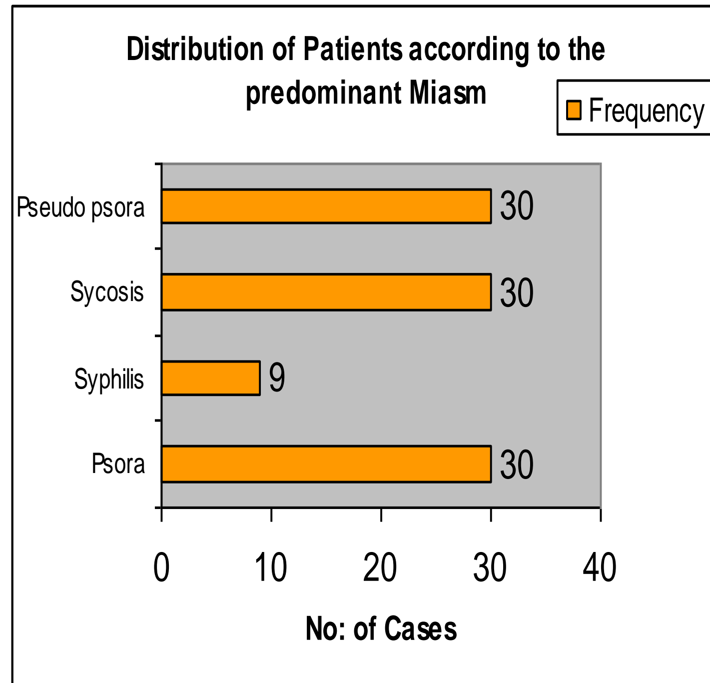


TABLE: 8
DATA RELATED TO THE TREATMENT
ORDER OF EFFECTIVE MEDICINES

Drugs administered	Total cases	Percentage
Calcarea carb	5	16.7
Merc sol	5	16.7
Calc phos	4	13.3
Hepar sulph	4	13.3
Sulphur	3	10.0
Baryt carb	3	10.0
Tuberculinum	3	10.0
Lachesis	2	6.7
Silicea	1	3.3

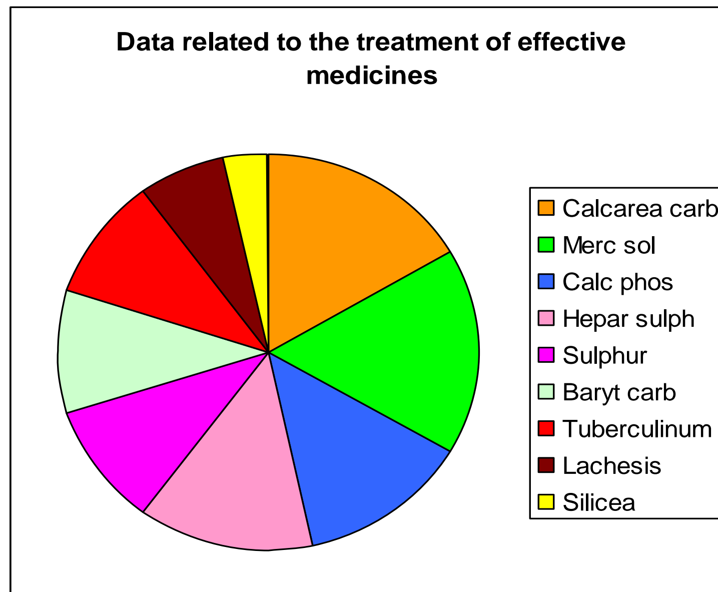


TABLE: 7
DISTRIBUTION OF PATIENTS ACCORDING TO THE MAJOR CLINICAL SYMPTOMS

Clinical symptoms	Frequency	Percentage
Recurrent attacks of sore throat	30	100
Hypertrophied Tonsils	30	100
Enlarged Jugulo digastric Lymphnodes	29	96.7
Difficulty in swallowing	28	93.3
Hoarseness	12	40
Halitosis	09	30

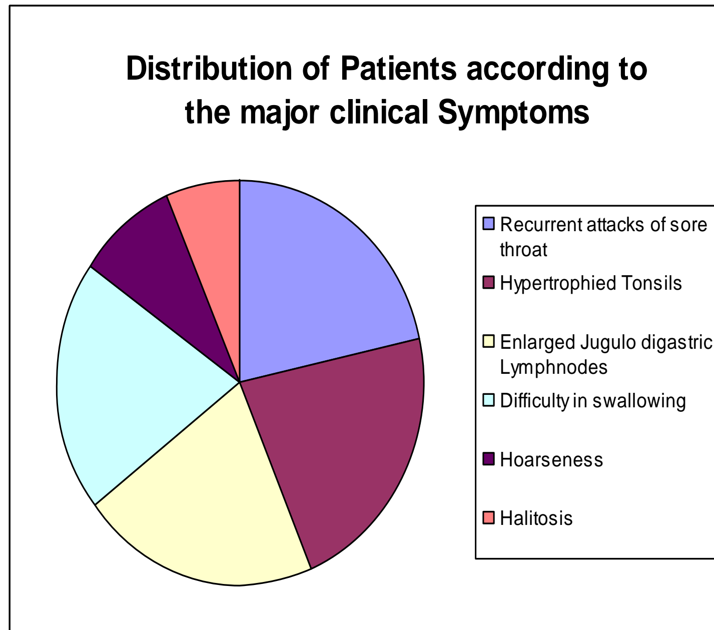
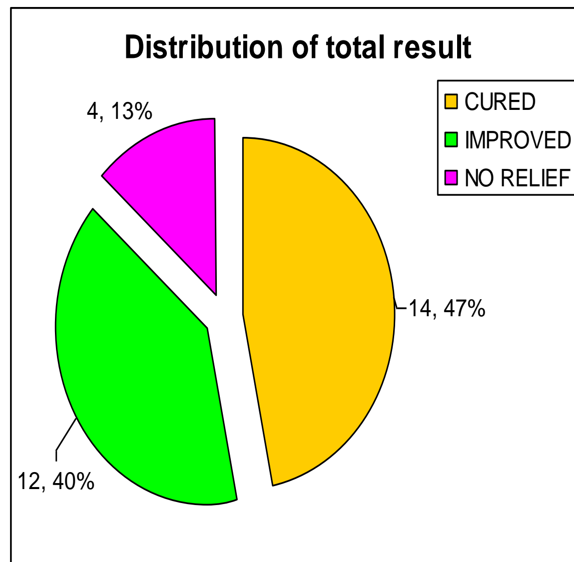


TABLE: 9

DISTRIBUTION OF TOTAL RESULTS

RESULTS	NUMBER OF CASES
CURED	**14**
IMPROVED	**12**
NO RELIEF	**04**



STATISTICAL ANALYSIS

Different scores were given to the various clinical symptoms for the purpose of comparison. The scores obtained before and after the treatment were analysed using the paired 't' test. The following are the steps in analysis

Purpose for analysis – To know if the observed difference between the scores before and after 8 months of homoeopathic treatment is significant or not.

Null hypothesis – there is no significant difference in the scores before and after treatment. Alternative hypothesis – there is significant difference in the scores.

Let the score before treatment be X and after treatment be Y. Find the difference in scores before and after treatment, let it be Z. (Z = X-Y).

Calculate the mean of the difference, Z^ = εZ / n, where n is the sample size, n=20.

Calculate the Standard deviation, S.D, where

$S.D = \sqrt{\varepsilon (Z- Z\hat{})^2 / n-1}$.or $S.D = \sqrt{\varepsilon Z^2 / n-1 - n(Z\hat{})^2 / n-1}$.

F. Calculate the standard error of mean, S.E, where

$S.E = S.D / \sqrt{n}$

G. Determine the 't' value at (n-1) degrees of freedom.

$t_{29} = Z\hat{} / S.E$

H. Comparison with table value – If 't' value obtained is more than the table value at t (n-1) degrees of freedom, the null hypothesis is rejected at 1% and 5% levels with P < .001

Hence the null hypothesis of no difference is rejected and the alternative hypothesis of significant difference is accepted.

PAIRED 't' TEST TO DETERMINE THE EFFECTIVENESS OF THE TREATMENT
TABLE: 10

X	Y	Z	Z^2
10	05	05	25
11	00	11	121
11	05	06	36

10	02	08	64
14	04	10	100
08	00	08	64
08	00	08	64
09	00	09	81
12	03	09	81
11	00	11	121
12	04	08	64
10	00	10	100
08	02	06	36
12	04	08	64
09	00	09	81
11	04	07	49
11	03	08	64
09	00	09	81
10	02	08	64
09	00	09	81
07	07	00	00
10	00	10	100
09	09	00	00
14	00	14	196
10	10	00	00
10	00	10	100
13	10	03	09
14	02	12	144
12	00	12	144
10	00	10	100
TOTAL		**$\varepsilon Z = 238$**	**$\varepsilon Z^2 = 2234$**

$\hat{Z} = \varepsilon Z / n = 238 / 30 = 7.9$

$S.D = \sqrt{\varepsilon Z^2 / n - (\hat{Z})^2} = 3.47$

$t = \hat{Z} / S.D / \sqrt{n} = 12.54$

Table value of t_{29} at 1% level of significance, $t_{29}a\ (.01) = 2.462$

Table value of t_{29} at 5% level of significance, $t_{29}a\ (.05) = 1.699$

$\therefore$ $t > t_{29}a$. So the null hypothesis is rejected and the alternative hypothesis is accepted.

INFERENCE

The study shows that there is significant difference between the scores representing the symptoms of chronic tonsillitis before & after treatment. The difference can be clearly attributed to homoeopathic medicines & can be said that the treatment is effective.

DISCUSSION

Thirty patients coming between the age group three & fifteen years irrespective of sex were included in the study. The parameters were the signs & symptoms of illness. Among the 30 cases, 11 were males & 19 were females. 4 patients belong to age group of 3 – 6 years, 12 belong to age group of 6 – 9 years, 11 belongs to age group of 9 to 12 years & 3 patients belong to 12 to 15 years.

Major clinical features were recurrent attacks of sore throat(100%), hypertrophy of tonsils (100%), enlargement of jugulo di-gastric lymph nodes(96.7%), difficulty in swallowing (93.3%), hoarseness(40%) & hallitosis(30%).

In 16.7% cases Calc carb was the indicated medicine, Merc sol in 11% of cases, Calc phos in 13.3%, Hepar sulph in 13.3%, Sulph in 10% of cases, Baryta carb in 10% of case, Tuberculinum in 10%, Lachesis in 6% & Silicea in 3.3% of cases.
Among the 30 cases, 14 were cured, 12 improved & 4 cases showed no relief.
Statistical evaluation of scores before & after treatment clearly shows that Homoeopathic medicines are effective in the management of Chronic tonsillitis.

Conclusion
Homoeopathic Medicines are effective in the management of chronic tonsillitis.
Remedies when given on the basis of individualisation are more effective.

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