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Homoeopathic management of bronchiectasis: A case study

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Abstract
On 15th March 2024, a 65-year-old female, Mrs A, came to the OP of Govt. Homoeopathic Medical College & Hospital Thiruvananthapuram, with complaints of difficulty in breathing, palpitation and cough with white sputum. She was unable to stand or walk. All complaints aggravated during movement, exertion, walking, night and lying down. Also she had weakness of body and oedema of both legs. She had recurrent attacks of these symptoms for last five years. Last month, she had fever with the respiratory complaints and diagnosed as bronchiectasis. Here, she was managed with Ars. alb 30 and Ant.tart 30 along with oxygen administration and discharged on 26/03/2024.

Keywords: Bronchiectasis, homoeopathy, pleural effusion

Introduction
Bronchiectasis is characterized radiologically by persistent bronchial dilatation and clinically by a syndrome of cough, sputum production and recurrent respiratory infections. In the past, it was considered as a neglected disease, but in recent years there has been a resurgence of interest in the disease, leading to clinical research and the development of new treatments [1]. This non-cystic fibrosis bronchiectasis increases the morbidity and reduces the quality of life. Several diseases can cause bronchiectasis. Idiopathic bronchiectasis was present in 40% of patients, followed by a post-infectious cause in 20%, chronic obstructive pulmonary disease (COPD) in 15%, connective tissue disease (CTD) in 10%, immunodeficiency in 5.8% and asthma in 3.3% [2].
A commonly used classification system distinguishes cylindrical, varicose, and saccular or cystic bronchiectasis. Although comprehensive, this classification has no clinical or therapeutic use. The modern clinical definition includes daily mucosal mucus and chest imaging showing dilated and thickened airways [3]. In case of clinical suspicion, a thin-section computed tomography (CT) scan helps to confirm the diagnosis of bronchiectasis [4]. Radiological bronchitis is diagnosed by high-resolution computed tomography of the chest when the diameter of the bronchus exceeds the diameter of the adjacent blood vessel (broncho-arterial ratio > 1). However, age can affect the ratio of bronchial arteries, with studies showing that 40% of the healthy population over 65 years of age have an abnormally high ratio. Therefore, the term "clinically significant bronchiectasis" is used when the radiological diagnosis is relevant to the study [1].
Treatment aims to reduce exacerbations, improve quality of life and prevent the progression of the disease. This is achieved by the treatment of bronchitis, supporting the effectiveness of airway techniques, medicines, and mucolytic agents (eg, inhaled isotonic or hypertonic saline) in some patients. Bronchiectasis is a disabling disease that is increasing in prevalence and can affect people of all ages. A major challenge is to apply new methods of phenotyping and endotyping to identify patient populations that would benefit most from a particular treatment. The goal is to better target existing and new treatment methods and achieve better results [5].

Case study
A 65-year-old female, Mrs A, came to the OP of Govt. Homoeopathic Medical College & Hospital Thiruvananthapuram on 15/03/2024 with complaints of difficulty in breathing, palpitation and cough with white sputum. She can't stand or walk. She was diagnosed having Bronchiectasis, admitted and managed with Ars.alb 30 and Ant.tart 30 along with oxygen administration and was discharged on 26/03/2024.

Presenting complaints

- Cough with white sputum, palpitation and difficulty in breathing. < lying down
- Oedema of whole body with pain in joints which was aggravated by motion, exertion and night

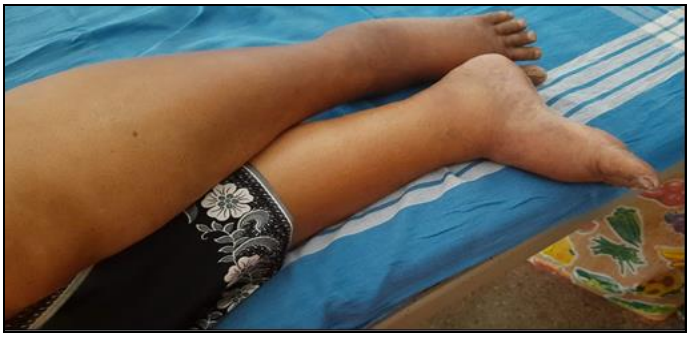
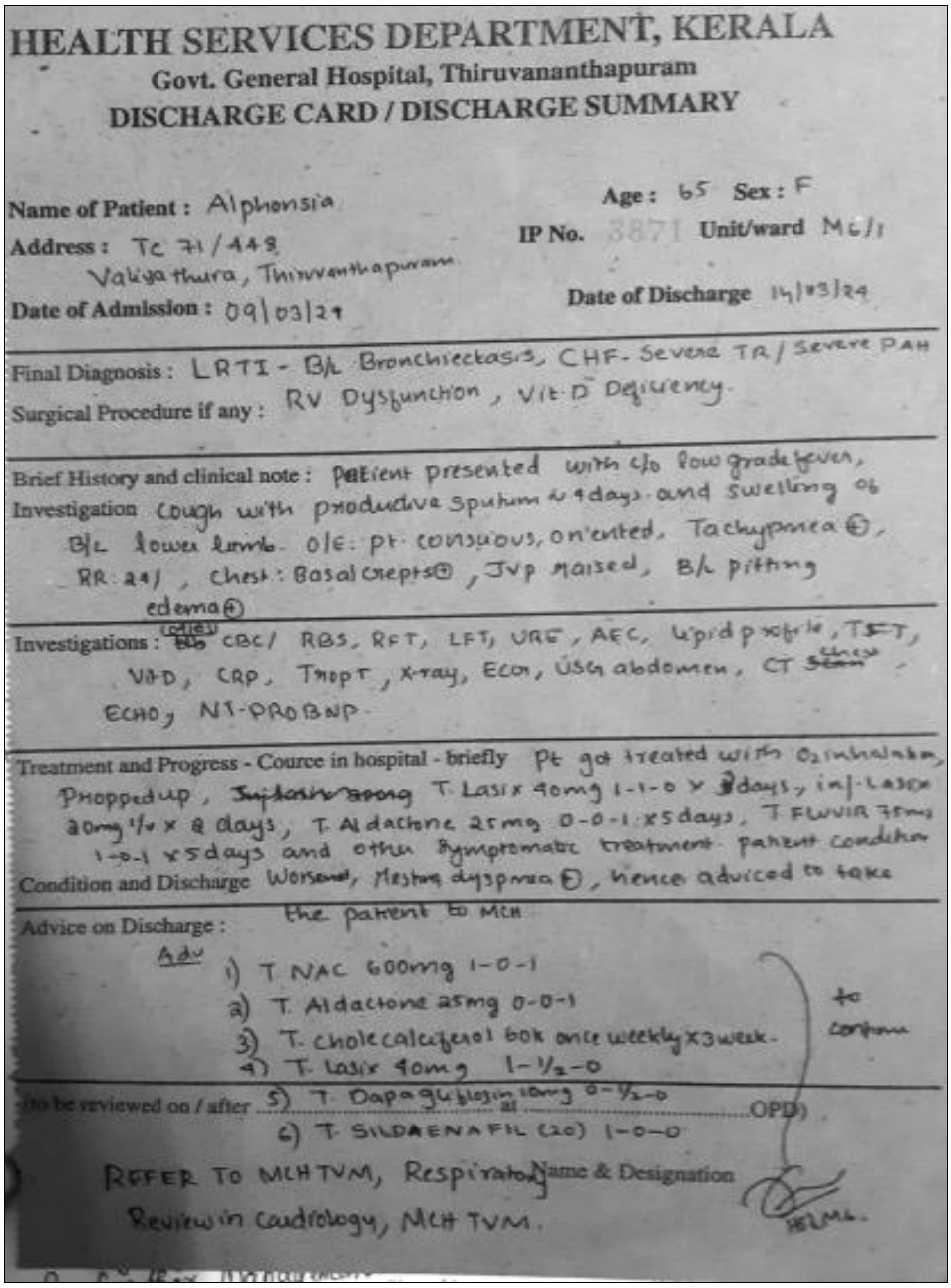


Fig 1: Pedal oedema

History of presenting complaints

Last month she had fever, cough with whitish expectoration and breathing difficulty. Admitted at General hospital and diagnosed having bronchiectasis, congestive cardiac failure and vitamin D deficiency.



HEALTH SERVICES DEPARTMENT, KERALA
Govt. General Hospital, Thiruvananthapuram
DISCHARGE CARD / DISCHARGE SUMMARY

Name of Patient : Alphonsia
Age : 65 Sex : F
Address : TC 71/448 Valiyathura, Thiruvanthapuram
IP No. 3871 Unit/ward MG/1
Date of Admission : 09/03/24
Date of Discharge 14/03/24

Final Diagnosis : LRTI - B/L Bronchiectasis, CHF- Severe TR / Severe PAH
Surgical Procedure if any : RV Dysfunction, Vit D Deficiency

Brief History and clinical note : Patient presented with c/o low grade fever, cough with productive sputum x 4 days and swelling of B/L lower limb. O/E: pt conscious, oriented, Tachypnea (+), RR 24/, chest: Basal crepts (+), JVP raised, B/L pitting edema (+)
Investigation

Investigations : CBC/ RBS, RFT, LFT, URE, AEC, Lipid profile, TFT, VitD, CRP, TropT, X-ray, ECG, USG abdomen, CT chest, ECHO, NT-PROBNP

Treatment and Progress - Cource in hospital - briefly Pt got treated with O2 inhalation, Propped up, Inj. Lasix 20mg stat T. Lasix 40mg 1-1-0 x 3 days, inj. Lasix 20mg 1/2 x 2 days, T. Aldactone 25mg 0-0-1 x 5 days, T. FLUVIR 75mg 1-0-1 x 5 days and other symptomatic treatment. Patient condition
Condition and Discharge Worsened, Resting dyspnea (+), hence adviced to take the patient to MCH

Advice on Discharge :
Adv
1) T. NAC 600mg 1-0-1
2) T. Aldactone 25mg 0-0-1
3) T. cholecalciferol 60k once weekly x 3 week.
4) T. Lasix 40mg 1-1/2-0
5) T. Dapagliflozin 10mg 0-1/2-0
6) T. SILDAENAFIL (20) 1-0-0

to continue

To be reviewed on / after ..... at ..... OPD)
REFER TO MCH TVM, Respiratory
Review in Cardiology, MCH TVM.
Name & Designation

Fig 2: Discharge Summary

History of previous illness
Complaint started five years back as recurrent attacks of cough, breathing difficulty and palpitation. Often, she took tablets from nearby medical shop, which temporally relieved the symptoms.

Family history
Not relevant

Personal history
- Patient is illiterate, obese, economically and socially good.
- Married at the age of 17 years and has 2 children.
- She has non vegetarian diet with poor appetite and thirst for warm water. Prefer 4/5 cups of tea daily.
- Stool and Urine - irregular stool. Urine nothing particular
- Sweat - Increased and has sleep is disturbed due to cough.
- She has aversion for covering, desires fanning.
- Desire for sweets and spicy food
- Thermally hot patient
- She had menarche at the age of 13 years and menopause at 50 years.
- She conceived 4 times and had 2 death.

Mind
Aversion to company. Doesn't like to speak.

Regionals
- She complains about occasional headache.
- Has pain in back which is aggravated by walking.
- Pain in both knee joints with oedema.

Physical examination
- Obese and dark in complexion
- Pulse rate - 82/min
- Resp. rate - 20/min
- BP 120/80 mm Hg
- She has no pallor, no jaundice, no clubbing and no lymphadenopathy
- She has marked bilateral pitting pedal oedema.
- O/E chest - crackles present b/l
- SpO2 - 77%

Investigations
- **ECG - 09/03/2024**
- Sinus tachycardia, HR - 100; Biphasic T wave V3, V4; T inversion V2.

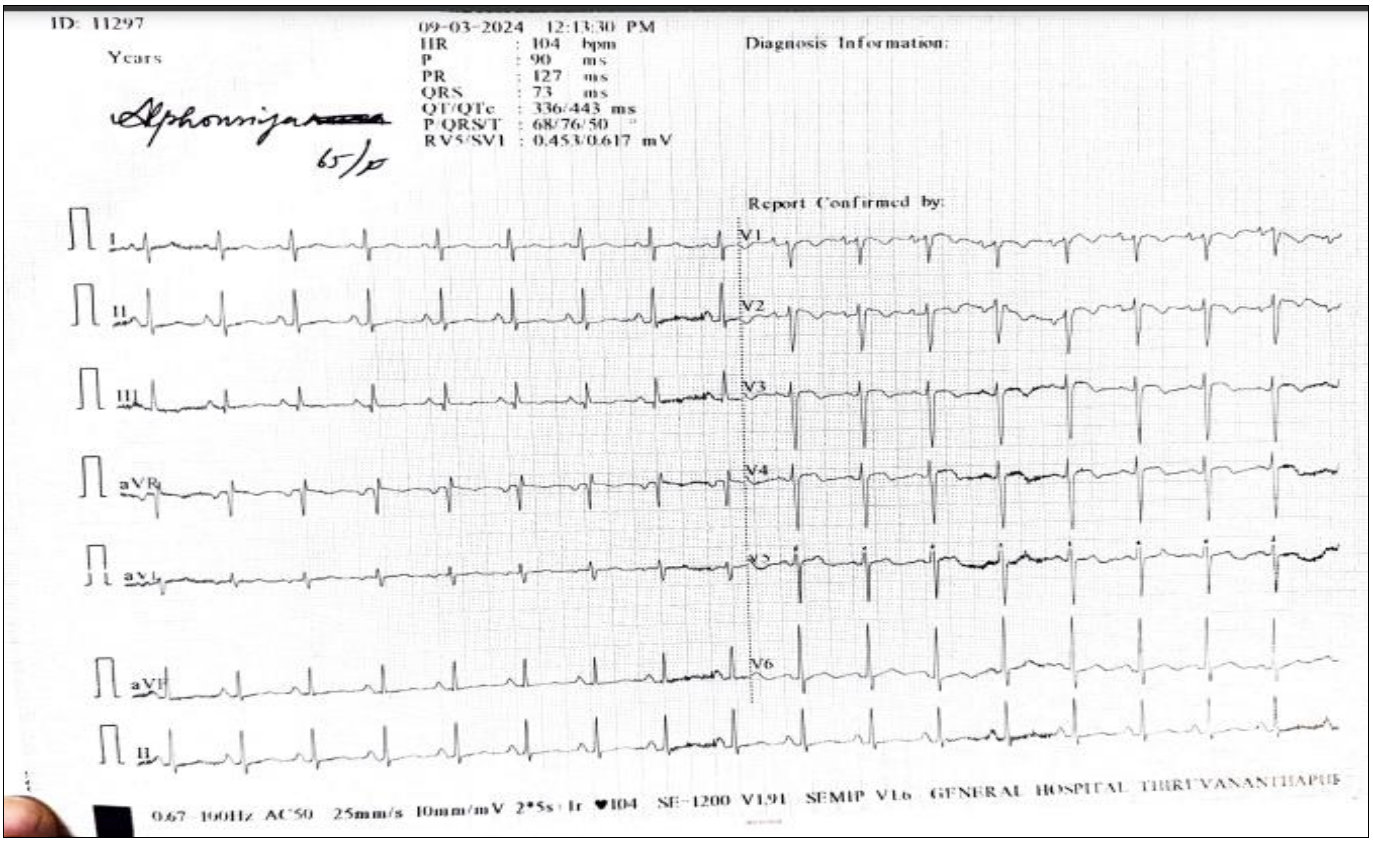


Fig 3: ECG Report

Blood test 09/03/2024
- Troponin T - 17.89 ng/
- NT Pro BNP - 4336 pg/ml

RGCB
DISCOVERIES FOR A BETTER TOMORROW

MEDICAL LABORATORY SERVICES
Under the Public Health Research and Services Program
(An initiative of Rajiv Gandhi Centre for Biotechnology, Government of India)
A NABH Accredited National Reference Laboratory

Investigation Report

Name : Mrs. ALPHONSIA
Age / Sex : 65 Year(s) / Female
Ref. Doctor :
Client : Walk-in

Patient ID : P2009131
Visit No. : GHT2456597
Registered On : 09/03/2024 03:04 PM
Collected On : 09/03/2024 03:04 PM
Reported On : 09/03/2024 05:18 PM

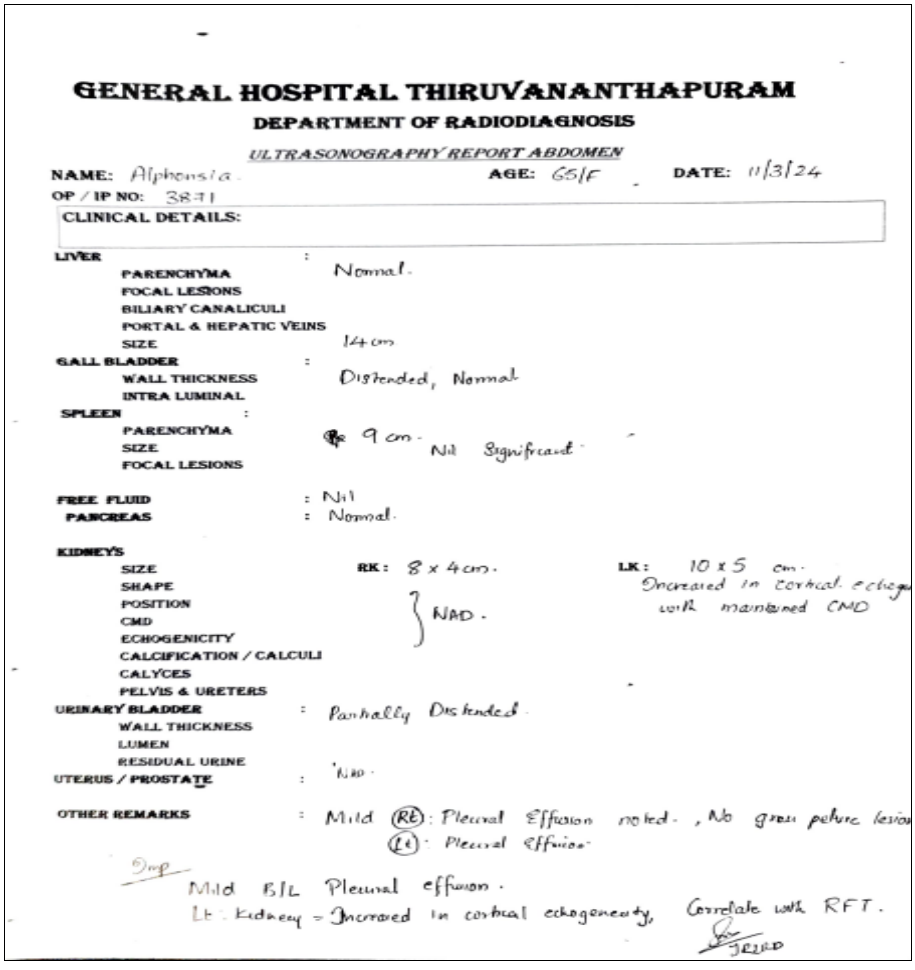
Test	Results	Units	Reference Range
BIOCHEMISTRY			
Troponin - T, Quantitative (ECLIA) - EDTA Plasma	17.89	pg/mL	Negative: 0-14 Low Risk (Need Observation): 15-30 Moderate to High Risk: 31-100 High Risk of AMI: > 100
NT - pro BNP (N-Terminal Natriuretic Peptide) - Serum	4336.00	pg/mL	10-125

Comment: Please correlate clinically.

-- End of Report --

Fig 4: Blood Report on 08/03/2024

- USG Abdomen - 11/03/2024
- Mild b/l pleural effusion;
- Left kidney increased in cortical echogenisity.



GENERAL HOSPITAL THIRUVANANTHAPURAM
DEPARTMENT OF RADIODIAGNOSIS

ULTRASONOGRAPHY REPORT ABDOMEN

NAME: Alphonsia AGE: 65/F DATE: 11/3/24
OP / IP NO: 3871

CLINICAL DETAILS:

LIVER :
PARENCHYMA Normal.
FOCAL LESIONS
BILIARY CANALICULI
PORTAL & HEPATIC VEINS
SIZE 14 cm
GALL BLADDER :
WALL THICKNESS Distended, Normal
INTRA LUMINAL
SPLEEN :
PARENCHYMA
SIZE 9 cm. Nil Significant
FOCAL LESIONS

FREE FLUID : Nil
PANCREAS : Normal.

KIDNEYS
SIZE RK: 8 x 4 cm. LK: 10 x 5 cm.
SHAPE
POSITION } NAD.
CMD
ECHOGENICITY Increased in cortical echoge with maintained CMD
CALCIFICATION / CALCULI
CALYCES
PELVIS & URETERS
URINARY BLADDER : Partially Distended.
WALL THICKNESS
LUMEN
RESIDUAL URINE
UTERUS / PROSTATE : NAD.

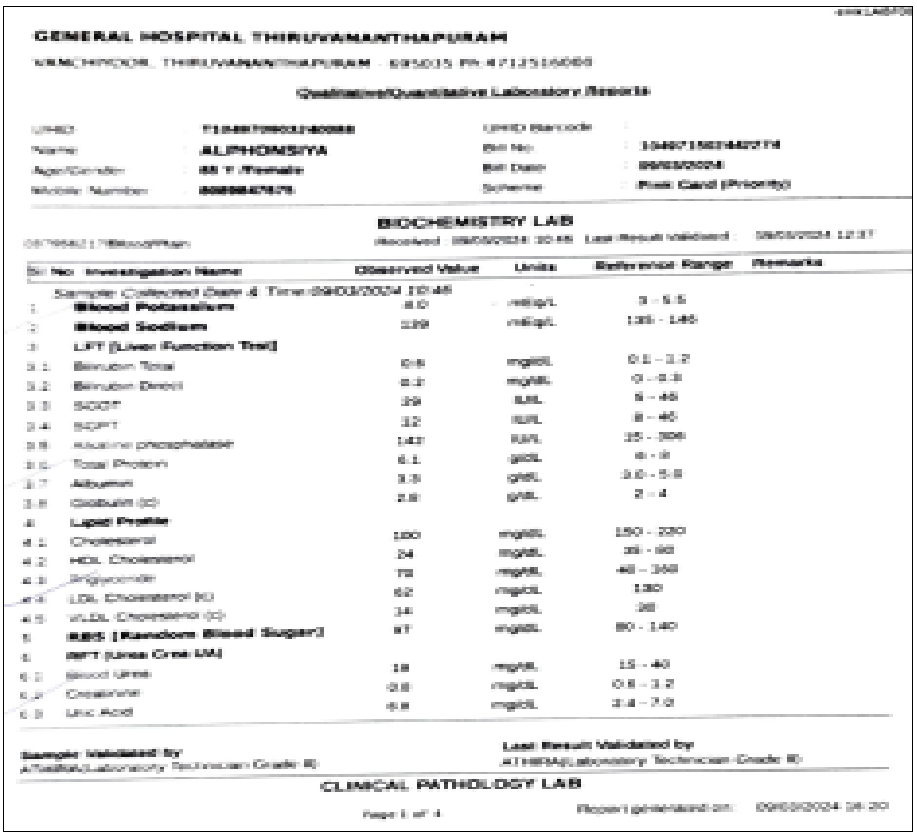
OTHER REMARKS : Mild (Rt): Pleural Effusion noted., No gross pelvic lesion
(Lt): Pleural Effusion.

Impr
Mild B/L Pleural effusion.
Lt. Kidney - Increased in cortical echogenecity, Correlate with RFT.

JERED

Fig 5: USG Report on 11/03/2024

09/03/2024 - Blood Test T. Cholesterol - 100mg%; LDL - 62mg%



GENERAL HOSPITAL THIRUVANANTHAPURAM

Qualitative/Quantitative Laboratory Reports

UHID: T1048/09/03/40088
Name: ALPHONSIYA
Age/Gender: 65 Y /Female
Mobile Number: 8089847575
UHID Barcode
Bill No: 1048/1502/442274
Bill Date: 09/03/2024
Scheme: Pink Card (Priority)

BIOCHEMISTRY LAB

Received : 09/03/2024 10:46 Last Result Validated : 09/03/2024 12:37

Sl No	Investigation Name	Observed Value	Units	Reference Range	Remarks
	Sample Collected Date & Time:09/03/2024 10:46				
1	**Blood Potassium**	4.0	mEq/L	3 - 5.5	
2	**Blood Sodium**	139	mEq/L	135 - 145	
3	**LFT [Liver Function Test]**				
3.1	Bilirubin Total	0.6	mg/dL	0.1 - 1.2	
3.2	Bilirubin Direct	0.2	mg/dL	0 - 0.3	
3.3	SGOT	29	IU/L	5 - 45	
3.4	SGPT	32	IU/L	5 - 45	
3.5	Alkaline phosphatase	143	IU/L	35 - 306	
3.6	Total Protein	6.1	g/dL	6 - 8	
3.7	Albumin	3.5	g/dL	3.5 - 5.5	
3.8	Globulin (c)	2.6	g/dL	2 - 4	
4	**Lipid Profile**				
4.1	Cholesterol	100	mg/dL	150 - 220	
4.2	HDL Cholesterol	24	mg/dL	35 - 60	
4.3	Triglyceride	70	mg/dL	40 - 160	
4.4	LDL Cholesterol (c)	62	mg/dL	130	
4.5	VLDL Cholesterol (c)	14	mg/dL	26	
5	**RBS: [Random Blood Sugar]**	97	mg/dL	80 - 140	
6	**RFT [Urea Cre UA]**				
6.1	Blood Urea	18	mg/dL	15 - 40	
6.2	Creatinine	0.8	mg/dL	0.6 - 1.2	
6.3	Uric Acid	4.8	mg/dL	3.4 - 7.0	

Sample Validated by: ATHIRA[Laboratory Technician Grade II]

Last Result Validated by: ATHIRA[Laboratory Technician Grade II]

CLINICAL PATHOLOGY LAB

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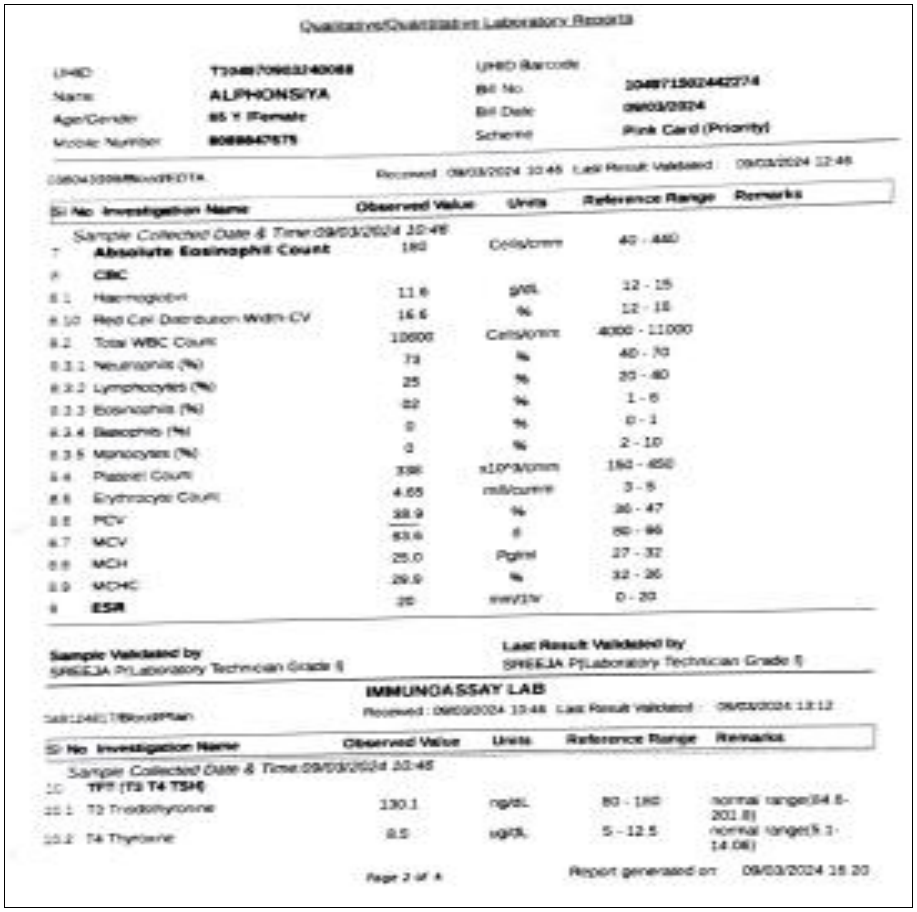
Fig 5: Blood Report on 09/03/2024



Qualitative/Quantitative Laboratory Reports

UHID: T1048/09/03/40088
Name: ALPHONSIYA
Age/Gender: 65 Y /Female
Mobile Number: 8089847575
UHID Barcode
Bill No: 1048/1502/442274
Bill Date: 09/03/2024
Scheme: Pink Card (Priority)

Received : 09/03/2024 10:46 Last Result Validated : 09/03/2024 12:46

Sl No	Investigation Name	Observed Value	Units	Reference Range	Remarks
	Sample Collected Date & Time:09/03/2024 10:46				
7	**Absolute Eosinophil Count**	180	Cells/cmm	40 - 440	
8	**CBC**				
8.1	Haemoglobin	11.6	g/dL	12 - 15	
8.10	Red Cel Distribution Width-CV	16.6	%	12 - 16	
8.2	Total WBC Count	10600	Cells/cmm	4000 - 11000	
8.3.1	Neutrophils (%)	73	%	40 - 70	
8.3.2	Lymphocytes (%)	25	%	20 - 40	
8.3.3	Eosinophils (%)	02	%	1 - 6	
8.3.4	Basophils (%)	0	%	0 - 1	
8.3.5	Monocytes (%)	0	%	2 - 10	
8.4	Platelet Count	398	x10^3/cmm	150 - 450	
8.5	Erythrocyte Count	4.65	mill/cumm	3 - 5	
8.6	PCV	38.9	%	36 - 47	
8.7	MCV	83.6	fl	80 - 96	
8.8	MCH	25.0	Pg/ml	27 - 32	
8.9	MCHC	29.9	%	32 - 36	
9	**ESR**	20	mm/1hr	0 - 20	

Sample Validated by: SREEJA P[Laboratory Technician Grade I]

Last Result Validated by: SREEJA P[Laboratory Technician Grade I]

IMMUNOASSAY LAB

Received : 09/03/2024 10:46 Last Result Validated : 09/03/2024 13:12

Sl No	Investigation Name	Observed Value	Units	Reference Range	Remarks
	Sample Collected Date & Time:09/03/2024 10:46				
10	**TFT [T3 T4 TSH]**				
10.1	T3 Triiodothyronine	130.1	ng/dL	80 - 180	normal range[64.6 - 201.8]
10.2	T4 Thyroxine	8.5	ug/dL	5 - 12.5	normal range[5.1 - 14.06]

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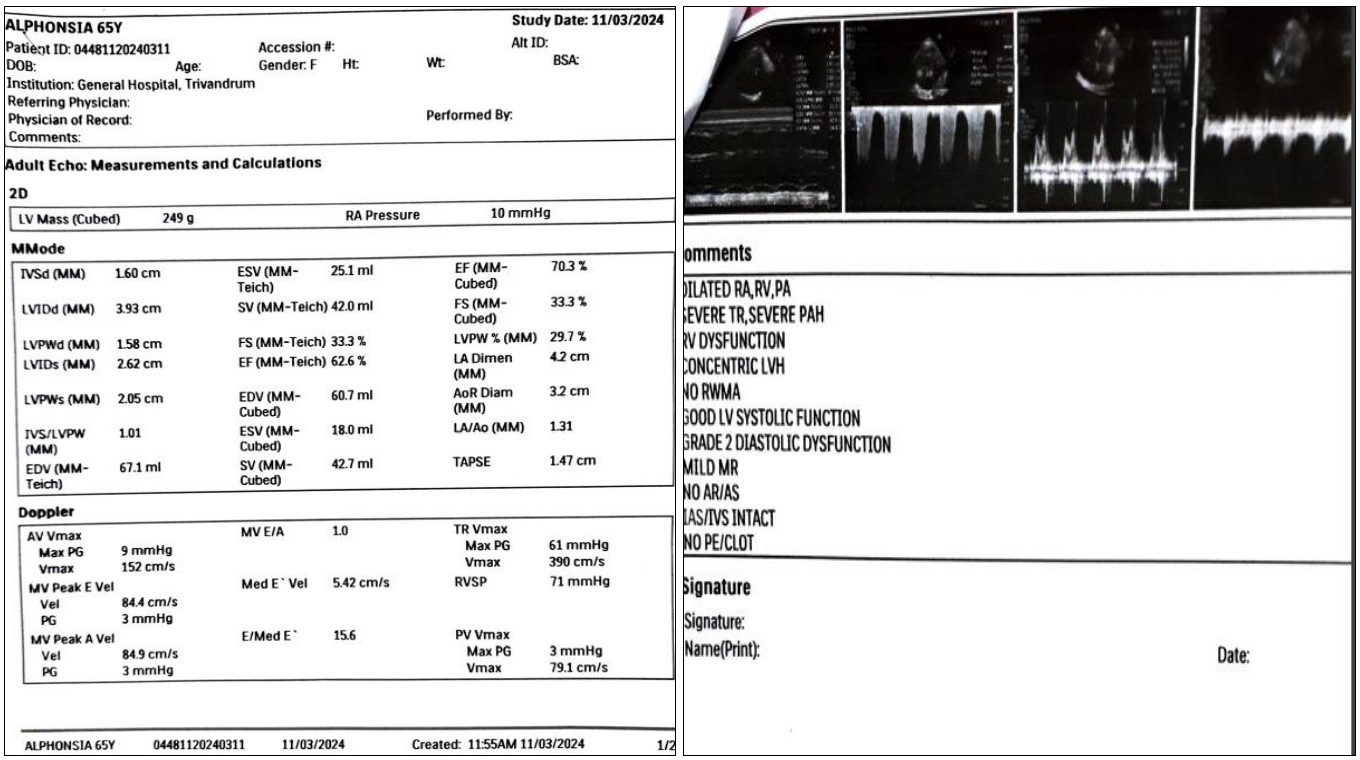
Fig 6: Blood Report on 09/03/2024

09/12/2023 - Echo cardiogram



ALPHONSIA 65Y
Study Date: 11/03/2024
Patient ID: 04481120240311 Accession #: Alt ID:
DOB: Age: Gender: F Ht: Wt: BSA:
Institution: General Hospital, Trivandrum
Referring Physician:
Physician of Record: Performed By:
Comments:

Adult Echo: Measurements and Calculations

2D

LV Mass (Cubed)	249 g	RA Pressure	10 mmHg

MMode

IVSd (MM)	1.60 cm	ESV (MM-Teich)	25.1 ml	EF (MM-Cubed)	70.3 %
LVIDd (MM)	3.93 cm	SV (MM-Teich)	42.0 ml	FS (MM-Cubed)	33.3 %
LVPWd (MM)	1.58 cm	FS (MM-Teich)	33.3 %	LVPW % (MM)	29.7 %
LVIDs (MM)	2.62 cm	EF (MM-Teich)	62.6 %	LA Dimen (MM)	4.2 cm
LVPWs (MM)	2.05 cm	EDV (MM-Cubed)	60.7 ml	AoR Diam (MM)	3.2 cm
IVS/LVPW (MM)	1.01	ESV (MM-Cubed)	18.0 ml	LA/Ao (MM)	1.31
EDV (MM-Teich)	67.1 ml	SV (MM-Cubed)	42.7 ml	TAPSE	1.47 cm

Doppler

AV Vmax		MV E/A	1.0	TR Vmax	
Max PG	9 mmHg			Max PG	61 mmHg
Vmax	152 cm/s			Vmax	390 cm/s
MV Peak E Vel		Med E` Vel	5.42 cm/s	RVSP	71 mmHg
Vel	84.4 cm/s				
PG	3 mmHg				
MV Peak A Vel		E/Med E`	15.6	PV Vmax	
Vel	84.9 cm/s			Max PG	3 mmHg
PG	3 mmHg			Vmax	79.1 cm/s

ALPHONSIA 65Y 04481120240311 11/03/2024 Created: 11:55AM 11/03/2024 1/2

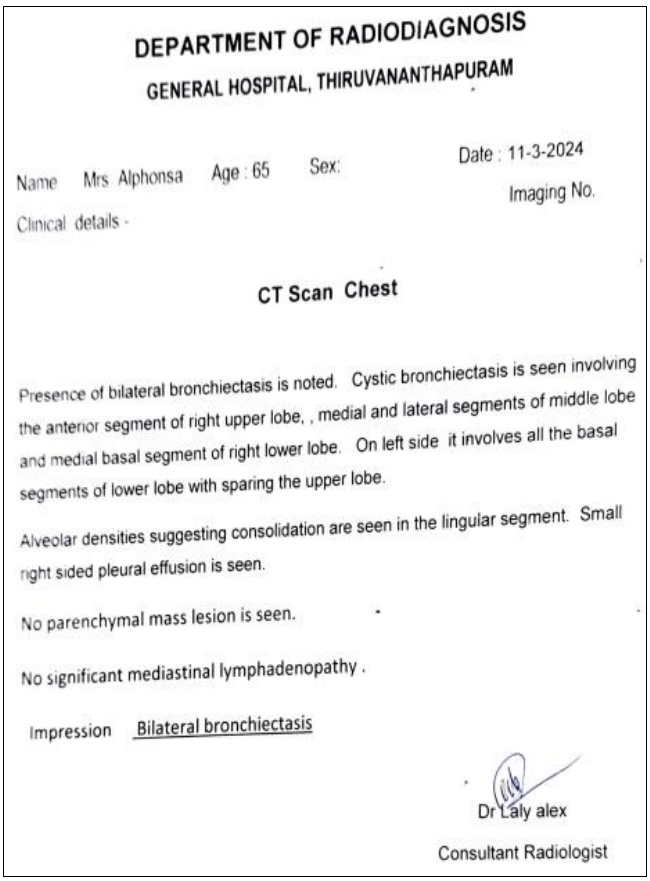
omments
DILATED RA,RV,PA
SEVERE TR,SEVERE PAH
RV DYSFUNCTION
CONCENTRIC LVH
NO RWMA
GOOD LV SYSTOLIC FUNCTION
GRADE 2 DIASTOLIC DYSFUNCTION
MILD MR
NO AR/AS
IAS/IVS INTACT
NO PE/CLOT

Signature
Signature:
Name(Print): Date:

Fig 7: Echo cardiogram

Severe TR, mild MR

C T Chest -on 13/03/2024
Impression - B/L Bronchiectasis.



DEPARTMENT OF RADIODIAGNOSIS
GENERAL HOSPITAL, THIRUVANANTHAPURAM

Name Mrs Alphonsa Age : 65 Sex: Date : 11-3-2024
Imaging No.
Clinical details -

CT Scan Chest

Presence of bilateral bronchiectasis is noted. Cystic bronchiectasis is seen involving the anterior segment of right upper lobe, , medial and lateral segments of middle lobe and medial basal segment of right lower lobe. On left side it involves all the basal segments of lower lobe with sparing the upper lobe.

Alveolar densities suggesting consolidation are seen in the lingular segment. Small right sided pleural effusion is seen.

No parenchymal mass lesion is seen.

No significant mediastinal lymphadenopathy .

Impression Bilateral bronchiectasis

Dr Laly alex
Consultant Radiologist

Fig 9: CT Scan -Chest

Analysis
- Aversion to company, doesn't like to speak. Anguish.
- Desire for sweets and spicy food
- Pain in both knee joints with oedema
- Cough with white sputum at night.
- Palpitation, aggravated by motion and exertion
- Difficulty in breathing. < lying down
- Oedema of whole body.

Provisional diagnosis
Bronchiectasis, CHF, TR

Repertorization - rubrics
- Respiration- difficult lying while
- Chest - palpitation, heart, exertion
- Stomach - Appetite, diminished
- Stomach - desires sweets
- Rectum - Constipation
- Mind - anguish
- Generality - heat sensation of
- Generality - dropsy, internal

Medicines
- Ars alb-18/8
- Lyc -17/7
- Sulph -17/7
- Cal.carb - 16/7
- Digita - 15/6
- Phos - 14/7
- Sulp -15/6
- Arg.nit - 14/6

Observation and follow up

16/03/24- Difficulty in breathing, palpitation and cough. Can't sit or stand. Weakness+++

BP 120/80 mm Hg. O2 saturation reduced. Appetite and thirst -reduced;

Rx Carbo veg30/3D (1-1-1)

Apocynum Q (15-15-15).

17/03/24- Difficulty in breathing < exertion; palpitation; cough with expectoration, oedema of Body. BP 120/70 mm Hg. O2 saturation reduced - 81%. Can't sit or stand.

Weakness+++. Appetite and thirst - reduced.

Rx Ant.tart 30/2D (1 0 1)

19/03/24 & 20/3/24 - palpitation >, O2 saturation reduced - 67%. Can't sit or stand.

Rx repeat + Oxygen administration.

Fig 10: On 19/3/24

Fig 11: On 25/3/24

Ant. Tart 30 / 2d and Kali mur 6x /4d was repeated in the following four days, along with O2 administration. 23/03/24 onwards cough and expectoration had slight relief. She was able to sit and walk with support. On 26/03//24, she was discharged.

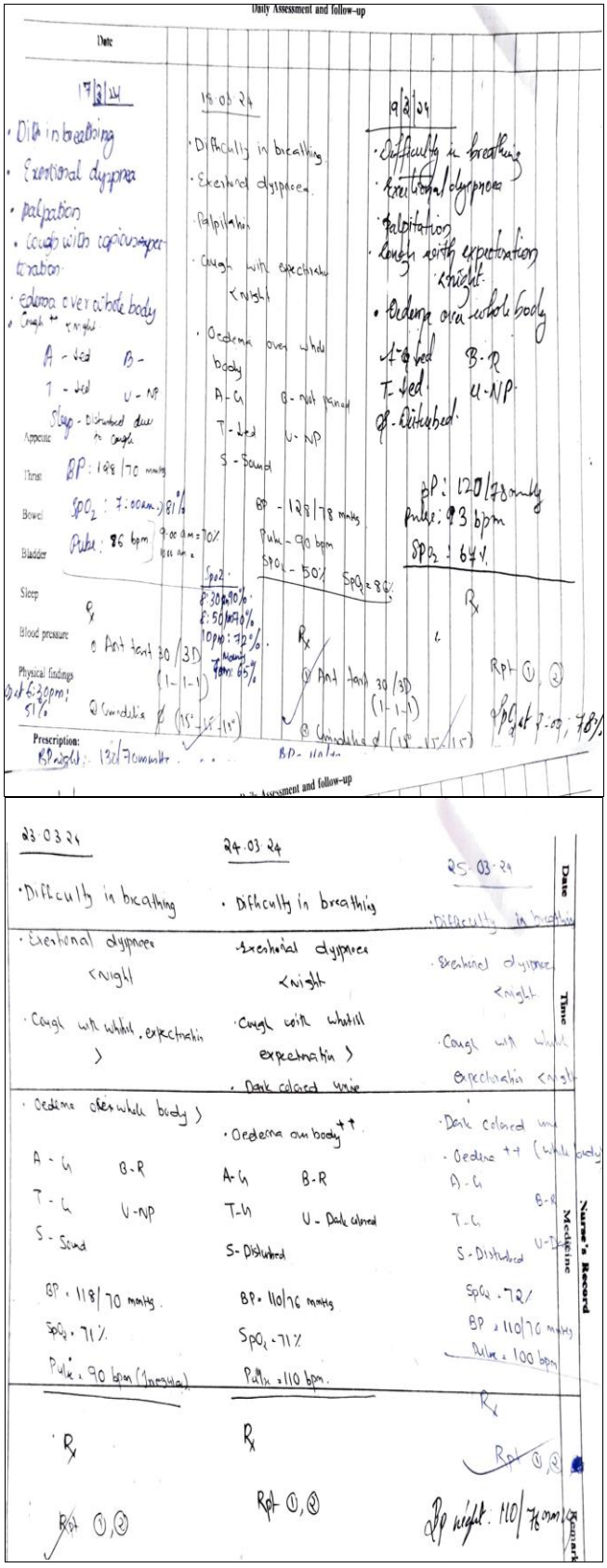


Fig 12: Case record showing daily observations

Discussion

Studies conducted on Ars alb says, it increases reactive oxygen species (ROS) levels, decreases the mitochondrial transmembrane potential and triggers caspase-dependent

apoptosis in human CD4+ and CD8+ T cells. [6]. Important symptoms in Asr.alb are suffocative cough worse on lying, night. Expectoration is there, burning heat all over. Wheezing respiration [7]. Hahnemann in his" Chronic Diseases" says that the original malady that has miasmatic, chronic nature, once advanced and developed to a certain degree it can never be removed by the strength of robust constitution or diet [8]. Aphorism 7 says that the affection of vital force is outwardly reflected as disease and these symptoms determines the appropriate remedy [9].

Conclusion

This 65-year-old female had the chief complaints as difficulty in breathing, palpitation, oedema and cough with white sputum. She was unable to stand or walk and came with the help of wheel chair. On second day onwards the SpO2 frequently began to vary, often reached 55%. Tinctures like Aspidosperma or Grindelia didn't worked. The 30th potency of Ars.alb and Ant.tart along with oxygen administration relieved her symptoms and was able to stand and walk.

Conflict of Interest

Not available.

Financial support

Not available

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