CHRONIC BRONCHITIS AND HOMOEOPATHY

ABSTRACT

Due to the increase in environmental pollutants, cigarette smoking and other harmful influences, the incidence of COPD has increased dramatically in the last few decades. It has become the most common cause of death worldwide. Homeopathy offers promising treatment for chronic bronchitis. According to the literature, treatment is curative rather than palliative.

KEYWORDS

Chronic bronchitis, chronic obstructive pulmonary disease, homeopathy, smoker's disease.

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INTRODUCTION:

Chronic bronchitis is one of the two major lung diseases grouped under COPD, chronic bronchitis is clinically defined as persistent cough with expectoration most days for at least quarter of the year for two or more succesive years. Cough is caused by excessive secretion of mucus. Chronic bronchitis is a chronic, ongoing, progressive inflammation of the bronchi in the lungs. It is generally considered one of two forms of chronic obstructive pulmonary disease (COPD) and is clinically defined as a persistent cough that produces sputum (phlegm) and phlegm for at least three months in two consecutive years. Chronic bronchitis is characterized by a persistent, loose, wet cough that produces excessive mucus. Bronchitis is a severely disabling disease with the potential for major complications and can be fatal, especially when associated with emphysema, another serious respiratory disease, and COPD. According to the National Heart, Lund and Blood Institute, COPD is the leading cause of disability and the fourth leading cause of death in the US.

Chronic bronchitis is most often caused by smoking, but it can also occur with long-term inhalation of other irritants into the lungs. Chronic bronchitis most often develops when irritants are inhaled into the respiratory tract and down into the bronchi, the small hollow passages that branch off the main airway from the mouth and nose. Normally, air and needed oxygen pass through the bronchioles into the alveoli, small hollow sac-like structures in the lungs, where the

oxygen is absorbed into the bloodstream. When the air is mixed with smoke or irritants, it can damage the lungs and their ability to receive enough oxygen. Long-term inhalation of irritants results in chronic irritation and inflammation of the bronchi leading to excessive mucus production and bronchial thickening, resulting in obstruction of airflow to the lungs. Eventually the lungs become scarred and chronic. A persistent cough develops. The excessive mucus production and inflammation of chronic bronchitis also creates a perfect breeding ground in the lungs for bacteria and viruses that can cause severe, even life-threatening infections, such as pneumonia. Lung infections can also further aggravate (worse) chronic bronchitis.

The longer your lungs are exposed to smoke or irritants, the more likely you are to develop chronic bronchitis. Chronic bronchitis can affect people of all ages.

This condition is more common in:-

- Middle and late adulthood.
- More in men than in women.
- More in smokers than non-smokers.
- More in urban than rural residents.

It is a severely disabling disease with the potential for major complications and can be fatal, especially when associated with emphysema, another serious respiratory disease, and a form of COPD. According to the National Heart, Lung and Blood Institute, COPD is the leading cause of disability and the fourth leading cause of death in the US. Chronic bronchitis develops more often as a result of smoking, but it can also occur with long-term inhalation of other irritants into the lungs. It can also develop from atmospheric pollution, occupation (cotton) and infections, family and genetic factors. The longer your lungs are exposed to smoke or irritants, the more likely you are to develop chronic bronchitis. Chronic bronchitis should be suspected in any patient older than 40 years. Present persistent cough with copious and long-lasting expectoration, recurrent respiratory infections, shortness of breath rather on exertion, cyanosis and swelling (patients usually called Blue Bloated) Hemoptysis can complicate.

Investigations for suspected chronic bronchitis included:

Chest X-ray: Anterior and lateral chest X-rays reveal signs of hyperinflation, including flattening of the diaphragm, enlargement of the retrosternal air space, and a long, narrow cardiac shadow.

Electrocardiography: May show features of right atrial and ventricular hypertrophy.

Pulmonary function test: These measurements are necessary to diagnose and assess the severity of the disease and help monitor its progress.

FEV1 is a reproducible test and is the most common index of airflow obstruction. Lung volume measurement shows an increase in total lung capacity, functional residual capacity and residual volume. The vital capacity decreases. The diffusing capacity of carbon monoxide decreases in proportion to the severity of emphysema. Arterial blood gases reveal mild to moderate hypoxemia without hypercapnia in the early stages. As the disease progresses, hypoxemia becomes more severe and hypercapnia predominates. Hypercapnia is commonly seen when FEV1 falls below 1 liter per second or 30% of predicted. During acute exacerbations, lung mechanics and gas exchange deteriorate. Complications of chronic bronchitis included mucopurulent relapses, carbon dioxide necrosis, respiratory failure, secondary polycythemia, pulmonary hypertension, and right ventricular failure (cor pulmonale). Chronic bronchitis can be treated and managed with homeopathic remedies. Treatment of chronic bronchitis in the modern conventional system involves a combination of steps to relieve symptoms and medication with antibiotics. Medicines of the allopathic system are expensive and have adverse effects due to long-term use. Homeopathic medicines have a wide scope in the treatment of chronic bronchitis. A holistic and scientific system of medicine visualizes each patient as a unique individual. A scientific approach must be mixed with the art of case-taking, careful recording and processing to arrive at a complete diagnosis of the person making the diagnosis of the disease, which will ultimately help in the selection of similimum. The scientific method must be combined with the art of casework, careful documentation and processing to arrive at a complete diagnosis of the individual and the disease that will ultimately aid in the selection of similimum.

ETIOLOGY:-

From this study we will learn more about the origin, prognosis and treatment of chronic bronchitis using carefully selected homeopathic remedies along with diet and yoga, Exercise.

1. Smoking cigarettes

The United States Surgeon General's Advisory Committee concluded in 1964 that cigarette smoking significantly increases the chance of developing chronic bronchitis. Several disorders of the respiratory system are associated with cigarette smoking. All these anomalies increase the risk of developing chronic bronchitis.

- Slow cilia movement.
- .Bronchoconstriction (through smooth muscle contraction).
- .Hypertrophy and hyperplasia of mucus-secreting glands.
- .Release of inflammatory mediators in the lungs.

2. RESPIRATORY RESPONSIBILITY

One of the characteristics of asthma is a tendency to increased bronchoconstriction in response to various external stimuli such as histamine and methacholine. However, many patients with COPD also have this feature of airway reactivity.

3. RESPIRATORY INFECTIONS

Childhood respiratory diseases were also evaluated as prospective risk factors for the eventual development of COPD. These have been investigated as potential risk factors for the onset and progression of COPD in adults. Therefore, although respiratory infections are a significant contributor to COPD flare-ups, it is still unknown whether childhood-onset respiratory infections or adult airway infections contribute to the onset and progression of COPD.

4. WORK EXPOSURE

There have been suggestions that increased levels of dust exposure at work can lead to problems with the respiratory system and blocked airflow. A number of specific occupational exposures have been proposed as risk factors for chronic airflow obstruction, including coal mining, gold mining, and cotton textile dust. The significance of dust exposure as a risk factor for COPD, independent of cigarette smoking, is uncertain, although nonsmokers in these occupations experienced some reduction in FEV.

5. AIR POLLUTION

Researchers have shown that those living in urban areas have more respiratory symptoms than those living in rural areas, which may be related to increasing pollution in metropolitan areas. A link between persistent airflow obstruction and air pollution has not yet been established.

6. PASSIVE OR SECOND-HAND EXPOSURE TO SMOKE

Children who are exposed to secondhand smoke have much less lung development. Tobacco smoking exposure also significantly reduces postnatal lung function.

7. GENETIC CONSIDERATIONS

Despite the fact that cigarette smoking is a major environmental risk factor for the development of COPD, the susceptibility of smokers to developing airflow obstruction varies greatly. There is increasing evidence that there are other genetic risk factors for COPD in addition to severe alpha1 antitrypsin deficiency.

SOME OTHER CAUSES OF CHRONIC BRONCHITIS

1. Acute bronchitis
2. Aluminum lungs
3. Blue and puffy syndrome

4. Chemical poisoning with acetic acid, coal dust, polychlorinated dibenzofurans
5. Defective expression of HLA class 1
6. Farmers Lung
7. Heart diseases
8. Lung cancer
9. MHC class 1 or class 2 deficiency
10. Addiction to nicotine

Pathophysiology

A persistent reduction in the rate of forced exhalation is the most typical finding in COPD. There is also an increase in residual volume, the ratio of total lung capacity, uneven distribution of ventilation and ventilation perfusion.

AIRFLOW BLOCKING:-

Spirometry, which involves forced expiratory maneuvers after the subject has inhaled to maximum lung capacity, is often used to assess airflow limitation, also known as airflow obstruction. FEV and total exhaled air volume during the entire spirometric maneuver (FEV) are important phenotypes discovered using spirometry. Patients with COPD associated with airflow obstruction have a chronically reduced FEV/FVC ratio. Unlike asthma, the lower FEV of COPD rarely responds significantly to inhaled bronchodilation, but often improves by up to 50%.

HYPERINFLATION:-

Lung volumes are often measured in lung function testing. In the late course of the disease, patients with COPD often experience progressive hyperinflation (increased total lung capacity) and air trapping (increased residual volume and increased ratio of residual volume to total lung capacity). Maximal expiratory airflow is maintained by hyperinflation of the chest during expiratory breathing as increased lung volume, increased elastic recoil pressure, and enlarging airways reduce airway resistance. As a result, hyperinflation helps compensate for airway restriction.

GAS EXCHANGE:-

The association between FEV and other physiologic abnormalities in COPD varies significantly, but some generalizations can be made. As long as the FEV does not decrease to 50% of the expected value, the PaO_2 values unchanged, and even a much lower FEV can be associated with a normal PaO_2, at least at rest. An increase in $PaCO_2$ is not expected until FEV is less than 25%

of projected, and may not occur even then. Although there may be some increase in pulmonary artery pressure earlier in the course, especially with exercise, severe pulmonary hypertension due to COPD, which leads to cor pulmonale and right ventricular failure, only affects those with a significant drop in FEV (25% of predicted value). with chronic hypoxemia.

Although emphysema and chronic bronchitis often occur simultaneously, each condition can be treated clinically and pathologically as a separate entity. Smoking and air pollution are significantly associated with the prevalence and severity of COPD. Although lung cancer has a higher mortality rate than COPD, COPD has a greater socioeconomic burden due to earlier onset and longer disease duration. Men are more likely than women to have emphysema and chronic bronchitis.

PATHOLOGICAL CHANGES

The bronchi and/or bronchioles contain pathological changes associated with chronic bronchitis. In some situations, both the small and large airways may be affected, while others may predominate or may not be present.

Clinical signs of large airways (bronchial) involvement include cough and sputum production. Histological changes include:

- goblet cells in the epithelium is increase in number.
- increased volume of submucous mucous glands

The Reid index is used for assessment, which is calculated as the ratio of the width of the submucosal gland mass to the distance from the basal lamina of the mucosa to the inner perichondrium. A ratio greater than 0.4 indicates expansion of the mucous glands. In the airway wall, there is typically a component of chronic inflammation in addition to an increase in cells and mucus-secreting glands, but the amount of this infiltrate can vary extremely.

The presence of goblet cells in the lining epithelium characterizes the histology of involvement of the small airways (bronchiolar). Goblet cells are usually negligible or absent in the distal airways. Since mucus in the lumen of the small airways can result in increased flow resistance, bronchiole involvement can be manifested by a reduction in maximal effortful expiratory flow. As with the large airways, inflammation can play a role.

As a result of increased cellular infiltrates and edema, superimposed acute inflammation in the airways of a patient with chronic bronchitis can help worsen symptoms. In the submucosa of this bronchus, a photomicrograph shows an increase in the number of chronic inflammatory cells. The clinical definition of chronic bronchitis is persistent productive cough lasting at least three consecutive months in at least two consecutive years without any pathological symptoms. Most patients smoke. Symptoms of emphysema are also often present.

Symptoms of chronic bronchitis

1. Persistent cough

2. Productive cough

3. Cough with sputum

4. Persistent winter cough that disappears in summer - an early symptom

5. Excessive secretion of mucus from the respiratory tract

6. Shortness of breath

7. Shortness of breath on exertion

8. Cyanosis

9. Mild fever

10. Mild chest pain

11. Episodes of acute bronchitis

12. Mallet fingers

13. Persistent cough that produces sputum (phlegm) and phlegm (coughing up or productive cough) for at least three months in two consecutive years

14. Shortness of breath (shortness of breath)

15. Wheezing

16. Chest pains

17. Fever

18. Fatigue or malaise

19. Mucus is often green or yellowish-green and can also be orange or pink, depending on the pathogen causing the inflammation

20. Shortness of breath

Diagnostic testing

The diagnosis of chronic bronchitis requires documentation of airflow limitation by pulmonary function testing, which also offers useful therapeutic information about the patient's response to inhaled bronchodilator medication. Obstructive airway disease is defined as a measured forced expiratory volume in one second (fev1) that is less than 70% of total forced vital capacity (fvc) or the fev1/fvc ratio. A fev1/fvc ratio of less than 50% implies end-stage obstructive airway disease. Most people over the age of 50 experience a decline in FEV1 of 30 mL per year, indicating true disease progression. This decrease is caused by age-related physiological changes in lung elasticity. Obstruction of airflow in the presence of chronic sputum production confirms the clinical diagnosis of chronic bronchitis.

In patients without the typical symptom of sputum production, signs of obstructive airflow abnormalities on pulmonary function tests are often accompanied by radiographic findings consistent with emphysema. Alpha1-antitrypsin deficiency should be assessed in younger patients with emphysematous obstructive pulmonary disease, especially those who have never smoked. Patients with an FEV1 of less than 1 L have a median survival of four years.

Gold stage	Severity	Symptoms	Spirometry
0	At Risk	Chronic cough, Sputum production	Normal
1	Mild	Sputum production with or without chronic cough .	FEV/FVC<0.7 & FEV> 80% Predicted.
2	Moderate	With or without chronic cough or sputum production.	FEV/FVC<0.7 &50%<- FEV< 80% predicted.
3	Severe	With or without chronic cough of sputum production.	FEV/FVC<0.7 & 30%<FEV<50% predicted

4	Very severe	With or without chronic cough or sputum production	FEV/FVC<0.7 & FEV<30% Predicted or FEV <50% predicted with respiratory failure or signs of right heart failure.

BLOOD TESTS

In patients with advanced chronic bronchitis and ventilator failure due to bronchospasm and inflammation, hypoxemia is a common finding on arterial blood gas sampling. As the condition worsens, concomitant hypercapnia is associated with worsening ventilatory gas exchange. Due to hypoxia, blood tests may show mild polycythemia.

CHEST X-RAY

Most patients with chronic bronchitis have a poor correlation between radiographic findings and symptoms. Hyperinflation, bullae, vesicles, flattening of the diaphragm, and peribronchial signs are examples of common but nonspecific findings.

ELECTROCARDIOGRAM

Abnormalities of the supraventricular rhythm such as multifocal atrial tachycardia, atrial fibrillation, or atrial flutter with “p” pulmonale may occasionally be seen on the electrocardiogram. Goblet cell hyperplasia, mucosal and submucosal inflammation, and increased smooth muscle at the level of the small non-cartilaginous airways are all found during airway biopsy. The Reid index can be used to pathologically quantify these changes.

SPUTUM CULTURES

Since cultures of sputum samples do not represent the organism(s) present at the distal level of the bronchi, the role of sputum cultures in non-hospitalized patients with acute exacerbation of chronic bronchitis remains limited. Gram staining of sputum is often recommended as a way to guide early antibiotic therapy. However, the importance of gram staining in the context of acute decision-making is downplayed due to the likelihood of multiple organisms. According to popular knowledge, there should be more than 25 white blood cells and less than 10 squamous cells per high-power microscopic field for expectorated sputum samples to be considered patients with a history of chronic bronchitis. new symptoms appeared during hospitalization. The best option for identifying the infectious agents causing the exacerbation is the use of "protected tip" cultures of material taken from the level of the airway that appears most inflamed on bronchoscopy in these patients and others in whom atypical organisms are suspected. . Your

doctor will first perform a complete physical exam, take your medical history, and ask about any symptoms you may be experiencing to diagnose chronic bronchitis. The following tests can be done to make a definite diagnosis.

PULMONARY FUNCTION TESTING (PFT)

Airflow and air volume in your lungs are measured in this test using a series of breathing exercises. This allows your doctor to assess your lung health in an unbiased way.

HIGH RESOLUTION COMPUTED TOMOGRAPHY (HRCT)

This particular CT scan will provide your doctor with detailed, high-quality images of your lungs. An open table is used for both the normal CT scan and the HRCT, and neither procedure takes more than a few minutes.

EXAMINATION OF SPUTUM

Analyzing the cells in your sputum can help determine the cause of some lung problems.

Differential diagnosis

BRONCHITIS

• Mid-life onset

• Symptoms progress slowly

• Long history of smoking

• Shortness of breath during exercise

• Largely irreversible airflow limitation

ASTHMA

• Onset early in life (often in childhood)

• Symptoms vary from day to day

• Symptoms at night/early morning

• Allergy/runny nose/eczema may also occur

• Family history of asthma

• Largely reversible airflow restriction.

CONVERTED HEART FAILURE

• Soft basilar crackle on auscultation

• Chest x-ray shows heart dilatation, pulmonary edema

• Pulmonary function tests showed volume limitation, not airflow limitation

BRONCHIECTASIS

• Large volumes of purulent sputum

• Commonly associated with bacterial infection

• Loud crackling/burning sound when listening

• Chest x-ray / computed tomography (CT) shows bronchial dilatation, bronchial wall thickening

TUBERCULOSIS

• Onset at any age

• Chest x-ray shows lung infiltration

• Microbiological confirmation

• High local prevalence of tuberculosis

OBLITERATIVE BRONCHIOLITIS

• Onset in younger non-smokers

• May have a history of rheumatoid arthritis or exposure to toxic fumes

• Expiratory CT shows hypodense areas

DIFFUSE PELVIC BRONCHIOLITIS

• Most patients are men and non-smokers

• Almost everyone has chronic sinusitis

Chest X-ray and high-resolution CT show diffuse, small centilobular nodular opacities and hyperinflation.

COMPLICATION

1. Acute bronchitis

2. Bronchopneumonia

3. Bronchiectasis

4. Cor pulmonale

5. Emphysema

6. High mortality rate

7. Polycythemia

8. Type 2 respiratory failure

9. Pulmonary hypertension

10. Pneumothorax

11. Elevated levels of angiotensin-converting enzyme (plasma or serum)

12. Respiratory failure

13. Deviation of the right axis of the QRS

14. Multifocal atrial tachycardia

15. Shortness of breath

Management

1. It is important to note that there is no known cure for chronic bronchitis. Depending on the severity, length and stage of the disease, the course of chronic bronchitis treatment varies from patient to patient. Most treatments for chronic bronchitis are ineffective in curing it completely due to its recurring nature. Therefore, the main goal of chronic bronchitis treatment is to temporarily relieve symptoms and stop the development of new problems.

2. Reducing or eliminating the patient's exposure to airborne irritants is the initial step in the treatment of chronic bronchitis. Regular smokers are encouraged to quit smoking forever to improve the effectiveness of medical treatment. Patients with chronic bronchitis should try to limit exposure to industrial toxins, chemicals, and secondhand smoke. Most individuals can get relief from symptoms such as coughing and breathing problems simply by limiting their exposure to irritants.

NO SMOKING

. The best strategy to reduce your risk of developing chronic bronchitis in the future is to stop smoking. Evidence of a faster rate of decline in FEV1 than the typical decline of 30 ml per year could be a significant motivator for smokers who continue to deny that their continued smoking will lead to symptoms in the future.

The use of various smoking cessation aids, such as support groups, behavior modification training, and nicotine replacement therapy, can be beneficial once a patient decides to quit smoking. These methods work best when the patient sees a supportive primary care physician regularly while quitting smoking. Primary care physicians should encourage and instruct the patient's family members to support the patient's attempts to quit smoking, which may require several attempts before the patient is successful.

Additional Management Considerations

Another wise management recommendation is to reduce or completely avoid long-term exposure to outdoor air pollution with high levels of sulfur dioxide. Examples of these pollutants include aerosol hair and deodorant products in the home, organic dust or harmful gases in the workplace, and aerosol hair and deodorant products. Another critical responsibility of the primary care physician is to oversee the education of the patient and family caregivers about the progressive nature of chronic bronchitis and its potential impact on future lifestyle and function. Realistic goal setting and advance directives that focus on concerns related to terminal management (such as ventilatory support and hospitalization) as well as ongoing pharmaceutical management and oxygen compliance should be addressed early in the patient's illness. A multidisciplinary approach using nurses, respiratory therapists and others to educate the patient about the disease (eg inhaler use, pulmonary rehabilitation) is encouraged.

Usefulness of Homeopathy:

With the use of drugs from another medical faculty, chronic bronchitis is primarily suppressed in the modern medical system. Since homeopathy is a holistic medical approach, it addresses each patient as a whole, reducing the likelihood of recurrence. Homeopathic doctors around the world have claimed to have relieved or cured patients of chronic bronchitis, another benefit of homeopathic treatment. It can be used simultaneously with allopathic treatment or for any ailments. However, these claims have not been scientifically evaluated or supported by evidence.

The methodological investigation presented was designed to rigorously evaluate the effectiveness of homeopathic remedies in the treatment of chronic bronchitis with the aim of supporting or refuting these claims. This will be valuable data for indexing in the repertory and the same will be immensely beneficial to the profession at large through judicious use of already existing homeopathic remedies.

HOMEOPATHIC TREATMENT

Commonly indicated medications for chronic bronchitis are as follows:

Ammonium-Carbonica: Chronic bronchitis, with great rattling in the chest, but difficult and feeble expectoration of tenacious purulent matter, often in old people. In old, aged and debilitated persons, hoarseness, cough every morning, about three o'clock. Shortness of breath, palpitations and burning in the chest. Slow labored, stiff breathing.

Antimonium tartaricum: In bronchitis with violent, convulsive cough, loud grunting in the chest, copious white expectoration, dyspnoea. Emphysema in the elderly. Cough and shortness of breath are relieved by lying on the right side. A large accumulation of mucus in the airways that cannot be coughed up and produces a rattling sound ("death rattle"). Especially in the morning there is great oppression of breathing, which forces the patient to sit up in order to breathe.

Arsenicum album: It is one of the most important remedies for chronic bronchial catarrh. It will rarely, however, be indicated in simple, uncomplicated, chronic bronchial catarrh, but much more frequently if emphysema has occurred. Suffocating catarrh. Cough aggravates after midnight; and lying on back. Expectoration thin, foamy, piercing pain in upper third of right lung. Wheezing.

Balsamum peruvianum: Bronchial catarrh with loud gurgling and copious expectoration. Bronchitis with muco-purulent, thick, creamy expectoration. Loud throbbing in the chest.

Bacillinum: It is a remedy highly esteemed by some competent observers; it seems to suit especially individuals who have constant colds, hardly getting rid of one before they get the other. The irritation is localized in the bronchial mucosa and leaves behind a difficult cough. At night, he is woken up by a cough, easy expectoration. Coughing up of indistinct, easily separated, thick mucus from the respiratory passages, followed after a day or two by a very clear ringing of the voice.

Baryta carbonica: Has been very beneficial in several cases of catarrh of old people, with excessive secretion of mucus and difficult expectoration, and in paroxysms of cough immediately after midnight.

Calcarea carbonica: Adapts to emphysematous chronic catarrh, if the cough is dry and distressing, comes on mainly at night with violent irritation of the respiratory organs, and if after some time of coughing tenacious and frothy mucus of salty or offensive sweet taste is coughed up. Sputum is sweet, very often white, yellow and thick. The nature of the cough is a dry tickling in a single attack, with all these pains in the chest. All these symptoms are worse in the cold and in the evening.

Carbo vegetabilis: Bronchitis of old people, with copious, yellow, fetid expectoration, dyspnoea, great rattling in the chest and burning, requires this remedy. Sputum: hard and greenish, yellow-green or purulent; brown, bloody; or less commonly tenacious whitish mucus or watery; sour or salty taste; unpleasant smell. Sensation of mucus in throat, at night, suffocation when coughing, better when sitting or moving.

Ipecacuanha: Ipecacuanha is the most similar drug; the grunting is louder and rougher, there is much coughing, but the patient raises little phlegm. There is a large accumulation of mucus, a spasmodic cough, nausea and vomiting, and difficulty in breathing. Bronchial catarrh; from sudden changes of weather or wet weather (Nat s); chokes and gags when coughing; he has to sit up at night to breathe; seizures are common and frequent.

Kalium bichromicum: Kalium bichromicum has for its designation though, a tenacious, sticky expectorant character; can be stretched into long strings. Hughes finds it useful when bronchitis has long persisted in a subacute state. The expectoration may also have bluish lumps and the cough is difficult especially in the morning, the tension seems to be in the epigastrium. It causes the secretion of a tough, fibrous mucus, - mucus which adheres to the part and becomes entwined into a long string when withdrawn. This symptom is the result of an inflammatory process that leads to the formation of plastic exudation.

Kali carbonicum: It is also valuable in bronchitis with dyspnoea, choking cough and sharp stitches in the chest. Indicated in bronchitis if the following symptoms are present: intense shortness of breath; although there is a great deal of phlegm in the chest, it is raised with difficulty. Breathing has the character of wheezing and wheezing. Dry and irritating cough, worse by eating warm food, exposure to cold, at 3 a.m.; tickling in throat, larynx, or bronchi, with expulsion of tenacious mucus or pus, which must be swallowed. Expectoration of small round lumps from the throat. Weakness of chest from brisk walking; also tension and oppression. Tension across chest when exhaling, when walking. Painful pain in chest from talking, breathing and lifting. Chest pressure.

Lycopodium clavatum: It is suitable for old people if there has been emphysema of the lungs and significant changes in the mucous membrane of the bronchi; constant tickling in the throat, loud grunting with weak or infrequent expectoration of gray color and salty taste, nocturnal exacerbations. Agg cough. from 4 to 6 p.m., often every other day, from exertion, from stretching the arms, stooping and lying down, lying on the left side, from eating and drinking

cold things. Cough (morning), with copious expectoration of greenish matter. Profuse expectoration of pus, when coughing.

Mercurius solubilis: A sovereign remedy for inflammatory bronchial catarrhs; is harsh and painful from the face down through the middle of the chest, a dry, raw rattling cough that is very debilitating; sputum watery, saliva-like, or yellow and purulent. There is fever and rotation

Nux vomica: The cough comes on with peculiar force between midnight and morning, is dry, spasmodic, very persistent and irritating, so that it causes pain in the bowels; is easily excited by change of temperature, and is associated with constant irritation in the chest and trachea; only in the morning, mostly after, very rarely before getting up, a thin cough begins with easy expectoration of simple phlegm. Cough with a sensation as if something were loose in the chest. Shallow breathing. Oppressed breathing. Dry dry cough; sometimes with bloody expectoration. Cough causes bursting headache and bruising in the epigastric region.

Phosphorus: It is indicated in bronchitis, especially in tall, slender persons with a rather tuberculous habit or inclination, with a tendency to stoop and hollow chest. In bronchitis or bronchial catarrh, it is indicated whether the disease affects the bronchial tubes high up or whether it extends down into the bronchioles. The symptoms are as follows: cough, with tearing pain under sternum, as if something were being released; suffocating pressure in upper chest with constriction of larynx.

Pulsatilla pratensis: It is much more useful in chronic than in acute bronchitis, when the following symptoms predominate: Cough, especially at night, excited by tickling in the trachea, with copious expectoration of phlegm; the mucus is mostly white, but is often mixed with yellowish or greenish lumps, which give it a greasy, offensive taste. Bronchitis with thick yellow expectoration; or dry, tickling cough from irritation in trachea, worse in evening and lying down, with dry airways or scratchy, raw feeling. Occasionally, dyspnoea or chest tightness occurs.

Senega: It is an old man's remedy, rattling in the chest, oppressed chest on rising, difficulty in raising phlegm, asthenic bronchitis in old people. Bronchitis, often in old people, with sneezing, sore chest walls, expectoration difficult, stiff, but profuse, often accompanied by kidney failure, aggravated by an evening stay in the open air.

Spongia tosta: It is one of the main remedies for chronic croupous bronchitis. Bronchial catarrh with wheezing, asthmatic cough, worse cold air, with copious expectoration and suffocation. Bronchial catarrh, with wheezing, asthmatic cough, worse cold air, with copious expectoration and suffocation; worse, lying with head down and in a hot room. Oppression of chest.

Sulphur: Sulphur responds well to persistent cases of chronic bronchitis, and excellent results are obtained here. His catarrh of the bronchial mucous membranes is accompanied by loud gurgling, persistent, profuse, thick, phlegm-purulent expectoration and accompanied by suffocating attacks. stuffiness; oppression and anxiety at night when lying on back. Attacks of

suffocation, especially at night in bed; he wants to have the windows and doors open. Dry cough in the evening in bed or waking up from sleep at night.

CONCLUSION:

A persistent cough that produces phlegm and phlegm for at least three months over two consecutive years is clinically considered to be chronic bronchitis. Bronchitis is a severely disabling condition that carries the risk of significant complications and can be fatal, especially when combined with emphysema, another serious respiratory condition, and a type of COPD.

Smoking is the main cause of chronic bronchitis, although other lung irritants can also cause it if inhaled over a long period of time. When irritating substances are inhaled into the respiratory tract, chronic bronchitis most often occurs. The lungs' ability to absorb enough oxygen can be impaired if pollutants in the air, such as smoke or allergens, are present. Long-term inhalation of irritants causes chronic irritation and inflammation of the bronchi, which in turn causes excessive mucus production, thickening of the bronchi and restriction of air flow to the lungs.

The likelihood of developing chronic bronchitis increases with the length of time your lungs are exposed to smoke or other irritants. People of all ages can get chronic bronchitis. It is more likely in men than in women.

Any patient over the age of 40 should be suspected of having chronic bronchitis. Presentation with prolonged cough, frequent respiratory infections, shortness of breath, and other cyanosis and edema (patients are usually referred to as blue puffy). Hemoptysis can make things difficult.

Chronic bronchitis can be treated with a number of homeopathic remedies. Each patient is seen as an individual in the scientific and holistic medical model. The scientific method must be combined with case-taking skill, careful documentation and processing to arrive at a comprehensive diagnosis, a diagnosis of the person, a diagnosis of the disease, and ultimately the selection of similimum. Most cases of chronic bronchitis are of psoriatic origin and can be effectively treated and managed by homeopathy.

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