CHILDREN WITH UPPER RESPIRATORY TRACT INFECTION

A Survey of Cases Seen at the Royal London Homoeopathic Hospital

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SUMMARY

A survey of experience in the treatment of upper respiratory tract infection in children seen at the Royal London Homoeopathic Hospital is presented. The results were assessed as Good in 20 out of 45 patients (44.5 per cent), Fair in 20 (44.5 per cent), and Poor in 5 (11 per cent).

INTRODUCTION

Cases of recurrent upper respiratory tract infection (URTI) make up an important part of the work load at the paediatric department of the Royal London Homoeopathic Hospital. The great majority of these represent failure on conventional treatment, in the sense that repeated courses of antibiotics have not reduced the incidence of infection. Clinical impression suggests that this type of problem responds particularly well to the homoeopathic approach; the present survey was undertaken in an attempt to see how far this impression would be borne out by the results.

PATIENTS AND METHODS

From 1 September 1975 to 15 June 1976, all children attending the outpatient department at the Royal London Homoeopathic Hospital who fulfilled the criteria for inclusion in the survey were selected for review and follow-up; thus both "old" and "new" cases were included. Initially, the requirements for inclusion were that, before first attendance, the child should have had URTI (tonsillitis, otitis media, "colds", "catarrh") necessitating antibiotics at least once a month for 6 months or once every 2 months for a year. (Children with significant bronchospasm were excluded.) However, it was not possible to adhere to these criteria with absolute rigidity, since for example some parents objected to antibiotics on ethical grounds or because they seemed to be ineffective, while other children were ill more or less continuously and so it was not possible to say what the frequency of attack was. However, no child was included unless he or she had been ill, continuously or intermittently, for at least 6 months.

Routine procedure in treating URTI at the Royal London Homoeopathic Hospital is as follows. At the first visit, a full conventional and homoeopathic history is taken, the child receives a physical examination and any necessary investigations, and then treatment is prescribed. This usually

contains two elements: (1) a remedy is given which, it is hoped, will reduce the incidence of infection, and (2) the mother is given an emergency remedy to be used at the first sign of infection. The mother is told that if the emergency remedy fails to act she should get in touch with her general practitioner in the ordinary way. Homoeopathy is thus regarded as a supplement to, rather than a substitute for, conventional treatment, although the hope is that the need for conventional treatment may be partially or wholly eliminated.

For the purpose of the survey, new patients were seen by myself if possible, or if not by one of the other homoeopathic physicians. The duration and frequency of URTI were elicited in as much detail as possible by questioning. Treatment was then prescribed, and a further appointment was given for a month's time. Subsequent appointments were made according to need. "Old" patients who fufilled the criteria for inclusion in the survey were filtered from the clinic as they returned for follow-up.

At each subsequent visit, results were assessed (by myself) by detailed questioning; the mother (rarely the father) was asked whether any further infections had occurred and, if so, how long they had lasted and whether they had been severe enough to necessitate calling in the general practitioner. Where possible the mother was given a printed diary form on which she was asked to record the details of any illness at the time of its occurrence, but this was not always possible owing to language and other difficulties.

Results were assessed at a minimum of 6 months after first attendance. Three categories were used: Good, Fair, and Poor. The criteria for each were as follows.

Good. A dramatic improvement, according to the mother's assessment. Objectively, there must have been not more than one episode of infection severe enough to require antibioties throughout the *whole* follow-up period, even if this was more than 6 months. (Some otherwise Good cases were relegated to the Fair category because relapse occurred after 6 months.) Cases in which infections were *always* aborted by the emergency remedy within 24 hours were also classified as good.

Fair. Improvement appreciable, but attacks still occur though lessened in either frequency or severity. Some of the mothers of children in this group described the improvement as dramatic.

Poor. Little or no improvement.

RESULTS

A total of 57 patients who fulfilled the criteria for inclusion in the survey were seen. In 12 of these cases follow-up was too short to allow a proper assessment. Of the remaining 45 results, 20 (44.5 per cent.) were classified as Good, 20 (44.4 per cent.) as Fair, and 5 (11 per cent.) as Poor. Details of the results classified as Good are given in the Table.

TABLE

Case	Age (yrs)	Principal complaint(s)	Duration	Frequency of attacks	Onset of improvement	Length of follow-up	Principal remedies	Remarks
1	7	tonsillitis	6 yrs	monthly	progressive	5–9 months*	Lachesis Nitric acid	Attacks coincide with mother's periods. Associated with mouth ulcers. Dramatic response to Nitric acid on each occasion.
2	6	tonsillitis	3 yrs	every 2 weeks	second visit	3 yrs	Silica Bell.	Incipient attacks always aborted by Belladonna. No further need for antibiotics.
3	9	tonsillitis	1 yr	every 2 months	first visit	5–14 months*	Phos.	No attacks since first visit. (Not seen over winter).
4	6	"colds", deafness	3 yrs	—	first visit	6–12 months*	Tub. bov. Carbo veg.	Hearing tests said to confirm improvement. (Not seen over winter).
5	4	tonsillitis	?	monthly	second visit	4–6 months*	Tub. bov.	One attack in follow-up period.
6	1	"colds"	1 yr	monthly (5 antibiotics in 6 weeks)	first visit	2 yrs	Tub. bov. Puls.	Three slight "colds" in follow-up period.
7	2	"colds" bronchitis	18 months	every 2 weeks	first visit	14 months	Tub. bov. Phos. Puls.	Mother reports "astonishing difference". One attack of scarlet fever while under treatment.
8	4	"colds", otitis media	4 yrs	every 2 weeks	first visit	14 months	Tub. bov. Puls.	Sister of Case No. 7. Mother reports this was "the first winter child could hear".
9	3	croupy coughs	2–3 yrs	"innumerable antibiotics"	progressive	6 months	Tub. bov. Phos.	No further antibiotics.
10	10	tonsillitis	8 yrs	?	progressive over 4 months	16 months —2 yrs*	Tub. bov. Bell.	No further attacks.
11	5	tonsillitis	?	every 2 weeks	second visit	1 yr	Tub. bov. Phos. Bell.	One attack during follow-up period. Not seen after winter.

12	5	"sinusitis"	5 yrs	every 3 months	first visit	2 yrs	Tub. bov. Puls.	Slight relapse after measles —responded to treatment. Very well at last 2 visits.
13	5	"colds"	3 yrs	every 2 months	first visit	8 months	Tub. bov. Aconite	"Colds" still begin, but respond at once to Aconite.
14	3	tonsillitis	2½ yrs	every 2 months	progressive	6 months	Merc. sol.	Incipient attacks respond swiftly to Merc. sol.
15	6	persistent cough	4 yrs	—	first visit	20 months	Tub. bov. Puls.	Adenotonsillectomy 8 months before attendance did not improve cough. Frequent antibiotics before attendance—none subsequently.
16	6	cough, epistaxis	1 yr	every month	first visit	1 yr	Tub. bov. Puls.	One antibiotic needed in follow-up period. All-round improvement reported.
17	7	tonsillitis	6 yrs	every 2 months	first visit	8 months	Tub. bov. Sulph. Phos.	"Very good winter compared with previous years"; attacks begin but respond well to emergency remedies.
18	3	otitis media, croup	6 months	every month	first visit	6 months	Tub. bov. Aconite Kali sulph.	"A very good winter"—psychological improvement also.
19	4	tonsillitis	1½ yrs	every 2–3 wks	first visit	1 yr	Sulph. Nux vom. Bell. Phos.	No attacks with fever since coming, though mild sore throats still occur.
20	5	tonsillitis	3–4 yrs	every 2 weeks in winter	first visit	2 yrs	Tub. bov. Phos.	Before attendance, attacks were increasingly severe, culminating in quinsy. "Miraculous improvement" in first 2 weeks; no further attacks since.

*Where two figures are given for length of follow-up, the shorter refers to the period when the patient was under direct observation (i.e. it is based on date of last attendance) while the longer refers to the time which has elapsed since clinical cure; in such cases the mother was told to bring the child back only if relapse occurred. Where only one figure is given, this refers to the date of last attendance. (Long follow-up in cases of apparent cure is usually explained by reattendance for unrelated complaints.)

DISCUSSION

The main purpose of the present study was not to prove the efficacy of Homoeopathy as a method of treating URTI in children but to review experience with a particular type of problem commonly encountered at the Royal London Homoeopathic Hospital. Nevertheless, it does seem possible to draw certain tentative conclusions.

An obvious criticism of a survey of this kind is that it lacks a control group. Unfortunately, there are great difficulties in finding a suitable matched control group for such a study, as has been pointed out by Evans in his review of the published evidence for and against adenotonsillectomy.[1] Not only would it be necessary to match the patients for age, sex, and clinical findings, but the motivation of the parents would have to be taken into account. For this reason the decision was made to use each patient as his or her own control and to compare the incidence of illness before and after treatment.

It might be said that a period on placebo should be included, but with a long-drawn-out illness such as recurrent URTI this would be difficult to evaluate and in any case the ethics of including a placebo would be questionable. It has to be recognized, however, that whatever method of assessment one adopts there are bound to be difficulties and uncertainties. Not the least of these concerns the definition of an "illness" and the grading of illness according to severity. A notable attempt to eliminate the subjective element in assessment of these factors was made by Badger *et al.* in the Cleveland study of the common respiratory diseases.[2] In that study, not only was a daily record of symptoms kept by the mother, but most of the illnesses were observed by a physician taking part in the study and each family was visited weekly by a field worker who reviewed the records. Clearly an intensive investigation of this kind could not be conducted by a busy hospital outpatient department; hence the method adopted here, with all its inherent limitations, seems to be the best compromise. Although reliance was thus placed on the mother's assessment of the child's progress, this assessment was carefully probed by detailed questioning, and no result was classed as Good unless the judgment of mother and physician completely concurred; in any case of doubt the result was classed as Fair rather than Good. This policy undoubtedly led to the exclusion from the Good category of some cases which probably deserved to be included, but it seemed preferable to an over-enthusiastic inclusion of dubious cases. In spite of these precautions, it must be admitted that an important element of subjectivity remains; hence the tabulation of results, which will enable the reader to form his own opinion of the kind of case for which Good results are claimed.

A third criticism could be based on the fact that the survey is partly retrospective. However, of the 57 patients studied, 13 were "new", and only 3 of these failed to reattend before a definite improvement had occurred. This low drop-out rate suggests that the over-all results are not seriously

distorted by failure of patients with Poor results to reattend. Indeed, the converse may well be true; the fact that parents who bring their children to the clinic are self-selected presumably means that most of them are strongly motivated to persevere with Homoeopathy in the face of indifferent results, and this might be expected to swell the number of such results.

It might be argued that the children who did well had gone into spontaneous remission just at the time they began to attend the hospital. Two points are against this, however. Firstly, in all the cases listed in the Table improvement was either immediate (first or second visit) or progressive; in fact, some otherwise Good cases were excluded from that category precisely because improvement did not occur until some months after initial attendance. Secondly, the ages of the children with Good results range fairly evenly between 1 and 10 years, whereas spontaneous improvement in recurrent URTI is commonest at about 6 years of age (Horn *et al.*).[3]

Respiratory illnesses are, of course, more prevalent in winter, and this is a possible source of error in the case of patients followed up for less than a year. However, most of those to whom this applies were studied throughout at least one winter; exceptions are indicated in the Table.

Whatever the shortcomings of a study of this kind, it does at least provide an explanation of why the parents of children with URTI who attend the Royal London Homoeopathic Hospital feel that this form of medicine has something to offer. In virtually every case, conventional treatment over a long period had failed to control infection, whereas with Homoeopathy there was a marked improvement in almost half the cases and some improvement in most of the remainder. It should be emphasized that almost all the patients seen at the hospital represent difficult clinical problems, which have defeated the best efforts of general practitioners and sometimes specialist centres using conventional methods, often over many years. That this should be so is perhaps not surprising, since there is little in the way of conventional treatment that can be offered except antibiotics or adenotonsillectomy. Antibiotics are freely prescribed in all forms of URTI, yet clinical impressions provide little evidence of whether an infection is viral or bacteriological.[4] Adenotonsillectomy is at best of questionable efficacy,[5] and moreover is attended by a morbidity and mortality which are not negligible.

REMEDIES

From the table it can be seen that by far the most frequently prescribed remedy in this type of case is Tuberculinum bovinum. Indeed, this comes as near to a specific as anything can in Homoeopathy. In a number of cases it seems necessary to repeat Tuberculinum fairly frequently (every 3 months or so). In addition, the polychrests are, of course, given when indicated. Chronic nasal "catarrh" often seems to respond well to a remedy such as Kali sulphuricum or Kali carbonicum in a low potency three times daily for a few weeks.

Attempts to reduce the size of cervical lymph nodes with Baryta carbonieum have given disappointing results, and so has the treatment of impaired hearing with Agraphis nutans.

The acute remedies most frequently used have been Aconitum for "colds" and Belladonna for sore throats. In each the mother is given a supply of the remedy (as a 30c or 200c) and instructed to treat the child hourly or every 2 hours for about 6 doses on the first day and then four times daily for a further 3 days if necessary. This regimen appears often to abort an infection if started early enough. Other acute remedies which are sometimes useful include Mercurius solubilis, Ferrum phosphoricum, and Lac caninum.

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