Alternative and complementary medicine for asthma

Readers of the review by D J Lane and T V Lane (November 1991;46:787-97) might conclude that hypnosis has little to offer asthmatic patients. Although the report of Ewer and Stewart is quoted as showing improvement in symptom scores and some peak expiratory flow rates and decreased use of bronchodilators, no mention is made of a 74.9% improvement (p < 0.01) in the degree of bronchial hyperresponsiveness to a standardised methacholine challenge test. These authors state that “while our hypnotic technique does not eliminate bronchial hyperresponsiveness it does provide a clinically useful and non-toxic adjuvant to drug treatment but may benefit about half of the asthmatic population.” This approach could well reduce the use of the toxic drugs, such as theophylline, gold, azathioprine, and methotrexate, mentioned as steroid sparing agents by Shiner and Geddes.

The British Tuberculosis Association’s study did not report negative results as stated in the review. On the contrary, “independent clinical assessors considered the asthma to be much better in 59% of the hypnosis groups and in 43% of the control group, the difference being significant.” These results were obtained by using only direct suggestion units, and no hypnosis plus autohypnosis groups; more advanced methods, such as reciprocal inhibition, were not used.

In my own study it was possible to withdraw oral prednisolone or to reduce the dose in 14 of the 16 patients treated by hypnosis. The number of hospital admissions during the first year of hypnotherapy fell to 13, compared with 44 during the previous year. This represented a reduction of 729 hospital days, which, at 1988 costs (L170 per day), saved the NHS £243.30. As some 55000 adults are admitted each year for asthma, savings to the NHS could be considerable if hypnotherapy were to be used more widely.

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AUTHOR’S REPLY We thank Dr Morrison for his interest in our article. On the question of bronchial hyperresponsiveness, he seems to have missed our discussion of this on page 794. The changes recorded by Ewer and Stewart, though significant statistically, are unlikely to make much difference clinically. We know of no work on the use of hypnosis in the sort of chronic persistent asthma that might be treated with the “toxic drugs” he mentions.

Perhaps we were unfair to dismiss the British Tuberculosis Association’s study of 1966 as producing “negative results.” In fact, the details of the recorded wheezing score, use of bronchodilators, and peak expiratory flow rate volume, divided by sex (their table IV), showed a difference between treated and control groups only for wheezing score in females (that is, five out of six comparisons showed no difference). The paper gives no details of the methods used for the independent clinical assessments other than that they were “made by a physician unaware of the patient’s treatment.”

Dr Morrison’s own study gave impressive results, but it is a pity that the comparative control period had to be retrospective. Careful attention to many aspects of the care of asthmatic patients can produce a reduction in corticosteroid treatment and admissions. As we stated in our review, if hypnosis is to be advocated as a means of obtaining these ends there is a need to establish both a reliable method of selection and one likely to be effective in patients susceptible to hypnosis and a standardised form of treatment acceptable to patients over long periods.

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We read the editorial entitled “Alternative and complementary medicine for asthma” by Dr DJ Lane and TV Lane (November 1991;46:787-97) with particular interest. Hypnosis has usually been advocated as a means of obtaining control of the asthma but in our experience the treatment often seems to produce a different effect. We are currently carrying out a controlled trial investigating the use of hypnosis as an adjuvant to asthma therapy. We will report the results of this study at a later date.

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Air pollution and respiratory morbidity

We read with interest the article by Dr J Britton (May 1992;47:391-2). This raises a number of important points but perpetuates confusion over EC limit values, EC guide values, and WHO air quality guidelines; this confusion is presently being addressed by the EC Committee of Sunyer et al to which Dr Britton refers. EC limit values and guide values are often expressed in terms of percentiles, with which individual measurements should not be compared. For example, the EC limit value for

Although we have international meetings and an increasing number of articles on speleotherapy, there have been relatively few studied articles. Some articles have discussed the temperature, humidity, volume, electrical characteristics, types of air flow, and gas content of the indoor environment, but no objective benefit of speleotherapy has been documented. Ten patients in our study group visited Damalas cave in the south of Turkey for three to four weeks in the summer, and all stated that they had felt comfortable.成功 for several months, and for many being able to decrease their bronchodilator drug dosage. Further controlled and objective studies are needed on this subject.

Harmless and Turkish seeds are two methods of alternative medicine that have not previously mentioned in published reports. The “bracelet” epidemic spread from south east Asia to Turkey, and asthmatic patients as well as those with rheumatological problems began using bracelets. Six patients in the study group were wearing bracelets for the relief of their pulmonary symptoms.

Alternative medicine has emerged as a consequence of continuing dissatisfaction with the accepted effective treatment for breathlessness. Some practices have arisen through experience that has accumulated over hundreds of years and have become traditional. Others have resulted from individual trials, which have had some public interest in alternative medicine will diminish in time with both progress in research for more efficient treatments and the realisation by patients of the effectiveness of conventional treatments.

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