Effect of Root Heal Therapy (RHT) on Asthma: A Quincy Experiment

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Abstract*—Asthma is a chronic inflammatory disease of the airways that affects people of all ages. It may manifest as severe attacks, which can require urgent health care. It causes limitations in daily activities, loss of school and work days, lung function impairment, reduced quality of life, and an adverse socioeconomic burden. There is no cure of asthma, once it is diagnosed it can be managed by a good treatment plan, so that patient can live a better quality of life with the disease. This present study was planned to compare the effect of traditional treatment alone and in combination with Root Heal Therapy on asthma cases. A Quincy experiment was conducted on 60 patients of Asthma, who were taking treatment from a physician working in Jaipuriya Hospital, Jaipur. Out of these 60 asthama patients who were receiving traditional treatment, 30 patients were given this RHT along with traditional treatment. Baseline status of asthma and Asthma Quality of life Questionnaire (AQLQ) was assessed. These cases were followed for 18 months, again they were assessed as per AQLQ. Changes in status of asthma in both the group over this period were compared with Chi-square test and Unpaired 't' test. It was found that significantly more cases were benefited with this RHT in the form of number of spells of asthma, duration of illness due to asthma, mean days of activity loss and proportion of cases needed hospitalization during last one year. Pulmonary Function test were also better in experimental group than control group. Although mean number of eosinofills decrease was also found higher in experimental group but it was not found significant. It is concluded that Quality of life of these asthma cases were significantly improved on physical, emotional, social and occupational domains of life in cases with RHT than the cases only on traditional treatment.*

Keywords— Asthma, Root Heal Therapy (RHT), Pulmonary function tests, Asthma Quality of life Questionnaire (AQLQ).

I. INTRODUCTION

Asthma is a chronic inflammatory disease of airways that affects people of all ages and imposes a substantial burden on patients, their families, and the community.[1] The burden of asthma is immense, with more than 300 million individuals currently suffering from asthma worldwide, about a tenth of those living in India. [1,2] Prevalence of asthma varied from 3-38% in children and 2-12% in adults, [3] being the commonest chronic disorder among children. It may manifest as severe attacks, which can require urgent health care. It causes limitations in daily activities, loss of school and work days, lung function impairment, reduced quality of life, and an adverse socioeconomic burden. About 15 million disability-adjusted life years are lost annually due to asthma, which represents 1% of the total global disease burden.[1] There are about 489,000 deaths attributable to asthma annually[4] and the majority of deaths occur in low- and middle-income countries, particularly Oceania, South and Southeast Asia, the Middle East, and Africa.[5] Indian studies shows a wide variation (4 – 20%) of prevalence in various

regions.[6] A recent multicentric Indian Study on Epidemiology of Asthma, Respiratory Symptoms and Chronic Bronchitis (INSEARCH) done with 85,105 men and 84,470 women from 12 urban and 11 rural sites in India estimated the prevalence of asthma in India to be 2.05% among those aged >15 years, with an estimated national burden of 18 million asthmatics.[7]

Prevalence of Bronchial Asthma has increased continuously since the 1970s and It has also increased the number of preventable hospital emergency visits and admissions. Apart from being the leading cause of hospitalization for children, it is one of the most important chronic conditions causing elementary school absenteeism.[8,9]

While a number of guidelines exist regarding the management of asthma in general, substantial differences exist across countries regarding the insights, attitudes, and perceptions about asthma and its treatment that suggest unmet, country-specific cultural and educational needs. [10,11,12] Till now there is no cure of asthma, once it is diagnosed it can be managed by a good treatment plan, so that patient can live a better quality of life with the disease. This present study was planned to compare the effect of traditional treatment alone and in combination with Root Heal Therapy on asthma cases.

II. METHODOLOGY

A randomized control Quincy experimental study was conducted on Asthma patients in Jaipuria Hospital of Jaipur Rajasthan India. This study was conducted on 60 patients of asthma taking treatment from a single physician i.e. Dr. V.D. Sharma from October 2013 to March 2015.

For study purpose, mild to moderate Asthma cases aged between 20-40 years were identified. Among these identified cases, cases having either sever asthma or any other illness were excluded from study. Cases that have done any kind of surgery were also excluded from study. Cases who have not taken written informed consent to be included for study were excluded from study. Cases who either has not taken treatment throughout as advise or not available to evaluate in end of study were also included from study. Finally 60 eligible asthma cases were selected for this study and luckily none of patient was absconded during study period.

After taking written informed consent from each of patients, these 60 cases were randomized by alternate allocation into two group i.e. Group 'A' who has given only the traditional treatment and Group 'B' were given Root Heal Therapy along with traditional treatment.

All these selected cases were group wise interrogated and investigated to assess the baseline status of Pulmonary Function through Pulmonary Function Tests (PFTs) along with general information of each patient. Asthma Quality of life Questionnaire with Standardized Activities (AQLQ)[13] were also assessed of each patient group wise.

After collection of desired baseline information's these patients were given treatment by a single physician and directed to note every consequences regarding Asthma. These patients were also asking to report after 18 months to researcher with all noted every consequences regarding Asthma.

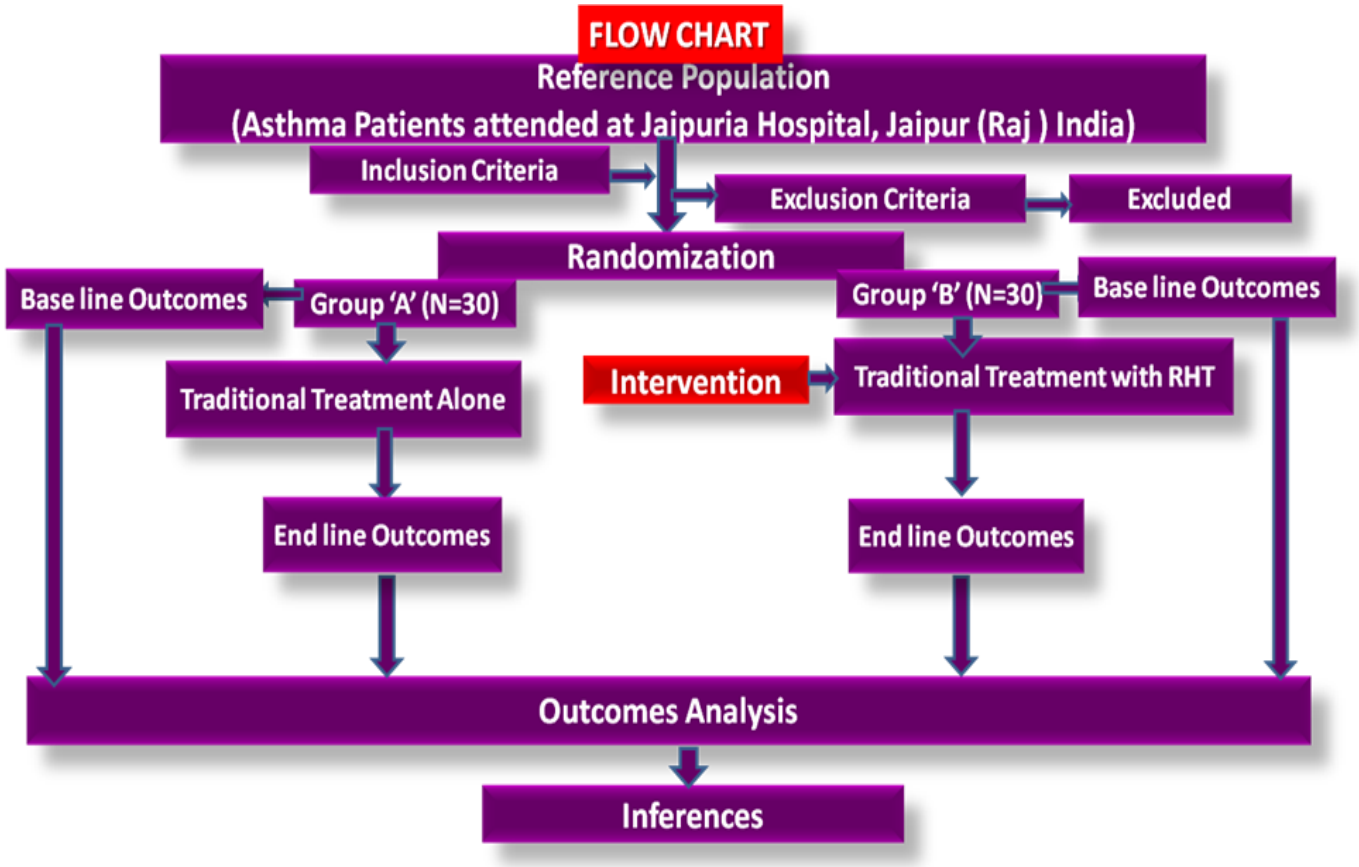
But group 'B' cases, along with traditional treatment were examined through 56 itemed Chakra block test questionnaire to find out that which Chakra is blocked and how much it is blocked. According to which Chakra is blocked and how much it is blocked, Root Heal Therapy is given to each patient of group 'B'

Root Heal Therapy

Patients assessed for "Chakra Block Test" having 56 questions.[14] By this questionnaire it can be found out that which Chakra is blocked with what emotion. That emotion of that Chakra is further investigated for exact cause of emotion blocking the Chakra. According to root cause found out by this procedure, psychotherapy was given in the form of practicing uposit emotion which has blocked a specific Chakra.

When patients of both groups came to report after 18 months to researcher, they was further interrogated for every consequences regarding Asthma and were examined for PFTs and AQLS.

Data thus collected were analyzed using paired and unpaired student's "t-test". To infer the significance of change within the group (Baseline to endline) paired student's "t-test is used and to infer significance of change between the groups (Group 'A' and Group 'B') unpaired student's "t-test is used with statistical software Primer version 6.



III. RESULTS

Out of 60 patients, 56 (30 in group 'A' and 29 in group 'B') has completed the study. Mean age in Group 'A' was observed 31.77 ± 6.03 years whereas in a Group 'B' it was 32.43 ± 6.0 years. There was a slight female preponderance in both the groups i.e. M:F ratio being1:1.1 in Group 'A' and 1:1.4. Likewise in both the groups were having about 5 times urban dominance over rural. These both groups were comparable as per studied bio-demographic variables i.e. there was no significant difference in distribution of cases as per age, sex and residence. (Table 1)

Table 1
Baseline Comparison of Group "A" and Group "B"

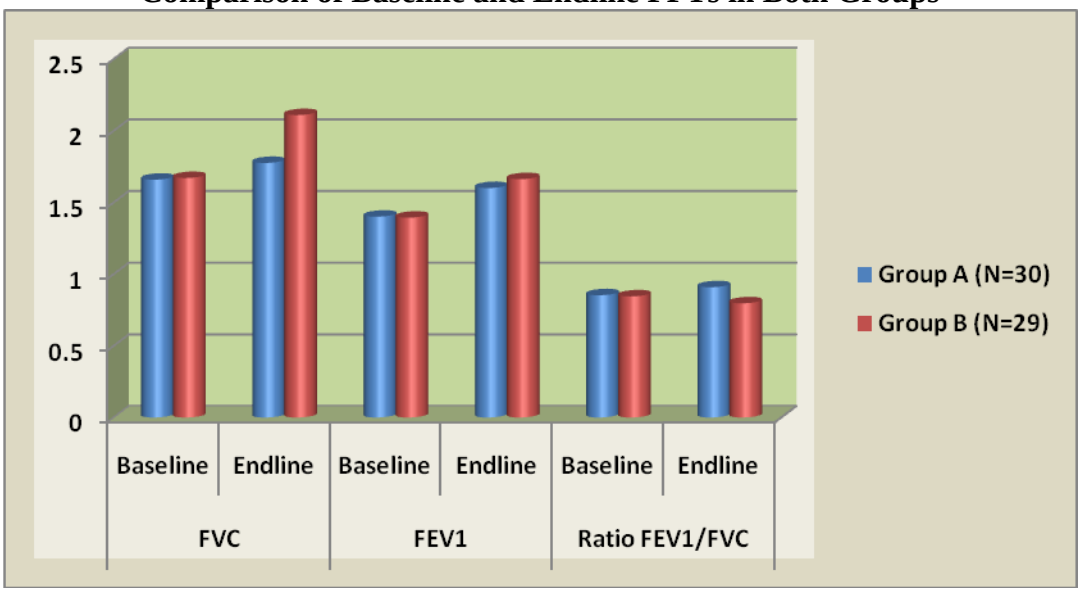
Variables		Group A (N=30)	Group B (N=29)	P Value	LS
Bio-demographic Variables	Age	31.77 ± 6.03	32.43 ± 6.0	0.672	NS
	M:F	14:16	12:17	0.794	NS
	U:R	25:5	24:5	0.906	NS
Baseline Pulmonary Function Test (PFTs)	FVC	1.659 ± 0.1785	1.671 ± 0.1758	o.761	NS
	FEV_1	1.401 ± 0.1899	1.394 ± 0.2007	0.957	NS
	Ratio FEV_1/FVC	0.8529 ± 0.1421	0.8451 ± 0.1616	0.895	NS
Quality of Life	AQLQ Scores	80.37 ± 11.04	82.23 ± 11.23	0.520	NS

When PFT of both group was assessed it was found that both groups were comparable as pulmonary functions test status. i.e. there was no significant difference in mean FVC, FVV_1 and ratio between FVC and FVV_1. (Table 2 & Figure 2)

Table 2
Comparison of Change in PFT in both groups

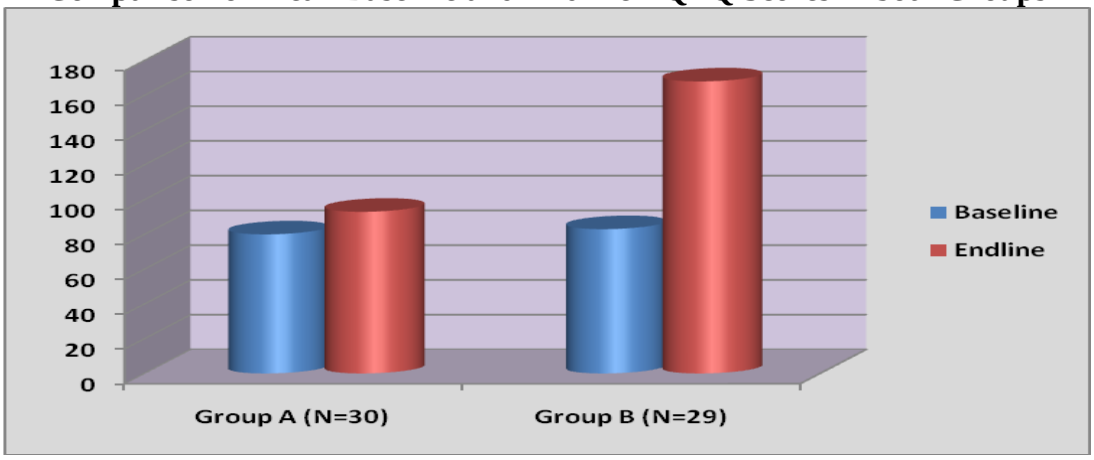
Variables		Group A (N=30)	Group B (N=29)	P Value	LS
FVC	Baseline	1.659 ± 0.1785	1.671 ± 0.1758	o.761	NS
	Endline	1.776 ±0.2107	2.11±0.2072	<0.001	S
	Mean Change	0.1172 ±0.0714	0.4386 ±0.1256	<0.001	S
FEV_1	Baseline	1.401 ± 0.1899	1.394 ± 0.2007	0.957	NS
	Endline	1.601±0.3748	1.663±0.1959	0.432	NS
	Mean Change	0.2002 ±0.0797	0.2686 ±0.0946	<0.001	S
Ratio FEV_1/FVC	Baseline	0.8529 ± 0.1421	0.8451 ± 0.1616	0.895	NS
	Endline	0.9089 ±0.2172	0.7966 ±0.1292	0.020	S
	Mean Change	0.0559 ±0.0172	0.0485 ±0.0166	<0.001	S

Figure 2
Comparison of Baseline and Endline PFTs in Both Groups



Likewise mean AQLQ scores of both groups were comparable i.e. there was no significant difference in mean AQLQ scores of both the groups. (Table 2 & Figure 3)

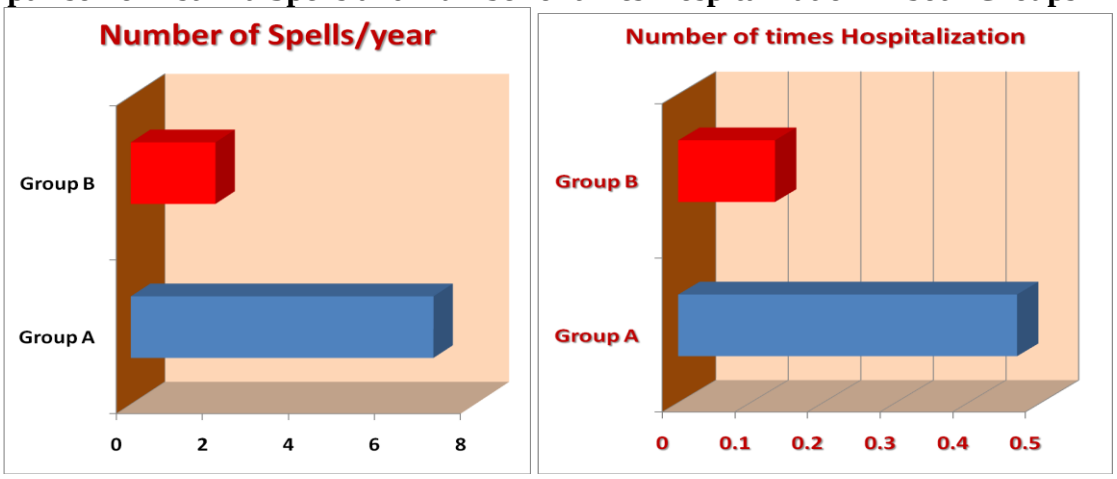
Figure 3
Comparison of Mean Baseline and Endline AQLQ Scores in both Groups



Baseline	80 ± 11	83 ± 13	0.520 NS
Endline	93±12	168±27	<0.001 S
Mean Change	13 ± 2	105 ±18	<0.001 S

When asthma was inquired on other parameters like number of asthma spells per year and number of times hospitalization per year, it was found that mean Asthma Spelles in last year was found 7.033±5.048 in Group 'a' whereas in group 'B' it was only 1.967 ±1.076. Likewise Mean number of times hospitalization due to Asthma in last year was found 0.4667 ±0.46 in Group 'a' whereas in group 'B' it was only 0.1333 ±0.036. On analysis it was found that both supra said parameters were significantly ($p<0.001$) reduce in RHT group. (Table 2 & Figure 4)

Figure 4
Comparison of Asthma Spells and Number of times Hospitalization in both Groups



Unpaired 't' Test -5.084 at 57 DF
P <0.001 S

Unpaired 't' Test = -3.890 at 57 DF
P <0.001 S

Effect of RHT was revealed it was found that **PFT were improved**, **Asthma Spells Decreased,** comparison of both When type of side effects were observed it was found that 13.9% patients in Group 'A' and 5.4% patients in Group 'B' developed a burning or stinging sensation. Dryness was seen in 8.3% and 5.4% patients in group 'A' and group 'B' respectively. Post inflammatory hyper pigmentation was seen in 5.6% patients in group 'A' and 2.7% patients in group 'B'. These distributions of side effects between both the groups were not found with significant variation. (Table 3)

Table 3
Summary of Comparison of both groups

Variables		P Value	LS	Interpretations
Mean Change in Pulmonary Function Test (PFTs)	FVC	<0.001	S	FVC Increased
	FEV_1	<0.001	S	FEV_1 Increased
	Ratio FEV_1/FVC	<0.001	S	Ratio FEV_1/FVC Decreased
Asthma Spells	Number/Year	<0.001	S	Asthma Spells Decreased
Hospitalization	Number/Year	<0.001	S	Hospitalization Decreased
Quality of Life	AQLQ Scores	<0.001	S	Quality of Life Improved

IV. DISCUSSION

Asthma causes Swelling of airways. This results in narrowing of airways that carry air from nose and mouth to lungs. Allergens and irritating things entering lungs trigger asthma symptoms. Generalized diminished airway dimensions as a novel susceptibility factor for concurrent symptoms of asthma and rhinitis in early childhood and supports the notion of a common patho-physiology in asthma and rhinitis.[15]

In this present study, mean age was 31.77 ± 6.03 years and 31.77 ± 6.03 years in Group 'A' and Group 'B' respectively with slight female preponderance in both the groups i.e. M:F ratio 1:1.1 and 1:1.4 in Group 'A' and group 'B'. Likewise in both the groups were having about 5 times urban dominance over rural. Ranabir Pal etall[6] also shows urban predominance but they also found male predominance. Male predominance was also reported by other authors.[16,17] But this female predominance in present study may be observed because of sweeping and other activities generating allergic condition in females as more elder group is considered in this present study. This explation is further supported by reports of

study conducted by Raj Kumar [18] who studied asthma cases of 18-48 years and found mean age 25.5 years with almost equal sex wise distribution of cases.

A symptom of asthma includes breathing, wheezing, coughing and tightening of chest. In severe cases asthma can deadly. Asthma has no cure but it can be managed with proper prevention and treatment.[19]

Many guidlines[10-12] for treatments of asthma were made time to time and many innovations[20] in managements of asthma were tried, mixed response of which were found. This present study also an effort in direction of not only management but treatment of this mis-managable disease. And it was found that with RHT not only quality of life was significantly improved but pulmonary functions were also significantly improved. Total number of asthma spells and number of timed hospitalization due to asthma was also decreased significantly.

V. CONCLUSION

It was concluded from this study that not only quality of life was significantly improved but pulmonary functions were also significantly improved with Root Heal Therapy. And total number of asthma spells and number of timed hospitalization due to asthma was also decreased significantly with Root Heal Therapy.

So Root Heal therapy should be tried to better manage asthma cases along with traditional treatment. Further studies are invited to know whether it has some role in tearing out the disease with its root.

CONFLICT

None declared till date.

REFERENCES

[1] Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention. [Last accessed on 2015 Mar 15]. Available from: http://www.ginasthma.org/uploads/users/files/GINA Report 2014.pdf
[2] Kant S. Socio-economic dynamics of asthma. Indian J Med Res. 2013;138:446–8
[3] Cavkaytar O, Sekerel BE. Baseline management of asthma control. Allergol Immunopathol (Madr)2014;42:162–8
[4] GBD 2013 Mortality and Causes of Death Collaborators. Global, regional, and national age-sex specific all-cause and cause-specific mortality for 240 causes of death, 1990-2013: A systematic analysis for the Global Burden of Disease Study 2013. Lancet. 2015;385:117–71.
[5] Burney P, Jarvis D, Perez-Padilla R. The global burden of chronic respiratory disease in adults. Int J Tuberc Lung Dis. 2015;19:10–20
[6] Ranabir Pal, Sanjay Dahal and Shrayan Pal. Prevalence of Bronchial Asthma in Indian Children Indian J Community Med. 2009 Oct; 34(4): 310–316.
[7] Jindal SK, Aggarwal AN, Gupta D, Agarwal R, Kumar R, Kaur T, et al. Indian study on epidemiology of asthma, respiratory symptoms and chronic bronchitis in adults (INSEARCH) Int J Tuberc Lung Dis.2012;16:1270–7.
[8] Reid J, Marciniuk DD, Cockcroft DW. Bronchial Asthma management in the emergency department. Can Respir J. 2000;7:255–60
[9] Gürkan F, Ece A, Haspolat K, Derman O, Bosnak M. Predictors for multiple hospital admissions in children with Bronchial Asthma. Can Respir J. 2000;7:163–6.
[10] Gupta D, Agarwal R, Aggarwal AN, Maturu VN, Dhooria S, Prasad KT, et al. S. K. Jindal for the COPD Guidelines Working Group. Guidelines for diagnosis and management of chronic obstructive pulmonary disease: Joint ICS/NCCP(I) recommendations. Lung India. 2013;30:228–67
[11] Agarwal R, Dhooria S, Aggarwal AN, Maturu VN, Sehgal IS, Muthu V, et al. Guidelines for diagnosis and management of bronchial asthma: Joint ICS/NCCP(I) recommendations. Lung India. 2015;32:3–42
[12] Parvaize A Koul and Dharmesh Patel. Indian guidelines for asthma: Adherence is the key Lung India. 2015 Apr; 32(Suppl 1): S1–S2
[13] http://www.qoltech.co.uk
[14] http://www.eclecticenergies.com/chakras/chakradotest.php

[15] Chawes BL. Upper and lower airway pathology in young children with allergic- and non-allergic rhinitis.Dan Med Bull. 2011 May;58(5):B4278.
[16] Jain A, Vinod Bhat H, Accharya D etall. Prevalence of bronchial asthma in rural Indian children: a cross sectional study from South India. Indian J Pediatr. 2010 Jan;77(1):31-5
[17] AK Singh[1], Vikram Kumar Jain[2], M Mishra. Clinical profile of bronchial asthma patients reporting at respiratory medicine outpatient department of teaching hospital .Indian Journal of Allergy, Asthama and Immunology. 2015; 29(1):3-6
[18] Raj Kumar, Nitesh Gupta, Indu Bisht. Inflammatory response to subcutaneous allergen-specific immunotherapy in patients with bronchial asthma and allergic rhinitis. Indian Journal of Allergy, Asthama and Immunology. 2015; 29(1):7-13
[19] www.aafa.org/page/asthama
[20] Sullivan SD[1], Lee TA, Blough DK, Finkelstein JA, Lozano P, Inui TS, Fuhlbrigge AL, Carey VJ, Wagner E, Weiss KB. A multisite randomized trial of the effects of physician education and organizational change in chronic asthma care: cost-effectiveness analysis of the Pediatric Asthma Care Patient Outcomes Research Team II (PAC-PORT II). Arch Pediatr Adolesc Med. 2005 May;159(5):428-34.