Allopathic medicine gone awry

To the Editor:

There has been much searching for reasons to explain the increases in upper respiratory tract-related diseases over the past 25 years. Schappert's data show that ear infections more than doubled between 1975 and 1990,1 and extrapolating his curve to the present suggests that by now this would have tripled. Although there are no national statistics for sinusitis, consensus points to increases as well. Asthma—while manifesting in the lungs and defined as a disease of the lungs—is triggered by irritants in the nasopharynx. Conditions that occur in the nose, such as allergies, chronic sinus infections, and viral upper respiratory infections, are the most common triggers for asthma. Even gastroesophageal reflux disease causes a reflex inflammatory response in the nasopharynx. The increase in the rate of asthma closely parallels that for otitis and, if extrapolated to the 25-year period ending in 2000, indicates, as in otitis, a rough tripling of incidence.2 Both these data sets should raise the question of what events occurred in the early 1970s that triggered the increases. Recent studies, using International Study of Asthma and Allergies in Childhood questionnaires, have also shown that the increase in asthma is related to Western orientation. Albania, other eastern bloc countries, and rural Chinese provincial cities do not share this increase.3 We can, perhaps, refine our search to the Western world in the early 1970s.

Rather than looking at the specific illnesses, or the “trees” of this problem, I think it useful to look at the forest. The forest, in this case, is the nose, because pollution in the nose—pathogenic or allergenic—is where all these medical problems begin.

The nasopharynx is normally cleaned by the combination of mucus and cilia. When mucociliary clearance is not sufficient, mast cells are triggered that release histamine, tryptase, and other enzymes. Histamine opens microvessels in the nasal tissues in an attempt to bathe the nasal cells and get rid of the irritant. Therefore, the body’s solution to pollution is dilution. Svensson and others4 have studied this process and conclude that its function is defensive.

From the time antihistamines were developed, we have been treating these problems using allopathic principles, that is, if it is wet, dry it out with antihistamines designed to block histamine. The effect of this blocking, however, is that nasal washing does not occur. Decongestants are designed to shrink membranes in the nose to facilitate draining, but this effect is obtained by constraining vessels opened by the histamine—they turn off the water for washing. The recent addition of nasal steroids to these treatments is designed to turn off the immune system so that it is unable to determine if the nose is polluted.

Antihistamines, decongestants, and combinations thereof were first available over the counter in the early 1970s, and, along with tobacco, were major advertisers for the growing television industry. For the past 25 years, people in the West have been systematically shutting off a defensive cleaning mechanism that has evolved over millions of years to wash the nasopharynx of pollutants. Rather than shutting it off, we need to find ways to facilitate it.

Saline nasal sprays, designed to moisten the nasal membranes, have been available for over 25 years. Hypertonic saline is available that is even more effective because it increases the flow rate of mucus through the nose. A hyperosmolar solution using xylitol increases the flow rate of mucus through the nasal membranes, have been available that is even more effective because it increases the flow rate of mucus through the nose. A hyperosmolar solution using xylitol increases the flow rate of mucus through the nasal membranes, have been available. Xylitol has been shown to reduce adherence of the major pathogens to nasal epithelial cells.5 It has also been studied as an osmolyte in that it reduces the saline concentration of the airway surface fluid, thus allowing innate antibacterial properties in that fluid to be more effective.6 None of these adjunctive treatments are drugs, and no drug studies have been done with any of them because transforming commonly available foods such as saline and xylitol into drugs is not economically realistic.

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References