

Essential Hypertension Treated By Homeopathic Therapeutics

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Abstract: *This article provides a comprehensive overview of the management of essential hypertension using homeopathic therapeutics. It begins by defining hypertension and outlining the JNC 7 classification. The article then delves into the causes and risk factors of primary and secondary hypertension, along with methods for diagnosing the condition. The management of hypertension is discussed in detail, including the JNC 8 guidelines and a focus on lifestyle changes. The article concludes with an in - depth look at various homeopathic remedies and their specific applications in treating hypertension, emphasizing the holistic approach of homeopathy in managing this prevalent health issue.*

Keywords: Essential Hypertension, Homeopathic Therapeutics, Hypertension Management, JNC Guidelines, Homeopathic Remedies

1. Definition

Hypertension is defined as a systolic blood pressure equal to or above 140 mm Hg and/or diastolic blood pressure equal to or above 90 mm Hg. Normal levels of both systolic and diastolic blood pressure are particularly important for the efficient function of vital organs such as the heart, brain and kidneys and for overall health and wellbeing. Blood pressure is measured in millimetres of mercury (mm Hg) and is recorded as two numbers usually written one above the other. The upper number is the systolic blood pressure - the highest pressure in blood vessels and happens when the heart contracts, or beats. The lower number is the diastolic blood pressure - the lowest pressure in blood vessels in between heartbeats when the heart muscle relaxes. Normal adult blood pressure is defined as a systolic blood pressure of 120 mm Hg and a diastolic blood pressure of 80 mm Hg.

However, the cardiovascular benefits of normal blood pressure extend to lower systolic (105 mm Hg) and lower diastolic blood pressure levels (60 mm Hg).

JNC 7 Classification of Hypertension

JNC 7 Category	Systolic Blood Pressure/ Diastolic Blood Pressure (mm hg)
1. Normal	120 - /80
2. Prehypertensive	120 - 139/ 80 - 89
3. Hypertensive	>140/90
4. Stage 1	140 - 159/90 - 99
5. Stage 2	>=160/100

Causes /risk factors of primary hypertension

- 1) Non - modifiable factors
 - Age
 - Positive family history
- 2) Modifiable factors
 - Obesity
 - Increase intake of saturated fat
 - Low level of physical activity
 - High salt intake
 - Smoking
 - Psychological stress

- Alcohol consumption

Causes of secondary hypertension

Renal diseases

- Renal vascular diseases – arteriosclerosis, fibromyalgia;
- Renal parenchymal diseases (glomerulonephritis), renal cyst (polycystic renal diseases), renal tumor (rennin secreting tumor), obstructive uropathy.

Endocrine diseases

- Adrenal - primary aldosteronism, Cushing syndrome, pheochromocytoma, congenital adrenal hyperplasia due to 11 - β hydroxylase or 17 α - hydroxylase deficiency;
- Thyroid, Parathyroid – Hypothyroidism, Thyrotoxicosis, Hyper Parathyroidism;
- Other - Liddle syndrome, Acromegaly.

Neurogenic: Psychogenic, acute increased intracranial pressure, acute spinal cord section. **Drugs:** Oral contraceptives, anabolic steroids, corticosteroids, NSAIDs, sympathomimetic agents, tri cyclic anti - depressants, cocaine etc.

Pregnancy: Eclampsia / pre - eclampsia

Diagnosing hypertension

Clinical presentation

Most people with hypertension have no symptoms at all; this is why it is known as the 'silent killer'. However, the patient needs to be assessed for a clinical history, sign and symptoms, BP reading, physical examination, basic investigations to confirm the diagnosis, other cardiovascular diseases risk factor, and secondary cause of hypertension or involvement of target organs.

Sign and symptoms may present as

- Headache
- Dizziness
- Insomnia
- Lack of concentration

Volume 12 Issue 12, December 2023

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- Loss of memory
- Palpitation of heart
- Nosebleed

Symptoms of hypertensive encephalopathy

- Acute severe headache
- Nausea and vomiting
- Visual disturbance
- Transient disturbance in speech
- Paraesthesia
- Fits and loss of consciousness

Physical examination

- Weight, Height
- Pulse rate, rhythm and character
- Jugular venous pressure
- Evidence of cardiac enlargement (displaced apex, extra heart sound) or evidence of decompensation (crackle, renal or abdominal bruit, radio femoral delay, abdominal aortic aneurysm)
- Evidence of kidney diseases (palpable kidney)
- Evidence of abnormality of endocrine system (enlargement of thyroid gland)
- Optic examination of fundi

History includes

- Duration of hypertension.
- Previous therapies: response & and side effects.
- Family history of hypertension and cardiovascular disease.
- Dietary and psychosocial history.
- Other risk factors: weight change, dyslipidaemia, smoking, diabetes, physical inactivity.
- Evidence of secondary hypertension: history of renal disease; change in appearance; muscle weakness; spells of sweating, palpitations, tremor, erratic sleep, snoring, daytime somnolence; symptoms of hypo - or hyperthyroidism; use of agents that may increase blood pressure.
- Evidence of target organ damage: history of TIA, stroke, transient blindness; angina, myocardial infarction, congestive heart failure; sexual function.

Complications

- Heart failure
- Coronary artery diseases
- Left ventricular hypertrophy
- Stroke due to cerebral haemorrhage or infarction
- Progressive renal failure
- Hypertensive retinopathy
- Atherosclerosis.

Management of hypertensive cases

The new Joint National Committee (JNC 8) hypertension guidelines, which were published in the Journal of the American Medical Association on December 18, 2013, compared with previous hypertension treatment guidelines, advise higher blood pressure goals and less use of several types of antihypertensive medications. The new guidelines emphasize control of systolic blood pressure (SBP) and diastolic blood pressure (DBP) with age - and comorbidity -

specific treatment cut - offs. The new guidelines also introduce new recommendations designed to promote safer use of angiotensin converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs). Important changes from the JNC 7 guidelines include the following:

- In patients 60 years or older who do not have diabetes or chronic kidney disease, the goal blood pressure level is now <150/90 mm Hg.
- In patients 18 to 59 years of age without major comorbidities, and in patients 60 years or older who have diabetes, chronic kidney disease (CKD), or both conditions, the new goal blood pressure level is <140/90 mm Hg.
- First - line and later - line treatments should now be limited to 4 classes of medications: thiazide - type diuretics, calcium channel blockers (CCBs), ACE inhibitors, and ARBs.
- Second - and third - line alternatives included higher doses or combinations of ACE inhibitors, ARBs, thiazide - type diuretics, and CCBs. Several medications are now designated as later - line alternatives, including the following: beta - blockers, alpha-blockers, alpha1/beta - blockers (eg, carvedilol), vasodilating beta - blockers (eg, nebivolol), central alpha2/ - adrenergic agonists (eg, clonidine), direct vasodilators (eg, hydralazine), loop diuretics (eg, furosemide), aldosterone antagonists (eg, spironolactone), and peripherally acting adrenergic antagonists (eg, reserpine).
- When initiating therapy, patients of African descent without CKD should use CCBs and thiazides instead of ACE inhibitors
- Use of ACE inhibitors and ARBs is recommended in all patients with CKD regardless of ethnic background, either as first - line therapy or in addition to first - line therapy.
- ACE inhibitors and ARBs should not be used in the same patient simultaneously.
- CCBs and thiazide - type diuretics should be used instead of ACE inhibitors and ARBs in patients over the age of 75 years with impaired kidney function due to the risk of hyperkalaemia, increased creatinine, and further renal impairment.

The change to a more lenient systolic blood pressure goal may be confusing to many patients who are accustomed to the lower goals of JNC 7, including the <140/90 mm Hg goal for most patients and <130/80 mm Hg goal for patients with hypertension and major comorbidities. The guidelines were informed by results of 5 key trials: the Hypertension Detection and Follow - up Program (HDFP), the Hypertension - Stroke Cooperative, the Medical Research Council (MRC) trial, the Australian National Blood Pressure (ANBP) trial, and the Veterans' Administration (VA) Cooperative. In these trials, patients between the ages of 30 and 69 years received medication to lower DBP to a level <90 mm Hg. Results showed a reduction in cerebrovascular events, heart failure, and overall mortality in patients treated to the DBP target level. The data were so compelling that some members of the JNC 8 panel wanted to keep DBP <90 mm Hg as the only goal among younger patients, citing insufficient evidence for benefits of an SBP goal lower than 140 mm Hg in patients under the age of 60 years. However,

more conservative panelists pushed to keep the target SBP goal as well as the DBP goal.

In younger patients without major comorbidities, elevated DBP is a more important cardiovascular risk factor than is elevated SBP. The JNC 8 panelists are not the first guideline authors to recognize this relationship. The JNC 7 guideline authors also acknowledged that DBP control was more important than SBP control for reducing cardiovascular risk in patients <60 years of age. However, in patients 60 years and older SBP control remains the most important factor.¹⁴

Special therapeutic considerations

ACE inhibitors and ARBs may not be an ideal choice in patients of African descent. Results of a subgroup analysis in the Antihypertensive and Lipid Lowering Treatment to Prevent Heart Attack Trial (ALLHAT) found that ACE inhibitors led to worse cardiovascular outcomes than thiazide - type diuretics or CCBs in patients with African ancestry. Despite the subgroup analysis of ALLHAT, results of the African American Study of Kidney Disease and Hypertension (AASK) support use of first - line or add - on ACEIs to improve kidney - related outcomes in patients of African descent with hypertension, CKD, and proteinuria.

As a result, the JNC 8 panelists recommend that all patients with chronic kidney disease and hypertension, regardless of ethnic background, should receive treatment with an ACE inhibitor or ARB to protect kidney function, either as initial therapy or add - on therapy.

One exception to the use of ACE inhibitors or ARBs in protection of kidney function applies to patients over the age of 75 years. The panel cited the potential for ACE inhibitors and ARBs to increase serum creatinine and produce hyperkalaemia. As a result, for patients over the age of 75 years with decreased renal function, thiazide - type diuretics or CCBs are an acceptable alternative to ACEIs or ARBs. In addition, the panel expressly prohibits simultaneous use of an ACE inhibitor and an ARB in the same patient. This combination has not been shown to improve outcomes. Despite the fact that the 2 medications work at different points in the renin - angiotensin - aldosterone system, other combinations of medications are better options, and the simultaneous use of ACEIs and ARBs is not supported by evidence.

Lifestyle Changes

As in JNC 7, the JNC 8 guidelines also recommend lifestyle changes as an important component of therapy. Lifestyle interventions include use of the Dietary Approaches to Stop Hypertension (DASH) eating plan, weight loss, reduction in sodium intake to less than 2.4 grams per day, and at least 30 minutes of aerobic activity most days of the week. The DASH trial convincingly demonstrated that over an 8 - week period a diet high in fruits, vegetables, and low - fat dairy products lowers blood pressure in individuals with high - normal blood pressures or mild hypertension. Reduction of daily NaCl intake to <6 g (100 meq) augmented the effect of this diet on blood pressure. Fruits and vegetables are enriched sources of potassium, magnesium, and fiber, and dairy products are an important source of calcium. In

addition, to delay development of hypertension, improve the blood pressure—lowering effect of existing medication, and decrease cardiovascular risk, alcohol intake should be limited to 2 drinks daily in men and 1 drink daily in women. Note that 1 drink constitutes 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80 - proof liquor. Quitting smoking also reduces cardiovascular Risk. It is obvious here that the JNC 8 guidelines move away from the assumption that lower blood pressure levels will improve outcomes regardless of the type of agent used to achieve the lower level. Instead, the JNC 8 guidelines encourage use of agents with the best evidence of reducing cardiovascular risk. In addition, the guidelines may lead to less use of antihypertensive medications in younger patients, which will produce equivalent outcomes in terms of cardiovascular events with less potential for adverse events that limit adherence.

Homeopathic Medicine View

Aconite nepallus

Drug Name	Aconite nepallus
Synonym	Monkshood
Kingdom	Vegetable
Family	Ranunculaceae
Part use	The whole plant including the root
Proved by	Dr. Hanhemann



Homeopathic Description

Palpitation of the heart, with great anxiety, heat of body, chiefly in the face, and great weariness in the limbs. —Shootings in the region of the heart when moving or going upstairs. —Sensation of compression and blows in the region of the heart. —Inflammation of the heart. —Chronic diseases of the heart, with continuous pressure in the l. side of the chest, oppressed breathing when moving fast and ascending steps, stitches in the region of the heart, congestions to the head; attacks of fainting and tingling in the fingers. —Fainting with tingling. —Pulse full, strong, hard; slow, feeble; threadlike with anxiety; quick, hard, small.

Allium Sativum

Drug Name	Allium Sativum
Common Name	Rasun
Synonym	Garlic
Kingdom	Vegetable
Family	Liliaceae
Part use	The mature bulb
Proved by	Dr. Hanhemann



Homeopathic Description

It acts directly on the intestinal mucous membrane and increases peristalsis. It has vasodilator properties. Arterial hypotension usually begins in 30 to 45 minutes after twenty to forty drop doses of the tincture.

Aurum metallicum

Drug Name	Aurum metallicum
Common Name	Gold
Synonym	Au
Kingdom	Mineral
Proved by	Dr. Hanhemann



Homeopathic Description

This homeopathic high blood pressure remedy is useful for serious people, focused on career and accomplishment, with blood pressure problems related to stress. Worry, depression or anger may occur, especially when these people feel they have made a mistake or failed in some way. A general tendency to feel worse at night, a strong wants for alcohol, sweets, bread, and pastries are other signs for Aurum.

Belladonna

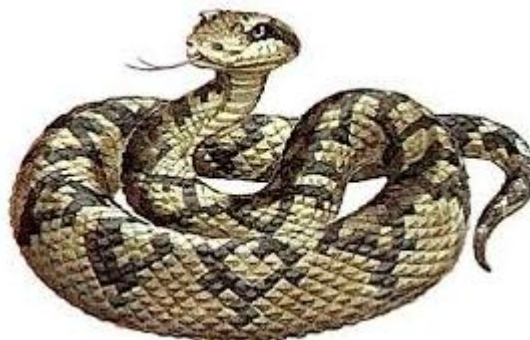
Drug Name	Belladonna
Synonym	Deadly Nightshade
Kingdom	Vegetable
Family	Solanaceae
Part use	The whole plant
Proved by	Dr. Hanhemann

Homeopathic Description

This high blood pressure remedy is useful if the symptoms come on suddenly, with great intensity and heat. The person’s face is flush, with dilated pupils, and beats and throbbing may be there in various parts of the body. Despite the general heat, the person’s hands and feet may be cold. Vertigo and pounding headaches, worse from jarring and light, may also occur

LachesisMutus

Drug Name	LachesisMutus
Synonym	Surukuku snake poison
Kingdom	Animal
Family	Ophidia
Part use	Venom
Proved by	Dr. C. Hering



Homeopathic Description

A person who needs this remedy typically is intense and talkative, with inner passion and agitation that need an outlet (pressure cooker). The person may have a strong fear of disease, and feelings of suspicion, revenge, or jealousy are common. The person may also have heart or artery problems, look flushed or purplish, and feel constriction in the chest, with beats in many areas. Feeling worse after taking a nap or on waking in the morning, and a strong intolerance of clothing around the neck (or any restriction) are other signs for Lachesis

Natrummuriaticum

Drug Name	Natrummuriaticum
Common Name	Namak (Table salt)
Synonym	Chloride of sodium
Kingdom	Mineral
Proved by	Dr. Hanhemann



Homeopathic Description

Rauwolfia use in high blood pressure without marked atheromatous changes in the vessels.



Homeopathic Description

A person who needs this remedy seems reserved and responsible but may have strong feelings (of grief, disappointment, anger, lingering grudges, and a fear of misfortune) inside. Headaches and palpitations are common, as well as a feeling of tension (even coldness) in the chest. The person feels worse from being in the sun, around midmorning, and better from being alone in a quiet place. A craving for salt and strong thirst can help to confirm the choice of this remedy.

Strophanthushispidus

Drug Name	Strophanthushispidus
Common Name	Arrow poison (Ghana)
Synonym	Kombe seed
Kingdom	Vegetable
Family	Apocynaceae
Part Used	Seed

Sanguinaria Canadensis

Drug Name	Sanguinaria Canadensis
Common Name	Blood Root
Synonym	Canada Tuccoon
Kingdom	Vegetable
Family	Papaveraceae
Part Used	Rhizome
Proved by	Dr. G. Bute



Homeopathic Description

A feeling that blood is rushing to the head, with flushed red cheeks and pulsing in the neck, may suggest this remedy. The person may have headaches or migraines (usually on the right and worse from light and noise). Frequent signs are right - side neck and shoulder problems. Also, allergies, heartburn, digestive problems, and burning pains are typical. Symptoms are worse from motion, and relief may come from being in the dark and sleeping. A craving for spicy food and a tendency to feel severe from eating sweets are other signs for Sanguinaria.

Homeopathic Description

The heart is easily and powerfully affected; systole is increased. Chronic degeneration of cardiac muscle, pulse small, frequent and irregular; great difficulty of breathing, and oedema. - Nervous palpitation and arrest of breathing. Stitches and twitches at apex beat. Loud heart sounds, slight regurgitant mitral bruit (child).

Rauwolfia Serpentine

Drug Name	Rauwolfia serpentine
Common Name	Indian snake root
Synonym	Devil pepper
Kingdom	Vegetable
Family	Apocynaceae
Part Used	Dry root with bark

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