

## Adenoids: electropuncture portrait

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The development and implementation of non-invasive and harmless diagnostic methods into practice remains an urgent problem in pediatrics. In recent years, electropuncture diagnostics (EPD) methods, such as the Nakatani method, auricular diagnostics, etc., have been increasingly used for these purposes [7]. One of the most informative is the method of electropunctural diagnostics according to R. Voll. According to the reaction of measurement points on the hands and feet to mechanical and electrical stimulation, the functional state of the meridians (organs and systems) of a person is assessed. The method allows detecting functional disorders at the preclinical stage, before the manifestation of the disease. The general health of the child is assessed at once.

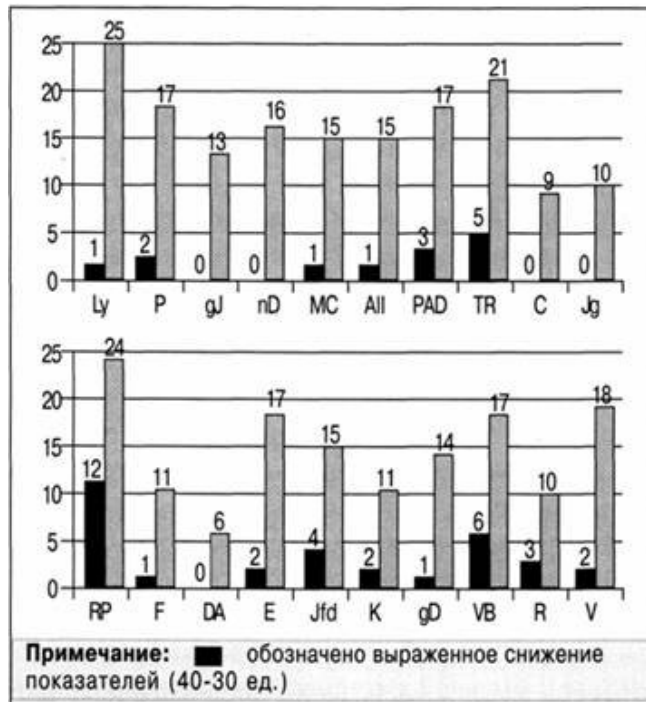
The EPD method according to R. Voll using the computer complex "ARM - Peresvet" examined 25 children aged 3 to 11 years (14 boys, 11 girls) with a clinical diagnosis: II-III degree adenoids (18 people), relapse after adenotomy (7 people), Concomitant diseases: bronchial asthma, frequent acute respiratory viral infections, biliary dyskinesia, reactive pancreatitis, atopic dermatitis.

The control group consisted of 12 children without ENT pathology (clinically and according to the EPD data according to R. Voll). These children were examined for diseases: vegetative-vascular dystonia, subacute bronchitis, hepatitis, myopia, enuresis, atopic dermatitis, reactive pancreatitis, gastroduodenitis (8 boys, 4 girls),

The identified indicators were assessed as follows:

Grade	conv. units
Norm	50-65
mild functional disorders	50-40 and 65-75
severe functional impairment	<40 and > 75

The data obtained are presented in Table 1 and graphically (Fig. 1).



Rice. 1. Violation of the functional activity of the meridians in ENT pathology

Table 1

Frequency of meridian disorders depending on the presence of ENT pathology

Meridian		With ENT pathology (25 people)		Without ENT pathology (12 people)	
		PERSONS	%	PERSONS	%
1-U	Lymphatic	25	100	0	0
R	Lungs	17	68	5	41,7
Gj	Colon	13	52	nine	75
ND	Nervous system	16	64	6	50
MC	Vascular system	15	60	6	50
AI	Allergy	15	60	5	41,7
PAD	Parenchymal epithelium. degeneration	17	68	3	25
TR	Endocrine system	21	84	3	25
WITH	Heart	nine	36	eight	66.7
Jg	Small intestine	ten	40	4	33.3
RP	Pancreas	24	96	5	41,7
F	Liver	eleven	44	12	100
DA	Joints	6	24	7	58.3
E	Stomach	17	68	ten	83.3
Jfd	Connective tissue	15	60	4	33.3
TO	Leather	eleven	44	3	25
Gd	Living tissue	fourteen	56	4	33.3
VB	Biliary system	17	68	6	50
R	Kidney	ten	40	5	41,7
V	Bladder	eighteen	72	2	16.7

The picture of the disease is characterized by the fact that almost all meridians have

violations. There is not a single organ that does not have violations at all with adenoids. At the same time, there is a different frequency of violations of certain meridians. We have identified 3 groups of meridians in connection with the different frequency of functional disorders in them (table 2).

table 2

Distribution of meridians into groups depending on the frequency of violations

%	Meridian
24-44	heart, small intestine, liver, joints, skin, kidneys
52-72	lungs, colon, nervous system, vascular systems, allergies, parenchymal-epithelial degeneration, stomach, connective tissue, adipose tissue, gallbladder, urinary bladder.
84-100	lymphatic systems (ENT pathology), endocrine systems, pancreas glands

At the same time, a pronounced decrease in functional activity was more rare and in isolated cases. However, on individual meridians, these changes were revealed with a greater frequency: on the meridians of the endocrine system in 5 children (20%), the gallbladder - in 6 children (24%), connective tissue degeneration - in 4 children (16%) and the pancreas - in 12 children (48%).

The frequency of pathology detected with EPD according to R. Voll correlates with the literature data on the clinical examination of children with adenoids, So, Borzov E.V. and Kuznetsova E.The. [2] found in 125 children with grade II - III adenoids:

general complaints - in 73.6% of patients;  
headaches - in 30.4% of patients; decreased appetite - in 27.2% of patients; restless sleep - in 26.4% of patients; rapid fatigue - in 21.6% of patients; prolonged subfebrile condition - in 11.2% of patients; enuresis - in 20.0% of patients;

hypertrophy of the palatine tonsils - in 66.4% of patients; an increase in various groups of lymph nodes - in 100% of patients; while submandibular - 92.8%  
posterior cervical - 71.2%,

Kochetkov P.A. [6] among children with adenoids revealed frequent and long-term illnesses - 73.5% with aggravated allergic anamnesis - 23.1%, chronic somatic pathology - 25.2%, vasomotor rhinitis - 46% of children.

According to some data [11], 2/3 of children with chronic rhinosinusitis have changes in the autonomic and cardiovascular systems. Samotokin M.B. [9] found signs of autonomic dystonia in 8 out of 10 children with hyperplasia of the pharyngeal tonsil. In general, in children and adolescents, the prevalence of autonomic dysfunctions ranges from 20 to 30% in the population [1].

The structures of the limbic system and the hypothalamus have a significant effect on the lymphatic system, as well as on the cardiovascular and other systems of the body. Any

trauma, any infection, intoxication negatively affects the hypothalamus, which leads to symptoms of vegetative-vascular, metabolic-endocrine and other disorders [12].

In practical work, there are often cases when at the reception of children for adenoids in the outpatient card, records of almost all specialists are found, each of whom discovered any functional disorders: vegetative-vascular dystonia, myocardopathy, intestinal dysfunction, posture disturbance, dysfunction of the biliary tract, etc. the picture is very similar to the picture with minimal brain dysfunctions in children [16].

How can you explain such widespread functional disorders in children with adenoids? Are adenoids a primary process or a secondary one?

Adenoids (adenoid vegetations) are hypertrophy of the nasopharyngeal (pharyngeal, or third) tonsil, located in the fornix of the nasopharynx. Together with the lingual and palatine tonsils, it is part of the lymphoepithelial pharyngeal ring.

Pathology of the pharyngeal tonsil in children is very common, up to 92% of those examined in children's groups [8]. The defeat of the nasopharyngeal tonsil is about 50% in the structure of all ENT diseases in children under the age of 7 years [2].

The functions of the palatine and pharyngeal tonsils are considered the same type, but their structure is different. The pharyngeal tonsil, in contrast to the palatine, has glands that open into crypts and drain them [8].

All tonsils are organs of the highest immune activity. Each of them, in contact with antigens in a certain area, forms an immune barrier of the mucous membranes of the nose and sinuses, transmits information about antigens to the entire immune system [2, 3, 6, 8].

Bykova V.P. et al [3] considers adenoids to be a physiological defense reaction of one of the organs of the immune system, specialized in relation to the pathogenic microflora of the upper respiratory tract. Rhinitis and sinusitis are always accompanied by changes in the pharyngeal tonsil.

In recent years, the opinion has been increasingly expressed that "the pathology of the nasopharyngeal tonsil is one of the manifestations of the general lymphoproliferative syndrome" [2].

Taking into account the obtained data of electropunctural diagnostics by the method of R. Voll, we can figuratively say that adenoids are the "tip of the iceberg" in the child's body. The largest components of this "iceberg" are functional disorders of three meridians: the lymphatic, endocrine system and pancreas. The frequency of their violations is highlighted in Table 3 for clarity.

Table 3

Frequency of meridian disorders depending on the presence of ENT pathology

Meridian	With ENT pathology	Without ENT pathology
LU	100	0
TR	85	25
RP	96	41,7

The frequency of dysfunctions of the pancreatic meridian in children with adenoids is several times higher than that in the absence of changes in the lymphatic meridian, i.e. without ENT pathology.

This fact can be explained on the basis of the concepts of oriental medicine and modern electropuncture. Thus, the pancreas meridian, like no other (except for the lymphatic), has the most extensive connections with the lymph nodes and lymphatic plexuses of various organs (half of all measurement points) [10].

So, according to the EPD according to R. Voll, with adenoids in children, the function of the pancreas almost always suffers. Violations were detected at the measurement points:

insulin - glucagon - in 15 children	(60%)
carbohydrate metabolism - in 19	(76%)
children fat metabolism - in 19 children	(76%)
protein metabolism - in 5 children	(twenty%).

Thus, in the majority of children with adenoids, preclinical signs of disorders of both exo- and endocrine functions of the pancreas, primarily carbohydrate and fat metabolism, are revealed. This explains to a large extent the fact of the frequent detection of so-called reactive pancreatopathy (dispancreatism) in children during ultrasound examination.

The most possible causes of dysfunction of the pancreas in children are primarily associated with the characteristics of the child's body [13]:

1. more intense and less perfect carbohydrate metabolism in children compared with adults;

2. Instability and rapid depletion of fat depots with a lack of food

carbohydrates;

3. various congenital (familial predisposition) and acquired factors of autonomic dysregulation.

Infections with a tropism to the glandular epithelium occupy a special place among the reasons for disturbances in the activity of the pancreas [4]. These are mumps, viral hepatitis, infectious mononucleosis, typhoid fever, enterovirus infection. The defeat of the pancreas in these infections is, as a rule, unstable, temporary and not always confirmed by laboratory data. These are more likely signs of dyspancreatism than acute pancreatitis.

The literature also continues to discuss the role of infection [5, 14] as a provoking factor of damage to pancreatic cells (beta cells), their autoimmune destruction in children with genetic markers of diabetes mellitus. The triggers are mumps, chickenpox, measles, scarlet fever, as well as flu and sore throat. In this case, the immune process leading to the clinical manifestations of type I diabetes mellitus begins several years before their onset. In this period of prediabetes, increased titers of auto-antibodies to islet cells and insulin are already detected in the blood.

Considering the previously mentioned fact that the pharyngeal tonsil has not only a lymphoid, but also a glandular structure [8], we believe that any infection nesting in it (adenoiditis) is tropic to the tissue of the pancreas and is dangerous with a possible violation of its function.

#### CONCLUSIONS

1. The use of electropunctural diagnostics according to the method of R. Voll in pediatrics allows you to identify a variety of functional disorders even before the stage of clinical manifestation of the disease.

2. According to EPD data, children with adenoids usually have disorders functions of most organs and systems.

3. The most affected organ in children with adenoids is the pancreas. Both exo- and endocrine functions are impaired.

4. Examination of children with adenoids is advisable to be carried out in a complex with the participation of pediatrician, ENT doctor, neurologist, cardiologist, allergist, gastroenterologist.

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