

Therapeutic efficacy of homeopathic medicines in combination with BRT in the treatment of cardiac arrhythmias

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Arrhythmias are the most common cardiac pathology, among them atrial fibrillation, or atrial fibrillation, and various options for extrasystole are often found. The causes of cardiac arrhythmias can be various diseases of the heart itself, such as: ischemic disease, valve lesions, myocarditis, valve defects, surgical interventions, etc., as well as electrolyte imbalance, drug intoxication, thyroid pathology, diabetes mellitus, disease lungs, etc.

Extrasystole is an extraordinary contraction of the heart muscle. In healthy people, this is a fairly common type of arrhythmia, but when the number of extraordinary contractions exceeds a certain value, as well as when they occur in coronary artery disease, they can be a harbinger of sudden death or the development of atrial fibrillation (AF).

MA - supraventricular tachyarrhythmia, characterized by uncoordinated activation of the atria with a subsequent deterioration in their contractility. The ventricular response to MA depends on the electrophysiological properties of the atrioventricular node, vagal and sympathetic tone, and the effect of drugs. Fast, irregular ventricular tachycardia with wide QRS complexes is characteristic of MA with conduction through the accessory pathway or for MA with bundle branch block. Too high a ventricular rate (more than 200 bpm) suggests the presence of an additional conductive bundle. MA occurs in many clinical situations. To characterize MA that is not a consequence of a reversible cause and lasts more than 30 seconds, the following terms are often used. The term "isolated MA" is used in young patients (less than 60 years old), without clinical or echocardiographic signs of cardiopulmonary disease. The prognosis for thromboembolic complications and death in these patients is favorable. "Idiopathic MA" implies that the cause of MA is unclear regardless of age and the presence of cardiovascular pathology. The term "non-valvular AF" applies to cases in which arrhythmia occurs in the absence of rheumatic mitral stenosis or an artificial heart valve.

The following definitions are recommended to characterize MA episodes. "Newly diagnosed episode of MA" - can be either the first episode of MA of various duration, or the next episode in cases when the onset of MA was previously asymptomatic or asymptomatic. "Recurrent MA" - the presence of 2 or more episodes of MA. "Paroxysmal MA" - arrhythmia stops spontaneously (usually within 7 days, more often in the first 24-48 hours). "Persistent or stable MA" - arrhythmia does not stop spontaneously (pharmacological or electrical cardioversion is required to eliminate it) and usually lasts more than 7 days. This form of MA can be either the first manifestation of MA or a manifestation of recurrent MA. "Persistent (chronic) MA" - a type of long-term persistent MA,

The goal of atrial fibrillation treatment is to reduce symptoms associated with arrhythmias and prevent possible complications.

There are 2 main approaches to the treatment of MA: restore and maintain sinus rhythm, or allow MA to continue, while maintaining control of the ventricular rate (ventricular rate 60-80 bpm at rest and 90-115 bpm with moderate physical activity).

load), and treatment aimed at preventing arterial thromboembolism. The first approach attracts with the ability to effectively alleviate the symptoms of arrhythmias, prevent thromboembolic complications and cardiomyopathy. It is important to remember that medical and electrical methods of restoring sinus rhythm (cardioversion) are associated with the same risk of thromboembolic complications and stroke, therefore, if these procedures are performed routinely and the duration of an MA episode exceeds 48 hours, preparation with the use of anticoagulants is necessary. The need for urgent cardioversion arises if arrhythmia is the main factor responsible for the occurrence of acute heart failure, hypotension, or worsening of angina pectoris in patients with coronary artery disease.

Pharmacological cardioversion is most successful with MA duration of 7 days. Antiarrhythmic pretreatment prior to electrical cardioversion, which can increase the success of the procedure and prevent early resumption of MA, is justified in patients with previously unsuccessful electrical cardioversion or when MA quickly resumed (immediately or in the first 2 weeks after the intervention). With a later resumption of MA or with the first electrical cardioversion in patients with persistent AF, pre-administration of an antiarrhythmic drug is considered unnecessary.

The use of antiarrhythmic drugs can be accompanied by the occurrence of various types of proarrhythmias and conduction blockades, therefore, although proarrhythmia rarely occurs in patients with normal ventricular function and normal baseline QT intervals, who do not have severe bradycardia, in most cases, medical treatment of AF should be started in a hospital. This is especially true for pharmacological cardioversion. When using drugs that prolong the QT interval, it is necessary to be monitored in the hospital for 24–48 hours after cardioversion to assess the effect of treatment on heart rate (the degree of its decrease) and timely intervention in case of ventricular tachycardia of the "pirouette" type. Due to the risk of rapid conduction through the atrio-ventricular node or atrio-ventricular conduction 1: 1 if atrial flutter occurs, a beta-blocker or a calcium antagonist should be given before starting treatment with class I antiarrhythmics. An initially safe drug may become proarrhythmic if the patient develops coronary artery disease or heart failure, or starts taking other drugs that, in combination, can be arrhythmogenic. In addition, given the certain toxicity of antiarrhythmic drugs, it becomes not superfluous to search for new ways to treat cardiac arrhythmias. which in combination can be arrhythmogenic. In addition, given the certain toxicity of antiarrhythmic drugs, it becomes not superfluous to search for new ways to treat cardiac arrhythmias. which in combination can be arrhythmogenic. In addition, given the certain toxicity of antiarrhythmic drugs, it becomes not superfluous to search for new ways to treat cardiac arrhythmias.

In this report, we focused only on those cases in which the use of conventional antiarrhythmic drugs was ineffective or in which patients refused them because of side effects. We observed 14 people, 7 of them with extrasystoles and 7 with atrial fibrillation. One of them with recurrent MA and extrasystoles. We tried to correct heart rhythm disturbances in these patients with the help of electronic analogs of homeopathic preparations manufactured on the hardware-software complex "IMEDIS-EXPERT" in combination with BRT.

Table 1 presents the characteristics of the patients.

Table 1

Patient characteristics

Patients nents	Age	Type of violations	Duration	Possible reasons emergence
K.V.	51	Extrasystoles	More than two years	After myocardial infarction
B.Kh.	38	Isolated MA	10 years	Not known
K.M.	50	Constant (chronic) MA	2 years	IHD, CABG
EAT.	60	Extrasystoles		IHD, CABG and stenting
Ya.G.	46	Extrasystoles	2.5 years	Not known
A.A.	57	Constant (chronic) MA	1.5 years	Myocardial infarction
K.V.	48	Extrasystoles		Myocardial infarction
H.L.	59	Persistent MA	4 month	On ultrasound increase atria
I.B.	63	Extrasystoles	4-6 months	Not defined
V.V.	67	Group extrasystoles	10 years	Ischemic heart disease, CABG, stenting
R.A	61	Recurrent MA	8 years	Ischemic heart disease, CABG, stenting
P.Z.	76	Constant (chronic) MA	12 years	Ischemic heart disease
Z.V.	48	Group extrasystoles	1.2 years	Not known
K.Yu.	80	Extrasystoles rolling to MA	10-12 years old	Ischemic heart disease

Below are presented almost all drugs that were used in one combination or another after the electroacupuncture vegetative resonance test.

Drugs that have been used to treat cardiac arrhythmias:

1. Atropinum compositum Comp.
2. Naja tripudians 12.
3. SIN 58 Tachicardia Comp.
4. Cactus 12.
5. Tachycardie Comp.
6. R 66 Herz-Irregularitats-Trop. Comp.
7. R 2 Goldtropfen-Essenzia aurea Comp.
8. Crataegus 12.
9. Primula comp. Comp.
10. Cactus Spez. Comp.
11. FM-complex 13 Heart Comp.
12. DRE 1 Dren. Arterioso-cardiaco Comp.

13. Glonoin-Homaccord Comp.
14. Spartium scoparium-Inj. forte Comp.
15. Digitalis 6.
- 16.29 co-HYPERT spag. Comp.
17. Herz komplex Comp.
18. Adonis Comp.
19. Kalmia D6.

Patients with high cholesterol levels were additionally prescribed drugs to correct the lipid profile of the blood and improve blood microcirculation.

Drugs used to correct blood lipid profile:

1. Cholesterinum D12.
2. Hypercholesterinaemie D6.
3. Sanguis suis-Injeel Comp.
4. Biofrid Lachsol Kapseln Comp.
5. Cholesterin complex Comp.
6. Pflanzenfett I D30.
7. Pflanzenfett II D30.
8. Pflanzenfett III D30.
9. Cronorgan n. 1 Comp.
10. Grosshirnhemispharen Comp.
11. Cholesterin-Ablagerungen Comp.
12. SIN 59 Ipercolest.-arterioscl. Comp.

Drugs used to improve microcirculation:

1. Lachesis 6.
2. Crotalus horridus
3. Naja tripudians 6
4. Vipera berus 6
5. Vipera redii D12
6. Aesculus Spez comp.

The treatment of extrasystole was especially successful. All patients, in addition to the selected drugs, were additionally prescribed Digitalis 30 for three days, then, depending on

the state of the rhythm of the heart. If there was no improvement, the daily intake of the drug was continued for several more days. It should be noted that, regardless of the type and duration of violations, almost all patients showed a significant improvement or almost complete cessation of extrasystole. In the future, either the treatment was completely stopped, or Digitalis 30 was prescribed once only when the extrasystole was repeated. The restoration of the heart rhythm in all patients was accompanied by a noticeable improvement in general well-being.

Treatment of MA proved to be more challenging. For the treatment of a young patient B.Kh. with idiopathic MA, the monopreparation Kalmiya was used. After a two-week intake of the drug, according to the patient, despite the 10-year prescription of MA, the restoration of the normal rhythm was noted, which has been preserved to this day.

23 ГОРОДСКАЯ КЛИНИЧЕСКАЯ БОЛЬНИЦА
им. "МЕДСАНТРУД"
ОТДЕЛЕНИЕ
УЛЬТРАЗВУКОВОЙ ДИАГНОСТИКИ
Москва, Яузская ул., д. 11

ВРАЧ
ОТДЕЛЕНИЯ Д. В.
ЭХОКАРДИОГРАФИЯ
№ 2
Возраст _____ лет, пол М/Ж

ЛОКАЦИЯ СТРУКТУР СЕРДЦА _____ затруднена

АОРТА (АО) в восходящей части диаметром 36 мм (N <= 40 мм)
стенки увеличенные, утолщены

Левое предсердие (ЛП): 50 мм (N <= 40 мм)
Левый желудочек (ЛЖ): 68 мм (N <= 55 мм) ЛЖ сист. 56 мм
Правый желудочек (ПЖ): 45 мм (N <= 30 мм) ПП _____ мм
(N <= 40 мм) — из виск. доступа (N <= 25 мм)

Нижняя полая вена (НВП) диаметром _____ мм экскурсия стенок при дыхании _____ снижена

РАСЧЕТ ОБЪЕМА ЛЖ по: Teicholz, Площадь/Длина _____ (N = 28-46%)

Диастолический объем (ДЛО): 84 мл dS 18 %
Систолический объем (КСО): 162 мл LVET 0.22 сек.
Ударный объем (УОК): 78 мл Vef 0.64 окр/с (N = 0.88-1.55)
Фракция выброса (ФВ): 37 % ЧСС 72 уд/мин
(N = 55-77%) ММЛЖ 5.57 г

АОРТАЛЬНЫЙ КЛАПАН (АК): створки _____ раскрытие створок 10 мм (N >= 15 мм)

МИТРАЛЬНЫЙ КЛАПАН (МК): створки _____ раскрытие створок _____ мм (N >= 25 мм). Скорость раннего диастолического закрытия (ЕF) передней створки МК 0.15 м/с систолическое движение _____

ТРИКУСПИДАЛЬНЫЙ КЛАПАН (ТК): _____

КЛАПАН ЛЕГОЧНОЙ АРТЕРИИ (КЛА): _____

СТЕНКИ ЛЖ (ср. зона): толщина _____ экскурсия _____

Межжел. перегород. (МЖП): 10 мм (N = 6-11 мм) 0.1 мм (N = 3-8 мм)
Задняя стенка (ЗС.ЛЖ): 7 мм (N = 6-10 мм) 20 мм (N = 9-14 мм)

ЗОНЫ ДИСКИНЕЗИИ СТенок ЛЖ: слабо-умеренная передняя перегородочная, задняя межжелудочковая, задняя межпредсердная, задняя межжелудочковая, задняя межпредсердная, задняя межжелудочковая, задняя межпредсердная

СЕПАРАЦИЯ ЛИСТКОВ ЭПИ- И ПЕРИКАРДА (в диастолу):
Перед сердцем _____ мм, позади ЗСЛЖ _____ мм, у верхушки _____ мм

ДОПЛЕР-ЭХОКАРДИОГРАФИЯ: проводилась _____ в/п прицельная доплеровская оценка _____ стенок _____

АК: Пиковая сист. скорость _____ м/с, глубина регургитации _____ ст.
МК: Соотнош. скор. E/A: 0.2, глуб. _____ сист. регургит. _____ ст.
ТК: Скорость регургитация _____ м/с, глубина регургитация _____ ст.
КЛА: Время ускор. потока (не) укорочено, регургитация _____ ст.

ЗАКЛЮЧЕНИЕ: Снижены сист. размеры. Выявлены умеренно выраженные дискинезии стенок ЛЖ с умеренно выраженными дискинезиями в области переднеперегородочной, заднеперегородочной, заднежелудочковой, заднепредсердной зон. Не выявлено признаков дисплазии миокарда.

№ 2 1000 2000 _____ г подпись _____

Rice. 1

Despite this, transient heart rhythm disturbances were noted periodically, especially with changes in the weather. After taking our drugs for 7-8 months, he stopped taking Allopurin. Currently, there are no significant complaints from the heart, the heart rate has become more stable.

The rest of the patients showed positive dynamics against the background of the treatment, although it was not always possible to restore the normal heart rhythm.

Thus, the studies carried out show the advisability of using the above drugs for patients with cardiac arrhythmias.

Literature

1. Recommendations of the American College of Cardiology and Heart Association, European Society of Cardiology, North American Society of Pacing and Electrophysiology for the Treatment of Patients with Atrial Fibrillation Date of conversion 11/15/2013.

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