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PRIMARY COMPLEX

Primary Complex is slowly becoming a houshold name in a number of families. What is the reason for this present trend?

Primary Complex comprises of the primary focus of tuberculous infection, lymphangitis and the associated tuber culous regional lymphadenitis. Though the primary complex frequently occurs in the lungs, it can also occur in the gastrointestinal tract, skin etc.

Following the natural tuberculous infection it takes 4 8 weeks for the child to become sensitive to the tuberculo protein and two months for the tubercle formation. It takes nearly one year for its radiological Visualisation in the lungs. Depending upon the various host factors like the nutritional status, immunological status etc, the evolution and manifestation varies from individual.

Only in a few cases obvious signs like a) Cervical lymphadenitis (b) Evidence of pulmonary parenchymal disease. (c) Doughy abdomen with hepatosplenomegaly etc.

Unlike adults, children with the primary complex often do not have the symptom like cough, sputum haemoptysis etc. The symptoms of childhood TB in its many forms are given below:

The following lead to-Suspecion- of primary complex.

i) Prolonged fever
ii) Loss of appetite
iii) Fatigue
iv) Cough
v) Night sweat
vi) Failure to thrive
vii) Loss of Weight
viii) Pallor
ix) Diahorrea
x) Abdominal pain
xi) Persistent cervical Adenitis.
xii) Chronic OTITIS Media.
xiii) History of contact in the family
xiv) Failure in Recovery.
xv) To normal health after exanth
xvi) Recurrent Respiratory infection,
xvii) Resistant skin infection.

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Pathology (or) pathogeneses:-

As soon as the organism enters the lungs-form, a Nidus in the peripheral aspect or lower part of the upper lobe or upper part of lower lobe. Histiocytes phagocytose them and take to the regional lymph node. Then the (i) initial focus (2) lymphangitis (3) regional adenitis form the classical features of primary complex. Sometime the primary node may show extensive inflammation—> caseating neurosis.

Initial focus is very small, (ie) a few mm in diameter. In 3-8 weeks time an allergy develops and local histology changes. It is characterised by central area of giant cells with (or) without caseation necrosis, surrounded by epitheliold cells, then by lymphocytes and finally surrounded by fibroblasts.

If the organism is having good immunity (or) on treatment the primary focus heals by fibroblastic proliferation—> final process of hyalinisation and calcification.

The calcified area may remain permanent (or) begin to resolve within 3 5 years and disappear.

Spread:

Can occur as local extension into bronchus, pleural cavity (or) adjacent organ (or) into the blood vessels producing Bacteremia.

Diagnosis of T. B.

It requires a number of approaches either separately or Simultaneously.

1 Clinical history
2 Physical examination
3 Roentgenographic examination
4 Tuberculin testing
5 Isolation & identification of tuberculous bacilli

History:-

Any child with the H/o contact of TB, should be suspected of having TB & investigated.

Clinical history:-

— initial onset is symptomless
— Even progressive disease may have minimal symptom.
— On occasion the so called typical symptom of PC may be formed.

Roentgenographic Examination (x-ray):

Should always be done. Lateral, oblique and PA views are required to bring out the lymph node shadow as they are not revealed well in PA view. Salient features are hylac node, cervical node, abdominal calcification, lesion of vertebral bodies, splenic enlargement.

MANTOUX:

To attain reproducability it is performed in a standardised manner. 5. 7. u (or) 0.1 ml of O. T. (Old Tuberculia) or PPD is given (Purified Protein Derivative) intradermally in Lt. forearm to produce immediate wheel.

It is read at 48 hrs & 72 hrs. Less than 5mm in diameter is considered negative. 5 to 9mm- doubtful- should be repeated.

Greater than 10mm- Consider positive.

Spread of TB:-

In the light of one's venture to state that upward trend is due to two complementary reasons. Firstly, there is increasing deterioration in hygiene which is promotive to faster spread of the infection. Secondly many patients usually get dejected with allopathic treatment for not only it does not cure, but also imprints new health problems.

Role of Homoeopathy in P. C. cases:-

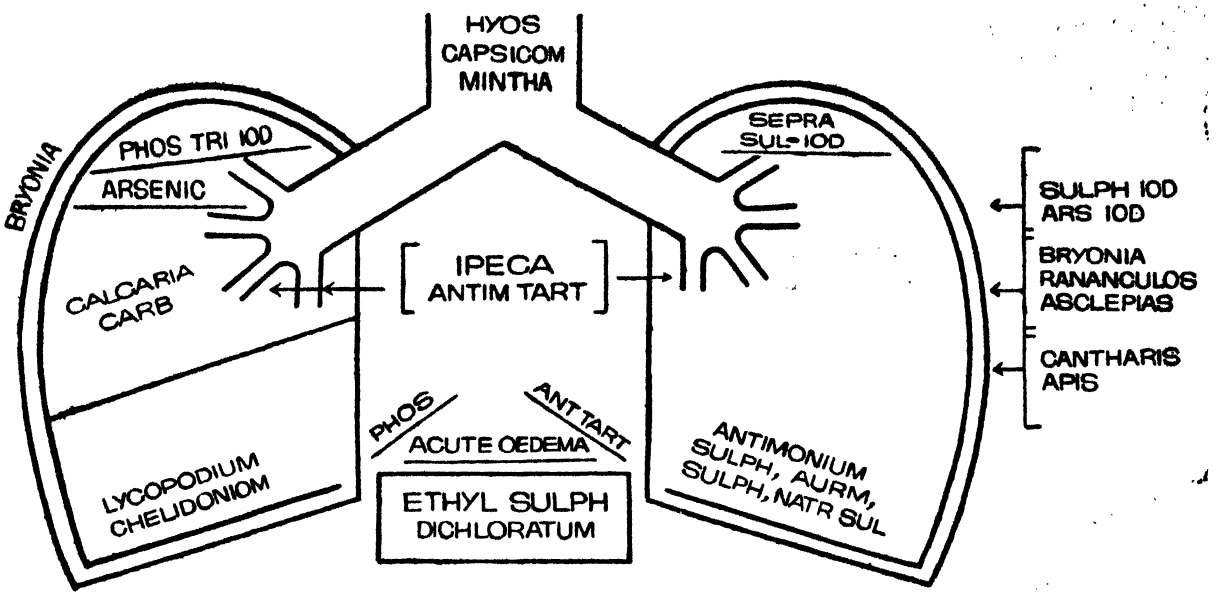
One might ask at this stage, why homoeopathy need bother with TB when a national (and international) programme employing allopathic treatment is already seized with the problem.

The information presently collected involve in all 1230 cases including the 30 under treatment by a practitioner. Amongst the Non tuberculin drugs reported to be useful are many like sulphur, phosphorus etc. Whereas the tuberculins include mostly Bacillinum and Tuberculinum. The author employed Tuberculinum in most of the cases while in some Bacillinum as the chief remedy. Non-tuberculins used were Ars. iodide, Baryta iodide, Stannum Iod. Calcar-iod and others, Silica and Hepar were especially used in opening of the lymph nodes and their drainage.

High light of this article is to present readers, that too particularly in paediatric age group. As it is difficult to get history in

detail, it may not be possible always with perfect SIMILIMUM.

In my practice, I applied Dr. L. Rousseau, and Dr. Fortier-Bernoville Topographical method of treatment. I found it successful in more then 90% of cases. The Topegraphy and its relative drugs are given below for the benefit of readers.



LESION / HAZINESS / OPACITY	—	DRUG
Left upper Zone (including pleura)	—	Sulphur Iodum Sepra
right upper Zone	—	Phosphorus triodatus
right middle Zone (Parenchymal)	—	calcarea carb
right middle Zone (Bronchi)	—	Antim Tart, IPECAC
Left middle Zone (Bronchi)	—	IPECA, Antim Tart
middle low involvement of right	—	Phellandrium
right lower Zone	—	LYCOPODIUM CHELI-DONIUM KALI CARB
Left Lower Zone Partially acting	—	ANTIMONIUM SULPHURICUM AURUM NATURUM SULPH. ARSENIC IODUM Oxygenoid Tuberculous Patient Special action on Rt.Lung

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