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AYURVEDIC MANAGEMENT OF CHRONIC ADENO TONSILAR HYPERTROPHY (TUNDIKERI)- A CASE REPORT

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ABSTRACT

Chronic Adenotonsillitis is a chronic inflammation of the adenoid and tonsils, which is characterised by tonsillar enlargement accompanied by dilated crypts with or without exudate. In Ayurveda, this condition can be correlated with *Tundikeri*, which is characterised by large swelling in the *Hanusandhi pradesha* that resembles a cotton seed *(karpasa phala)*, due to the vitiation of *kapha* and *Rakta*. This case report presents the successful Ayurvedic management of Chronic adenotonsillar hypertrophy in a child aged 9 years who presented with Nose blockage, enlarged tonsils, snoring, ear pain, and mouth breathing for 3 years. The patient was treated with Shamana therapies, including oral medication possessing *Kapha-shamaka* and *Shothahara* properties, along with local therapeutic procedures *such as kanta pratisarana, gandoosha, and karnapichu*. Remarkable improvements were noted within two weeks of treatment, including a reduction in clinical symptoms, a decrease in tonsillar size, and a lower frequency of infections. This case highlights the potential of Ayurveda as a safe and effective alternative for managing chronic adenotonsillitis, which may help reduce the necessity for surgical interventions.

KEYWORDS: *Tundikeri*, Chronic Adenotonsillitis, *kanta pratisarana, karna pichu.*

INTRODUCTION

Adenotonsillar disease is a common pediatric otorhinolaryngological disorder worldwide. The disorder affects the upper respiratory tract.[1] Adenoids are a subepithelial collection of lymphoid tissue at the junction of the roof and posterior wall of the nasopharynx and cause the overlying mucous membrane to be thrown into radiating folds.[2] Palatine tonsils are ovoid masses of lymphoid tissue situated in the lateral wall of the oropharynx between the anterior and posterior pillars.[3] The prevalence of Chronic Tonsillitis in school-attending children was reported as 17.82% in India.[4] Adenotonsillar hypertrophy is defined as the condition in which adenotonsillar tissue enlarges in dimension and accordingly invades a larger space in the nasopharyngeal wall, which can lead to the development of serious problems such as snoring, abnormal and sleep-disordered breathing, obstructive sleep apnoea, speaking, smelling, tasting, swallowing difficulties, mouth breathing, and orofacial problems.[5] It can also cause intermittent airway obstruction, chronic alveolar hypoventilation, and even lead to severe cardiopulmonary complications such as right ventricular (RV) failure and cor-pulmonale, a near-lethal culmination of pulmonary artery hypertension (PAH).[6] The treatment options for ATH are split into two directions: conservative or surgical management. The conservative (watchful) pathway is a convenient non-invasive option, especially when there is asymptomatic ATH or when there is a contraindication like bleeding tendencies. It is done with the reduction of weight and nutritional support, as well as the application of nasal continuous positive airway pressure if necessary. Moreover, it is often accompanied by the use of medical treatments like antihistamines, antibiotics, and nasal steroids, even with the absence of their recent clinical supportive studies, in addition to their potential side effects. Even though adenotonsillectomy is generally considered safe, it holds some risks like any other

surgical procedure. These include perioperative bleeding, infection and anaesthetic complications, and others.[7]

In Ayurveda, Adenoiditis and Chronic tonsillitis can be correlated to *Kantashaluka* and *Tundikeri* respectively, based on the clinical features mentioned under *Kantagata rogas*. Symptoms include matted and elevated swelling resembling the plum seed (*Kolavat grathita unnataha shopha)* leading to obstruction (*Margavarodha)*[8] in *kantashaluka* and a hard swelling (*katina shopha*)in the throat which looks like the seeds of cotton fruit (*Karpasi beeja sadrusha*) in Tundikeri.[9]

In Ayurveda, the treatment modalities are explained as *Shodhana* therapies such as *Nasya*, Shamana therapies such as *Kavala*, *Gandoosha*, and *Dhoomapana* and *Sthanika Upakrama* (local therapeutic procedures) such as *Kanta Pratisarana*.[10]

This study reports a case of Adenotonsillar hypertrophy (*Kantashaluka* and *Tundikeri)* in a 9-year-old child which was successfully managed with Ayurvedic treatment. Informed consent was taken from the parents for publication of the case and clinical details.

CASE REPORT

A 9-year-old female child was apparently healthy until about two months prior to presentation, when she went on a family trip during which she played in a swimming pool. On the following day, she developed left-sided ear pain, which was initially mild but continuous in nature. Over time, the pain gradually increased in intensity, interfering with her daily activities and sleep. There was no history of trauma, fall, or foreign body insertion into the ear. Approximately one and a half months before presentation, the child developed progressive bilateral nasal obstruction. As the nasal blockage worsened, the mother noticed that the child began mouth breathing during sleep, associated with snoring. Although snoring had been present for the past 5–6 years, it had previously been neglected as the child was otherwise healthy. The child also experienced intermittent episodes of breathing difficulty during sleep, suggestive of upper airway obstruction. To alleviate the symptoms, the mother administered nasal drops prescribed by a local physician, which provided only temporary relief. Due to the persistence and progression of symptoms, the child was subsequently taken to a nearby ENT specialist. Following clinical examination and investigations, she was diagnosed with Grade III Acute Adenoiditis and left tympanic membrane perforation. Surgical management, likely adenoidectomy with an associated ear procedure, was advised, and medications were prescribed, though the details were not available. As the mother was unwilling to proceed with surgical intervention, further ENT follow-up was discontinued. Seeking conservative and alternative management, the child was brought to the Shalakya Tantra Outpatient Department, Shri Kalabyraveshwara Swamy Ayurvedic Medical College and Hospital, on 27th October for Ayurvedic management.

Examination

Ashtasthana pareeksha

- Nadi: 90 bpm
- Mutra: 4-6 times/day
- Mala: 1-2 times/day
- Jihwa: lipta
- Shabda: vikruta
- Sparsha: prakruta
- Drik: prakruta
- Akruti: Madhyama

Systemic examination

CNS- conscious, oriented
CVS- S1,S2 heard, no murmur
RS- B/L NVBS

Local examination

Nose and paranasal sinus examination	
A] External nose examination	• Osteocartilagenous frame work- normal
B] Anterior rhinoscopic examination	• Nasal passage- narrow bilaterally • Nasal discharge- no • Nasal mucosa- not inflamed • Nasal septum – no deviation • Inferior turbinates - bilaterally hypertrophied
C] Posterior rhinoscopic examination	• Discharge or bleeding- absent • Adenoids- pinkish irregular mass noticed in posterior pharyngeal wall
D] Functional examination of nose	• Patency test a) Spatula test –area of condensation was equal on both the sides b) Cotton wool test – movement of cotton wool equal on both the sides c) Sense of smell- able to perceive mild, moderate and strong odours
E] Paranasal sinus examination	• On palpation- Frontal, Maxillary and Ethmoidal sinuses – tenderness absent bilaterally

Oral cavity examination

- Lips– normal
- Buccal mucosa- normal
- Gums and Teeth– NAD
- Hard palate- slightly high arched palate
- Tongue- coated

- Floor of mouth – NAD
- Retromolar trigone- no inflammation

Examination of Oropharynx

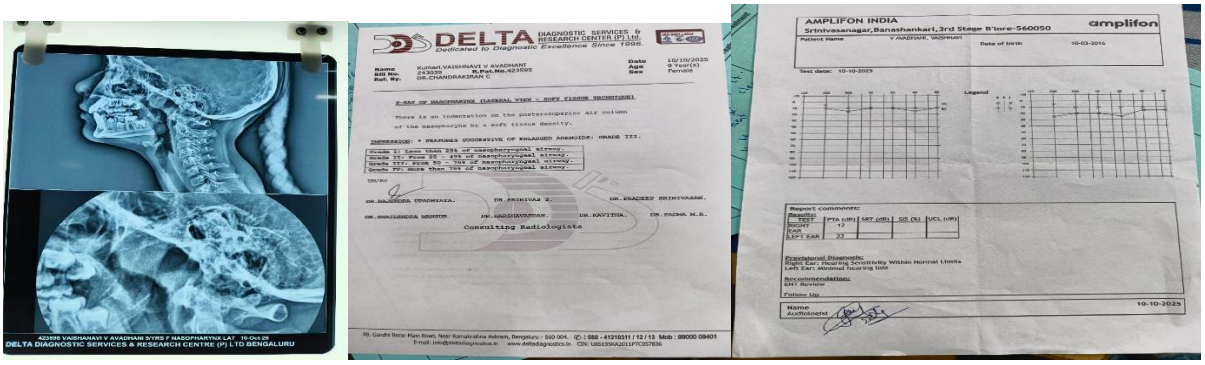
1.Tonsil	a) Inspection Presence – tonsils b/l enlarged, congestion present, hyperaemia of anterior and posterior pillars present Size- Grade II bilateral tonsillar hypertrophy present Symmmetry- bilateral enlargement shape-irregular yellowish deposits(Crypts) in the right tonsil Membrane- absent b) Palpation soft in consistency tenderness absent
2. Anterior pillars	• Congestion- Mild present bilaterally • Ulcer- absent • Proliferative growth – absent
3. Soft palate	• Redness- absent • Bulge or swelling – absent • Uvula- present in mid line, not elongated, not odematous
4. Posterior pillars	Congestion- Uniformly present bilaterally Ulcer- absent Proliferative growth – absent
4.Posterior pharyngeal wall	Granular presentation
5. Base of tongue	Normal

Ear examination

A. Physical examination	Pinna and surrounding area- NAD bilaterally
B. Otoscopic examination	**External auditory canal- no occlusion bilaterally** **Tympanic membrane-** **Right ear – intact, slightly retracted cone of light- visible** **Left ear – congestion +, hyperemia ++, small central perforation +**
C. Examination of mastoid	NAD, tenderness absent bilaterally
D. Examination of eustacian tube (valsalva maneuver)	patent on right side of ear, left ear – not patent

INVESTIGATIONS

X-ray of nasopharynx (lateral view)	Impression: Enlarged Adenoids Grade 3
PTA	**Impression** Right ear – hearing sensitivity WNL Left ear- minimal hearing loss



Treatment given

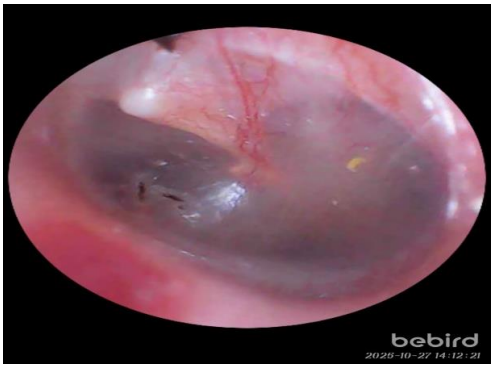
- *Kanta Pratisarana* with *Chavya +Tankana Bhasma* with *Madhu* For 10 Days
- *Sthanika Abhyanga* with *Moorchita Tila Taila* followed by *PPS* for 10 days
- *Karna Pichu* with *Jatyadi Taila* to left ear for 10 days
- *Triphala Kashaya* gargling for 10 days
- Tab *gandaka rasayana* 1-0-1 (A/F) for 10 days

Advice at the time of Follow-up

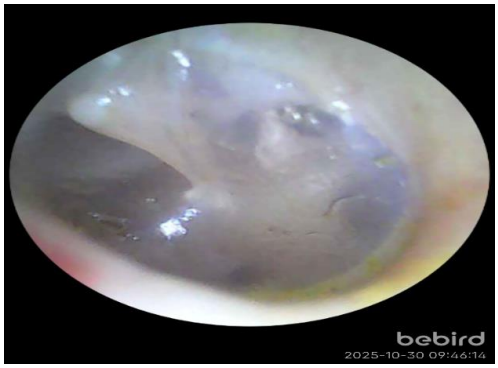
1. *Karna pichu* with *Jatyadi Taila* for 10 days
2. *Triphala Kashaya* gargling twice daily for 3 weeks
3. *Sitophaladi churna* (1tsp) + *Trikatu churna* (1/2 tsp)+ *Haridra churna* (2tsp) ½ tsp-0- ½tsp with honey.

Before treatment

After treatment



Before treatment



After treatment

DISCUSSION

Mode of action

Chronic Adenotonsillar Hypertrophy is a frequent pediatric condition characterized by upper airway obstruction, recurrent throat infections, sleep-disordered breathing, and middle-ear involvement. Although adenotonsillectomy is commonly recommended in chronic cases, surgical risks and parental concerns necessitate effective conservative management options.

In Ayurveda, the condition correlates with *Tundikeri* and *Kantashaluka* described under *Kantagata Rogas*. *Sushruta* explains *Tundikeri* as a hard inflammatory swelling resembling a cotton fruit (*karpasa-phala-sannibha katina shotha*), caused by vitiation of *Kapha* and *Rakta*, leading to obstruction and pain in the throat. The chronic presentation in this case indicates *bahu kapha avastha* with associated *agnimandya* and *ama*, evidenced by coated tongue, recurrent infections, and persistent tonsillar hypertrophy.

The treatment was planned to address both the local pathology and systemic doshic imbalance through *kapha-Shamana, Shothahara, Lekhana, And Srotoshodhana* measures.

Kanta pratisarana with *Chavya* and *Tankana Bhasma* was administered to reduce tonsillar hypertrophy and clear crypts off bacteria and debris by virtue of its action of pratisarana. *Chavya*, owing to its *katu rasa*, *ushna virya*, and *tikshna guna*, acts as *deepana* and *kapha-vatahara*, while *Tankana Bhasma* possesses *lekhana* and *kapha-vilayana* properties, making this combination effective in chronic obstructive conditions of the throat.

Triphala Kashaya gargling was advised for its *Tridoshaghna*, *Shothahara*, and *Vrana-ropana* actions, which helped in reducing inflammation of the tonsillar and pharyngeal mucosa and preventing secondary infections. *Sthanika abhyanga* with *Moorchita Tila Taila* followed by *Swedana*, facilitated improved local circulation, reduced lymphatic congestion, and relieved *margavarodha* caused due to aggravated *Kapha* in the neck and nasopharyngeal region.

Associated ear pathology was managed with *Karna pichu* using *Jatyadi Taila*, which is indicated in *Vrana* and *Shotha*. Its *Ropana* and anti-inflammatory properties supported healing of the tympanic membrane perforation and improved Eustachian tube function, thereby reducing ear pain and hearing impairment.

Systemic medications were administered to correct *Agnimandya*, prevent recurrence, and enhance immunity. Gandaka Rasayana was used for its *Rasayana*, *Krimighna*, and *Vyadhikshamatva Vardhaka* actions making it beneficial in chronic and recurrent inflammatory conditions. The combination of *Sitopaladi Churna, Trikatu Churna*, and *Haridra Churna* helped pacify *Kapha*, improve digestion, and control chronic inflammation. *Trikatu* enhanced metabolic activity and

drug bioavailability, while *Haridra* contributed its well-known anti-inflammatory and antimicrobial actions.

The significant reduction in tonsillar size, nasal obstruction, snoring, mouth breathing, and ear symptoms following treatment suggests that appropriately planned Ayurvedic management can effectively control Chronic Adenotonsillar Hypertrophy. This case supports Ayurveda as a safe, conservative, and non-invasive therapeutic approach that may reduce the need for surgical intervention in selected pediatric patients.

CONCLUSION

This case shows that chronic adenotonsillar hypertrophy (Tundikeri) in children can be effectively managed with Ayurvedic treatment. The combined use of local therapeutic procedures and internal medicines resulted in noticeable improvement in symptoms, reduction in Adeno tonsillar enlargement, and relief from nasal obstruction and ear-related complaints. The treatment was safe, non-invasive, and well tolerated, indicating that Ayurveda can be considered a useful conservative option and may help in reducing the need for surgical intervention in selected cases of Chronic Adenotonsillitis.

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