

HYPNOSIS IN ASTHMA

by

A. PHILIP MAGONET, M.D.



HEINEMANN

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B.Sc., M.D., C.M.

President Medical Hypnosis Association

Foreword by

ROGER FRANCIS TREDGOLD

M.A., M.D., D.P.M.



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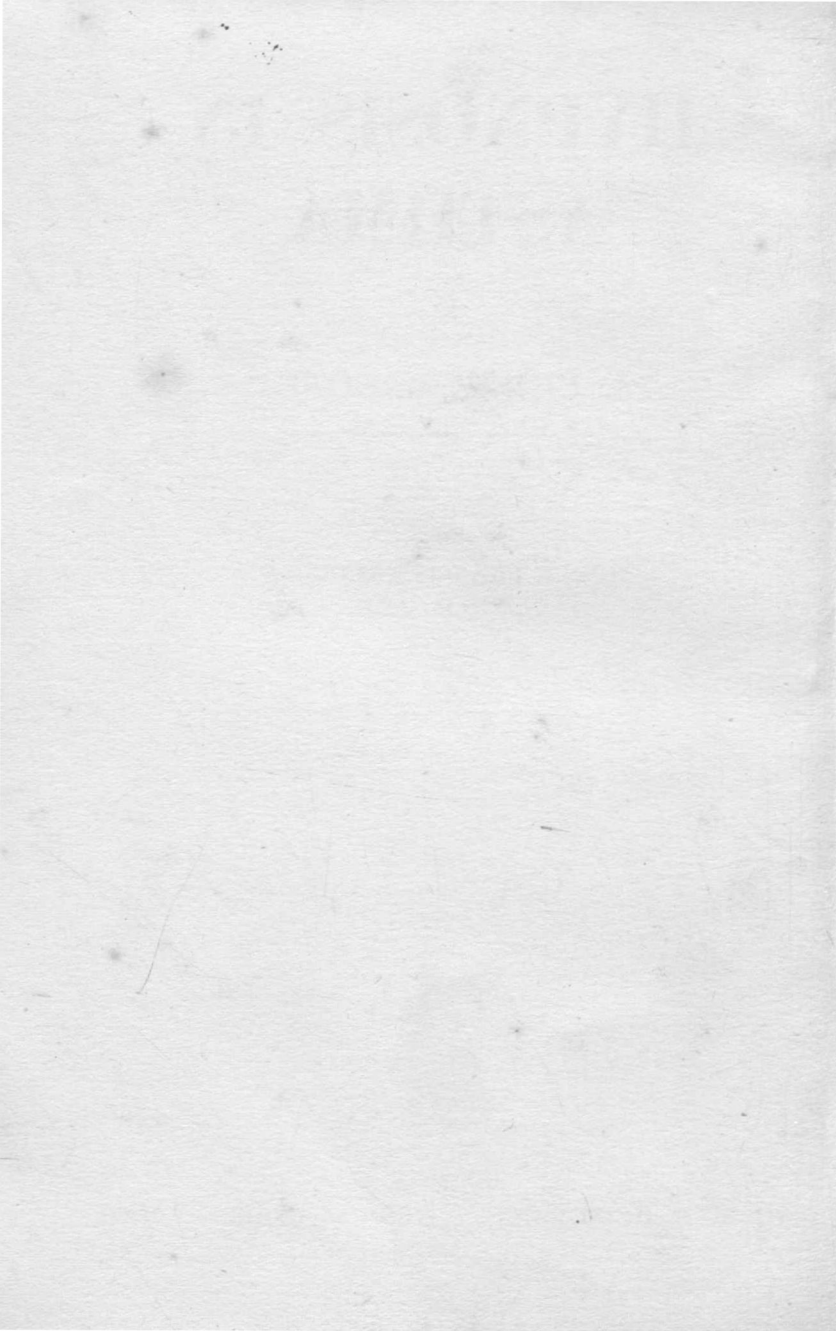
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TO ESTHER, MY WIFE,
AND MY CHILDREN,
JONATHAN AND BEVERLEY

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FOREWORD

Dr. Magonet has kindly asked me to write a foreword to this book, which is an example of some rashness on his part. Some may think the publication of a book on this subject is another example; for hypnosis, in certain quarters, still produces more alarm than relaxation. The sooner, therefore, that objective accounts can be collected and published, the better.

From this small book, it seems at least clear that hypnosis can be used as a tool in the investigation and treatment of certain cases of asthma which have failed to respond to other methods. This in itself is worthy of very serious consideration by chest specialists and psychiatrists alike, for there can be few who are not perplexed by some intractable cases. Dr. Magonet would make no claim to have a panacea. He would be the first to regard this book as an introduction to further study, which is obviously needed, in detail. In particular one would welcome information on the cases which do not respond to hypnosis. One hopes that Dr. Magonet himself may later be in a position to write more and so continue to establish the work in which he has been a pioneer and in which his personal experience must be practically unsurpassed.

R.F.T.

London, 1955.

INTRODUCTION

This book has been written with the object of drawing attention of the medical profession to the tremendous value of hypnotherapy in the treatment of bronchial asthma. Hypnosis is slowly becoming recognised as a powerful therapeutic weapon in the battle against ill health and I know of no condition where it is more needed than in the fight against asthma.

It is impossible to obtain accurate figures of death directly attributable to asthma; nevertheless reference has been made to the Statistical Review of the Registrar-General for Scotland (1940-8) bearing in mind possible errors of certification due to diagnostic difficulties. From these reports it would seem that the average annual death rate is 3,268 for England, Wales and Scotland. It is significant that by far the greatest number of deaths in England and Wales were recorded during 1940 (4,167), a time of particular stress in the life of the nation. This bears out the hypothesis that bronchial asthma is a form of bodily reaction to stress.

Just recently a well-known physician writing about asthma had this to say: "While in many instances, especially in *children and young adults*, much improvement can be expected and the disabling attacks become infrequent, real cure is rare and chronic intractable cases common." Another doctor writes, "The prognosis is much graver in patients developing asthma when *past 30 years of age*; for then infection of respiratory tract is common and may persist. In England and Wales during the years 1938-49, deaths from asthma amounted to 0.6% of all deaths, accounting for roughly 3,000 deaths per annum; approximately 96% of those dying from this cause were *over 30 years of age*."

This book deals with 37 asthmatic patients; 11 children and 26 adults, and some of the latter have had asthma for as

long as 40 years. Everyone had been clinically investigated and treated by every modern medical means over a period of years, but still went on having their attacks. They were referred for hypnotherapy as a last resort and my consulting rooms became a human salvage depot, a place of last hope. That these people were restored to health by means of this form of treatment should give our profession a powerful incentive to adopt it.

In my book "Hypnosis in Medicine" (1952) I strongly recommended the use of hypnotherapy in the asthma clinics of our hospitals. I now do so again with even greater vigour, for to ignore this form of treatment is to deny a proven weapon in the battle against asthma.

I wish to tender my thanks to Sir Zachary Cope for reading the manuscript and for his valuable criticism.

I hope that this small volume will prove of value to medical practitioners in their treatment of this fearsome complaint.

A. PHILIP MAGONET

10, Harley Street,
London, W.1.
January, 1955.

CHAPTER I

ANATOMY

THE bronchial tree is not complicated. The trachea divides at its bifurcation opposite the 4th or 5th thoracic vertebra into a right and left bronchus. Further sub-divisions lead to all parts of the lungs, the calibre becoming smaller and smaller until the terminal bronchioles lead into the respiratory bronchioles which in turn lead by way of a vestibule, atrium and infundibulum to the small saccules called air cells or alveoli.

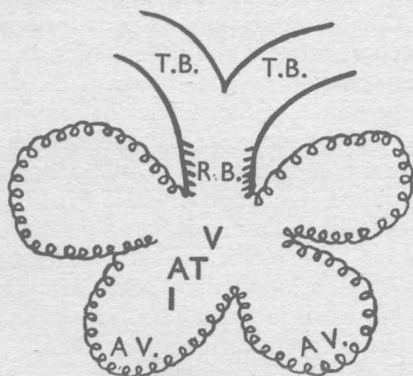


DIAGRAM OF TERMINATION OF RESPIRATORY BRONCHIOLE.

T.B.=TERMINAL BRONCHIOLE; V=VESTIBULE;
 AT=ATRIUM; I=INFUNDIBULUM; AV=ALVEOLUS.

The *BRONCHIAL TUBES*, rigid because they are encased at the front and sides by cartilaginous plates, are conduits for the express purpose of carrying air to that portion of the tree

which actually performs the function of oxygen exchange. The respiratory bronchioles with their alveolar sacs make up the group which carry on the specific function of the organ.

The walls of these bronchioles contain a highly developed musculature which expands and contracts much as a bellow does; thus the respiratory bronchioles can increase or decrease the air supply whenever necessary.

The *ALVEOLAR SACS* themselves are lined by epithelium outside of which lie the capillaries and they are so close together that even less space than their own width separates them.

The fact that bronchiolar muscles are constricted by pilocarpine and histamine and relaxed by atropine, epinephrine and ephedrine indicates that parasympathetic bronchoconstrictor and sympathetic bronchodilator nerves exist.

MUCOUS MEMBRANE lines the whole of the respiratory tract, becoming naturally thinner as the smaller bronchioles are reached. Ciliated epithelium extends throughout the surface of the trachea, bronchi and bronchioles, in which are the mucous and mucoserous glands. Many of the deeper mucous glands reach the lumen of the tubules by passing through the muscular coat of the bronchi. In the smaller tubules the mucous membrane becomes folded into longitudinal ridges.

In addition to the *CARTILAGINOUS PLATES*, *ELASTIC TISSUE* in longitudinal bundles is found throughout the whole of the bronchi and bronchioles and also two layers of *muscular tissue* are described, a longitudinal and a circular. The latter surrounds the bronchial tubes as a continuous layer of annular fibres lying internal to the cartilaginous plates.

Blood vessels of two-fold origin accompany each bronchus. The *PULMONARY ARTERY*, carrying the venous blood to be aerated, passes along the bronchioles to the alveoli. Here the vessels break up into an immense network. The *BRONCHIAL ARTERIES* supply nutrition to the various coats of the bronchi and the bronchial glands.

Rich plexuses of *LYMPHATICS* surround the bronchial tubes but are absent in the respiratory bronchioles.