ICR Symposium: Homoeopathic Management of Epileptiod Disorders

Vadodara, September 2018

Case 6 to 9 Dr. Chandrabhan/MKP & CRG

OBJECTIVES: (For Case 1 & 2 – Acute / Active state)

1. To understand the parameters of accepting cases of epilepsy for homoeopathic treatment in a rural setup with limited resources.
2. To know the importance of observation while dealing with the active/ acute/ emergency condition of convulsion.
3. To learn data collection in cases of epilepsy.
4. To understand the importance of intensified common symptoms in arriving at prescription.
5. To understand the importance of anamnesis (history of complaints) for prescribing in acute/active convulsive state.
6. To understand importance of evaluation of symptoms in construction of totality and differential MM in cases of epilepsy.
7. To learn to infer susceptibility and choose posology in cases of epilepsy
8. To understand the role & action of homoeopathic drugs in an acute/active state of convulsion.

DIRECTIVES:

1. Go through the case, would you accept this case or not?
2. If yes, give reason. If no then also specify.
3. Come to provisional diagnosis.
4. Identify common and characteristic symptoms in the case.
5. Select appropriate approach and formulate totality of the case and differentiate closely coming remedies.
6. Suggest on potency and repetition in the case.

CASE – 6 **CRG / SUJIT / CHANDRABHAN**

Registration No: BHD 9984	Name: Master A.B.C.	Date of Case Taking: 17/2/18/8PM
Age: – 7 years	Sex: Male	Education:
Marital Status: Single	Diet: Veg/Non-veg	Religion: Hindu
Address: Talawadi, Bhopoli	Occupation- student	Informant: Relatives

Casualty:
K/C/O of CAH since 2015
A lean thin Mangolian like dark complexioned male child brought by relatives in conscious state with continuous and multiple episodes of convulsion from ½ hour. Since morning 2-3 episodes of convulsions appeared. But it was single episodes of convulsion. But the last episode having multiple convulsions which is continuing since ½ hour for which pt came with following presentation (whenever convulsions appeared, before, it happens in following order)

Data taken from parents:
Before convulsion:
- Sleeplessness++ (2 days back)
- Irritability++ (1 day back)
- Violent behavior: Starts to throw things & bites near to anyone++ (few hours back approx 5-6 hours)
- Restlessness++ - starts to roam here & there in round (1-2 hours before)

During Convulsion (1-2 minutes):
- Consciousness
- Stiffness of all over body++
- Jerking/trembling all over body++
- Eyes rolling upward++, Red eyes++
- Scream/crying++
- Salivation – Thin ++ & Ropy++

After convulsion:
- Sleepiness / drowsiness++
- Confusion++
- Appetite decreased ++
- Thirst - increased LQLI for cold water++
- Urination increased frequency++

Note: Such type of seizures started since 2015 that time 16 episodes of convulsion appeared in a month. But parents did not much care about it. But once a day multiple convulsion appeared in a day and pt had to admit in valsad hospital. That time pt was in coma for 9 days.

Regular treatment: Since 2015 Tab Hyson 10/bd, Tab Floricot 1/2/od

O/E:

T- 96.4F, P- 94, RR- 32/Min
S/E- RS AEBE, Clear. CVS- S1S2 (N) P/A- SOFT/NT
CNS- conscious, oriented??
Reflexes:

	LEFT	RIGHT
BICEPS JERK	++	++
TRICEPS JERK	++	++
KNEE JERK	++	++
ANKLE JERK	++	++
PLANTAR JERK	N	N

CASE – 7 **DR. MKP / CHANDRABHAN**

Name: DPK	Age: 34years	Add: Vevoor/Palghar	Religion-Tribal/Malhar Koli/Hindu

<u>In casualty / IPD at 11:45 am 4/10/17</u>

- k/C/O Seizure disorder since 1 year & HTN since 2-3 years, not taking any treatment.
- One episode of **convulsion** in morning approx.. 1 hour back**.**
- Pain in epigatrium & periumbilical region pain since 2-3 days (1/10/17) with nausea & vomiting (occasionally)
- generalized weakness+
- Can't walk properly/trembling +
- Speech- not clear.
- H/o fall last night under influence of alcohol, abrasion over shin of tibia (left)
- Pt. is a chronic & binge ethanol consumer with tobacco chewing came with complaint of:
- H/O irrelevant talk on & off since 1 year.
- complete loss of appetite since 1 year
- Last alcohol intake –??1-2 days back.
- Urine- normal but dark yellow urine.
- Stool- passed twice today.
- H/O abstinence for 1-2 days, thereby leading to visual & audio hallucinations.

<u>Psychiatry evaluation at 2:55 pm on same day. (chronology of current state)</u>

(Note: Most of data observed or taken from relatives.)

<u>10-15 days back: History of binge alcohol and complaints are continuing since then:</u>

- GIT, abdomen (stomach, epigastrium, periumbilical extends up to left iliac region) - Pain++ <evening,
- Nausea++, vomiting (occ.)

<u>(4-5 days back for 2-3 days) Abstinence of alcohol:</u>

- GIT, abdomen (stomach, epigastrium, periumbilical extends up to left iliac region) - **Increased -** Pain++ <evening, Nausea++, vomiting ++

<u>Since 1-2days:</u>

- Sudden, constant, progressive
- Trembling all over body
- Irrelevant talk (on & off)
- Hallucination+ sees dead bodies++, god++, insects++, Ants crawling & biting him++.
- Snakes around him++, sees children near to him
- Spitting & abusing nearer to him

<u>Today morning:</u>

One episode of convulsion - in morning at 9-10 am.

H/O Such convulsion started since 1 year back till now 4-5 episodes appeared.

ODP: Onset - sudden, Duration - 10-15minutes, **P** - Progressive. Most of the time convulsion appeared on abstinence of alcohol. Every time convulsion has same presentation like as:

Before convulsion - (1-2 days back)
- Becomes silent, does not communicate
- Appetite decreased
- Perspiration
- Dullness++

During convulsion-
- Eyes twitches++
- Unconsciousness
- Vertigo / falling down
- Tonic clonic spasm
- No frothing from mouth
- No tongue bite
- No involuntary passage of stool / urine

After convulsion-
- Weakness++

Accompaniments
- Thirst- increased for cold water frequently sips of water+3
- Sleeplessness,
- Appetite decreased,
- Dark yellowish urine

Additional data
Past history: K/C/O Seizure disorder since 1 year & HTN since 2 - 3 years, not taking any treatment.
Family History: Father - 60years CVA - Operated 2 Years Back. Mother- 55 Years HTN
Injuries /wound: H/o fall last night under influence of alcohol, abrasion over shin of tibia (left)

O/E: T - 98.2^{0}F P – 96 – 104 m RR-18m BP-150-110mmhg
HGT – 101 mg / dl
General- P+/O^0/C^0/I^0/ Conjunctiva-reddish Hand tremor +
S/E: RS – Clear / AEBE CVS - S1, S2 - N CNS – conscious / disoriented.
P/A: Guarding+ / tenderness / L^0 K^0 Spleen - palpable

INVESTIGATION: 4/10/17 (already done):
Hb - 10.4 WBC - 6800 Platelets – 235000 ESR – 72 increased
BUN- 37.2 increased S. Creatinine - 3.2 increased
Na -134.1 K-4.1 Cl-96.5
Total bili - 0.80 / Direct bili - 0.40 SGOT- 64.3 SGPT-38.1
Urine routine: Albumin– trace, Epithelial cells - few, Pus - 2-3, Sugar - absent, ketone - absent.
USG abdomen (2-3 days back) - NAD
MRI – brain (6 months back) - NAD

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CASE – 8 DR CRG / DR SUJIT / DR CHANDRABHAN

OBJECTIVES:

1. To treat a case where condition is not favorable with lack of resources
2. Demonstrating importance of antenatal, obstetric history of mother in evaluating case of epilepsy.
3. Importance of psychosocial - educational circumstances in interpreting patient as person in cases of epilepsy.
4. To understand importance of knowledge of miasm in case of epilepsy.
5. Demonstrating efficacy of homoeopathic remedy in cases of chronic refractive case on long term antiepileptic

DIRECTIVES:

1. Do SFFT and come to diagnosis with co morbidity.
2. Read life space, identify mental characteristics which individualize as patient as a person considering his social and educational background
3. Construct CI and come to miasmatic diagnosis- fundamental and dominant of case.
4. Select suitable approach and Construct remedial totality and come to final selection of remedy with suitable potency.

Name - M. paghi	Age/sex- 20years/male
Marital status- single	Education- illiterate
Occupation- mostly remains at home otherwise helps in farming to his parents	Religion/caste-hindu/adiwasi
Diet- veg/non veg both	Uncle/aunts- not any
Brothers- no	Sisters- no
Father- 60 years, labor in building construction	Mother- 40 years, housewife/ farmer
Add- Bhopoli	Income- BPL

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CHIEF COMPLAINTS:

NO	LOCATIONS	SENSATIONS	MODALITIES	ACCOMPAINMENTS
1	CNS- Brain Since at age 3-4 years 0-sudden D-total duration- ½-1hour P-non progressive F-initially 3-4 times/day Than 2-3 times/week Than 3-4 times/month (It is constant since a long time since many years??) Sensorium Eyes Mouth Tongue Body whole Note- 1st episode appeared with prolonged fever	Convulsions: Pre ictal phase- -Vertigo++ -Sensation as if surrounding is roaming Ictal phase (3-4 minutes)- -Unconsciousness -Up rolling -Frothing++ -Deviation -Bite+ -Stiffness ++ -Twitching/Jerking++ -Profuse Perspiration++ -No involuntary passage of stool/urine Post ictal phase (1/2 hour-1 hour)- -Restlessness++ -Confusion++	No past h/o head injury < evening 3-4 pm++	
2	CNS-Brain- Since childhood O-Sudden D-?? P-non progressive F- multiple episodes	-Constant jerking ++ -Fidgety ++ -Involuntary movement	<mental excitement++ <mental exertion++ <talking while++	

ASSOCIATED COMPLAINTS:

1	RS Since 8-10 years O- ?? D- ?? P-??	-Frequent cold and coryza++ - Thick nasal discharge++ -sneezing++ -cough with thick white-yellow-sticky expectoration++	< cold++ <cold water intake++ <night++ <sleeping while++ >warmth application++	
2	GIT-Abdomen Since 4-5 years O- sudden D- ??, P-?? F-occ, 1-2	-Colicky pain++ -No nausea -No vomiting -No eructation -No burning	<?? >By massage++	

	times/months L- mostly at left iliac region and umbilicus			
3	Mind- intellect Since childhood O- gradual D- constant P- non - progressive	-Wise- -Can't write his name and any word+++ -Can't read any – sentences+++ -Can't solve the calculation+++ -Comprehension good -Memory weak++ -Speech- slurred++ Incoherent ++		

PHYSICAL CHARACTERS

- Appearance – Lean, Tall, Dark Complexion
- Gait - Shambling with right foot
- Tongue - white coated++
- Perspiration - Moderate specially on chest & trunk, offensive++, oily++
- Appetite - increased
- Salivation - while sleeping
- Hunger - tolerable
- Thirst - increased, LQSI for cold water
- Craving – bitter+++, Spicy++, sour++
- Aversion - sweets++
- Stool - normal semisolid
- Urine - Normal pale colored
- Patient's mother's obstetric history - G2 P2 A0 L2, Age at the time of conception 20 years, planned pregnancy, delivery FTND at home, birth weight not known. But baby did not cry immediately after birth for 10-15 minutes.
- Developmental landmarks:
    - Dentition 5 - 6 months
    - Head holding 5 - 6months
    - Turning prone 3 - 4 months
    - Sitting 5-6 months
    - Crawling 7-8 months
    - Standing 1 year
    - Walking 1 year
    - Objects grasp 1 year
    - Babbling 6-7 months
    - Words 1-2 year
    - Sentences 2 years
    - Bladder control 2 years
    - Breast feeding up to 2 years, solid up to 2-3 years
- Parental Attitudes towards child - Affectionate
- Sleep - 10 -12 hours per day, lies on lateral side with deep sleep, jerks (myoclonus) ++ and salivation ++ during sleep
- Dreams – N/S
- Thermal – Chilly

Past history - N/S

Family History- Father: TB, Uncle: died due to CVA

- O/E – T-Afeb, P 80/m, R 18/m, BP-120/80 mmhg, WT-40kg, HT-167cm

Cervical lymph nodes enlarged B/L S/E- RS: AEBE N, PA: soft &NT, CVS: S1 S2, CNS: Conscious oriented, sensation & motor function normal, all reflexes normal except B/L knee and ankle jerk exaggerated, muscle strength normal, tandem walk positive, rhomberg positive

Note - Antiepileptic RX Tab Gardenol 60 mg/od since 14-15 years continue.

LIFE SPACE:
A 20 years old tall, dark complexioned, lean-thin, well dressed with slippers male patient came for CD with his mother. The patient was looking foolish through facial expressions but sitting quite & clam. The patient belongs to a poor tribal family lives with his parents in the Bhopoli village itself. He is the single male child of his parents. The parents never use to say, scold or beat him because he is the only male child. The father works as a labor in construction line (Bandh-Kam). So, most of time he stays out of home. Whenever father comes at home, he spends most of time with his children & takes care of patient. Mother is a house wife, also does farming on her farm. Mother is very calm, cool & quite lady. She always takes care of the patient. She does not allow to leave patient alone because of his illness. The patient does not go to school. He left his study in an early age in first or second standard as school teachers used to beat the students when they did not complete their homework. So, patient also got fear about it that teachers might beat him also. Secondly most of the time patient used to get convulsions in the school. So, due to this fear of illness, parents did not allow him for school. Patient has not any close friend. Most of the time patient lives at home & helps his mother in her household work. Generally, he does not go outside from the home. He hesitates to make new friends due to his slurred & incoherent voice "Mahala laaz vatate"(He feels shyness). Patient comfortably plays with children younger than him, hesitates to play with elder children. Because they tease him. Most of the time he remains silent, does not speak much to anyone because of his voice. Sometimes children (neighboring to him) tease him than patient does not respond or say anything revert back to them. Sometimes if children beat him while playing than he gets angry & beats them slightly& immediately runs away. He hides himself at home & does not tell about this incident to his parents that his parents might scold or beat him. So he has fear about it. Patient never goes in the family functions because he has fear of getting ashamed about his voice. Once a time, patient was caught by people of village when he was trying to steal apples from a garden for his friends. Friends ran away & he was caught only. People beat him. He felt bad & scared. After this event he always has fear that if he commits any mistake, people would beat him. So, patient does not quarrel with anyone & avoids to commit any mistake. Patient is not demanding, obstinate. Once he came to know about police that they beat badly anyone who does commits crime. After that, patient has fear about police that if he commits anything wrong, police would beat him. So he avoids to do any mistake. He does not have fear of being alone at home. Once patient worked hard as a labor on brick station but people used to say him about his voice, felt ashamed on himself. After that he left the job.

Observation: Patient is smiling / laughing all the time while CD. He is very co-operative, following instruction well given to him. Patient has slurred, incoherent speech. Patient shows involuntary moments like jerking of any part specially in right shoulder, lower limbs while talking, such condition aggravates whenever he gets mental excitement.

FOLLOW UP CRTITERIAS:-

1. Abdominal pain intensity/frequency
2. Cold/coryza intensity/frequency
3. Involuntary movement of muscles esp. u/l & l/l
4. Convulsion intensity/frequency
5. Reading efforts started
6. Writing efforts started
7. Math problem solving ability efforts started
8. Sleep-jerk
9. Sleep-salivation
10. Any new co
11. Appetite
12. Thirst
13. Stool
14. Urine
15. Weight

Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	RX
30/3/18 screening																ACTION A
9/4/18	No any co Case reposted															ACTION B
23/4/18	No any co Case reposted															ACTION C
28/4/18	No any co Case defined, Pt hurried, Cd half done, decided to finish in next visit															ACTION D
5/5/18	Cd completed No any co															ACTION E
12/5/18	0	0	>5%	0	-	-	-	>5%	occ	0	n	n	n	n	40kg	ACTION F
18/5/18	0	0	>5%	0	-	-	-	>5%	0	0	n	n	n	n	-	ACTION G
26/5/18	0	0	>10%	0	-	-	-	>10%	occ	0	n	n	n	n	40kg	ACTION H
	Case discussed, Cal carb fixed as CR, but not instructed yet to release															
3/6/18	0	0	>50%	0	sq	sq	sq	>25%	>50 %	0	n	n	n	n	40kg	ACTION I
11/6/18	0	0	>50%	0	sq	sq	sq	.25%	.75%	0	n	n	n	n	40 kg	ACTION J
18/6/18	0	0	>50%	0	sq	sq	sq	>30%	0	0	n	n	n	n	41kg	ACTION K

25/6/18	+	+	>++	0	sq	sq	sq	>++	0	0	n	n	n	n	-	ACTION L
2/7/18	0	>+50%	>++	0	-	-	-	>++	0	0	n	n	n	n	43kg	ACTION M
9/7/18	0	0	>++	1 attack / 10 min.	-	-	-	>++	0	0	n	n	n	n	-	ACTION N
16/7/18	occ	0	>++	0	-	-	-	>+	0	0	n	n	n	n	-	ACTION O
23/7/18	occ	0	0	0	-	-	-	>++	0	0	n	n	n	n	-	ACTION P
1/9/18 Gap of 3weeks	<+	<+	<++	1 episodes	-	-	-	<++	0	Worm infestation	n	n	n	n	-	ACTION Q

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CASE – 9 DR. PANDYA / DR BSJ / DR. CHANDRABHAN

OBJECTIVES:

1. To understand importance of organic factors in brain in case of epilepsy in paediatric age group.
2. Understanding the criteria of Homoeopathic Cure.

DIRECTIVES:

1. Go through the case and prepare SFFT and come to diagnosis.
2. Read the case and try to identify the mental generals of patient
3. Come to reportorial totality with suitable approach and final selection of remedy, Evaluate the remedy response.

Name- KP	Age/sex- 3years/male	Education- nursery student	Occupation- student	Marital status- single
Religion/caste- Hindu	Diet- veg/non veg both	Father- 46 years/ production executive in API factory	Mother- 36 years, housewife	Uncle/aunts- not any
Brothers- no	Sisters- no	Add- Boisar		

CHIEF COMPLAINTS:

NO	LOCATIONS	SENSATIONS	MODALITIES	ACCOMPAINMENTS
1	CNS- Brain Since 1 year O-sudden D-4-5 minutes (pre-ictal and ictal phase) P- progressive F-till now 5 times 1st on 14/07/17 2nd on 10/10/2017 3rd on 12/12/17 4th on 16/01/18 (4 consecutive episodes on same day @ ½ hour interval) 5th on 30/03/18 Note- 1st 3 episodes with high grade fever 4th&5th times convulsion appeared without fever	Convulsions: Pre-ictal phase- -Twitching of eyes than radiates to whole body -Screams loudly -Vomiting with yellowish expectoration No fever Ictal phase -Unconsciousness -Up-rolling eyes -Frothing from mouth2 -Tongue bites2 -Stiffness of whole body2 -Jerking of whole body2 Post ictal phase- -Restlessness2 -Sleepiness2	No past h/o head injury <night++ <sleep during++ <early morning++ >By frisium 5mg ½-o-1/2 >SypValperin 200 5ml 1-0-1 (since oct 2017) >Tab Valperin 200 1-0-1	

ASSOCIATED COMPLAINTS:

Location	Sensation	Modality	Accompaniment
1) RS Since Childhood O- sudden D- 30 days P- progressive F- 4-5 times/yrs	-Thin nasal discharge2 -Rattling in chest2 -Heaviness of voice -Cough – loose expectoration greenish/ yellowish2 -Difficulty in respiration especially difficulty in inspiration	< COW 2 < winter 2 < cold rainy weather 2 < night 2 <morning 2 (Up to 8/9 am) >Allopathy Rx >By warm application2	
2) Mind Since 2yrs O- gradual P- progressive	-Obstinacy 2 -Anger violent -Hits near to him2 -Throws things away -Crying 2 -Runs here & there -Restless2 -Cannot sit t one place more than 5 minutes -Instruction follows well -Attention span good	< contradiction2	

PHYSICAL CHARACTERISTICS:

- Appearance: lean/thin
- Weight gain: 12 kg → 13.3 kg in 1 month
- Skin: Discoloration white- below B/L knee since childhood
- Perspiration: profuse3, partial: scalp2/abdomen1/back1, Oily 2, warm2.
- Appetite: N
- Thirst: Profuse++, ½ glass frequently for cold water
- Craving: Potatoes3, Pungent2, Rice2, Ghee 2
- Aversion: Fruit2, Sweet2,
- Stool: Regular, 2/day, semisolid consistency
- Urine: Regular, 5-6/1-2, controllable
- Mother's obstetric history: P1L1A0.
    - Antenatal: Planned - pregnancy, morning sickness2, backache1
    - Mental state pregnancy during: normal
    - Delivery: ceaser, I/V/O- feto-placental insufficiency, premature,
    - Birth weight- 2.2 kg
    - Neonate problem- hypoglycaemia with hyper-Bilirubinemia, stayed 12 days in NICU.

- Mother- foetus bound- attachment
- Developmental landmark:
  - Dentition: 9 months
  - Head holding; 6-7month
  - Turning prone-5-6 month
  - Sitting- 1yr
  - Crawling - 1yr
  - Standing - 1yr
  - Walking 1 ½ yr
  - Object grasp - 18month
  - Removes cloths/shoes- 2 ½ yrs.
  - Speech - words- 1yr
  - Sentences- 2yr
  - Control - bladder- 2yr, bowel- 3 yrs
  - Breast feeding - continue, & solids - 11 month
- Sleep: 8-9 hrs on abdomen2Concomitants- jerking myolonus 2 during.
- Dreams: No
- Thermal: C2H3.

Past History: No
Family History: No

Physical examination:
O/E: T - Afeb, P - 80/m, RR - 18/m, WT - 13.5 kg, HT - 96cm
Cervical lymph nodes enlarged B/L
S/E - RS: AEBE N PA: soft & NT CVS: S1 S2
CNS: Conscious oriented, sensation & motor function normal, reflexes normal, muscle strength normal

Investigation:
MRI – brain - 2/2/18: chronic left MCA territory infarct involving the left putamen & left corona radiata. Gliosis present in left putamen and corona radiata suggestive of chronic left MCA territory infarct.
EEG - 27/1/18: Abnormal drug induced EEG - showing bifrontal epileptform activities.

LIFE SPACE:
3 years old male child came to admit in view of status epileptics. After resolving the state while CD patient sitting on a chair with his parents. Patient is a single child of his parents. He has moderate physic with fair complexion. Patient is well groomed wearing socks. Patient is sitting quiet, clam& nicely playing mobile games continuously. But if parents are trying to snatch it from him to distract, he gets irritable, angry & starts to cry & tries to hold mobile. Patient is by nature irritable, obstinate & stubborn to get the things whatever he wants. He will demand continuously until he gets desired things. If parents try to distract him, he does not pacify & forget easily about it. Generally, he demands for food, chocolate & toys. If these things are not provided, patient starts to weep, cry & demand continuously& gets angry. In anger he hits the person near to him by his hand. While playing with children or colleagues patient starts to quarrel & hit them if they do not play according to him or does not follow his instructions. Every time patient wants that the game should be played according to him. If not done, he does not play & gets angry. In anger he starts to weep, cry, hit, throw sand & stones on them. If his instructions are fulfilled, he becomes quiet. Once a time he saw an orange bike in the market patient started to demand for it & showed temper tantrum until he was provided. Patient shares his things like toys, chocolates etc with his friends. Patient gets mix up easily with everyone. Patient has fear of darkness, to being alone & ghost. At

night patient does not remain or go alone, always fear of ghost & darkness. If someone goes with him he easily handles the situation. Such fear of ghost appeared in the patient because friends use to threaten him about ghost. Patient is very much attached to his father even he calls him as his friend. Father tries to fulfil every demand whatever patient wants. Generally, father does not beat him because father has fear that patient might get ill after it. But water goes beyond limit, father beats him &patient starts crying & complain about him to his mother. That time patient continuously demands to beat father revert back. If mother slightly touches father as a punishment, patients becomes silent. Mother also takes care of patient because he is the only child. Patient studies in nursery. He easily mixes up with his friends. He shares his things, tiffin with his friends. Patient completes his homework, whatever given to him but if sometimes his mother asks about homework than he replies “tum teacher hokya?”. Patient gets happy to go to school. Patient is good in study. Patient does not hesitate to meet strangers, easily approachable. Patient likes to play with animals, does not have fear with them. Patient does not sit comfortably on a place more than 5-10min. He continuously runs here & there.