HOMOEOPATHIC EDUCATION & CHARITABLE TRUST

&

INSTITUTE OF CLINICAL RESEARCH [ICR]

VADODARA SYMPOSIUM- SEPTEMBER 2018

Season's Greetings!

As you know **Vadodara Symposium** is to be held on **28th-29th- 30th September, 2018**.

This time we are coming up with a clinical topic of HOMOEOPATHIC MANAGEMENT OF EPILEPTOID DISORDERS.

The word "EPILEPTOID" is not used frequently in our medical textbooks leading to some level of confusion as to its meaning which leads to questions like ….

- What is the meaning of Epileptoid Disorders?
- What kind of clinical conditions are covered under this term?
- What type of cases are we going to discuss in the symposium?

The meaning of EPILEPTOID is -

> 1: epileptiform. 2: exhibiting symptoms resembling those of epilepsy

Therefore, we are going to cover all the clinical conditions which has resemblance or causes seizures and epilepsy.

As we know the various causes of seizures are like….

- Infections
- Vascular
- Metabolic
- Trauma
- Toxins
- Tumours
- Congenital anomalies
- Degenerations
- Miscellaneous….

Introduction…

The word epilepsy is derived from the Greek words, '**epi'** meaning upon and '**lepos'** meaning to seize. In ancient times an attack of seizure was believed to be due to the patient's soul being seized by a demon or god or inflicted or possessed by a supernatural power. In India, the popular belief was that the angry ancestral spirit or soul entered the patient's body and attempts were made to drive out the same. On the other hand, in Europe, there were some who believed that epilepsy was a Holy sickness, or Divine Disease and Alexander the Great, Julius Caeser, Napolean Bonaparte, Charles Dickens, Dostoyevsky and Van Gogh suffered from it. It is said that Shri Ramkrishna Paramhans may also have had seizures. It was Hippocrates and Sushrut in India who discounted the myths and were the first to observe that seizures originated from the brain.

At the global level, it is estimated that nearly 70 million people suffer from epilepsy.

Looking to the demand of the subject for in-depth study some important aspects are given here.

Epidemiology

Epilepsy is the second most common and frequently encountered neurological condition that imposes heavy burden on individuals, families, and also on the healthcare systems. As per a recent study, 70 million people have epilepsy worldwide and nearly 90% of them are found in developing regions. The prevalence of epilepsy across the globe is estimated to be 5-9 per 1,000. The study also estimated a median prevalence of 1.54% (0.48-4.96%) for rural and 1.03% (0.28-3.8%) for urban studies in developing countries. With a conservative estimate of 1% as prevalence of epilepsy, there are more than 12 million persons with epilepsy (PWE) in India, which contributes to nearly one-sixth of the global burden. The huge burden from India can probably be attributed to large population, lower income and education, sociocultural prejudices, inadequate resources, competing with infectious and noncommunicable diseases, and the low importance given to public health aspects of epilepsy. Though existing for centuries and well-known for more than 2,000 years (as described by Hippocrates), it is only in recent years that epilepsy has attracted the attention of the medical community. Consequently, efforts are being made for better understanding of the disease and also to organize comprehensive services. In order to organize preventive, promotive, curative, and rehabilitative services for formulating a PWE (the public health approach), understanding the burden, distribution, risk factors, and determinants of epilepsy through epidemiological approaches becomes crucial.

Definition

Most recently, the International League against Epilepsy (ILAE) has revised its conceptual definition of epilepsy to an operational definition to bring the term in concordance with common usage.

Accordingly, epilepsy is defined as a

> Disease of the brain with any of the following conditions:
>
> i. At least two unprovoked (or reflex) seizures occurring >24 h apart;
> ii. one unprovoked (or reflex) seizure and a probability of further seizures similar to the general recurrence risk (at least 60%) after two unprovoked seizures, occurring over the next 10 years; and
> iii. diagnosis of an epilepsy syndrome.

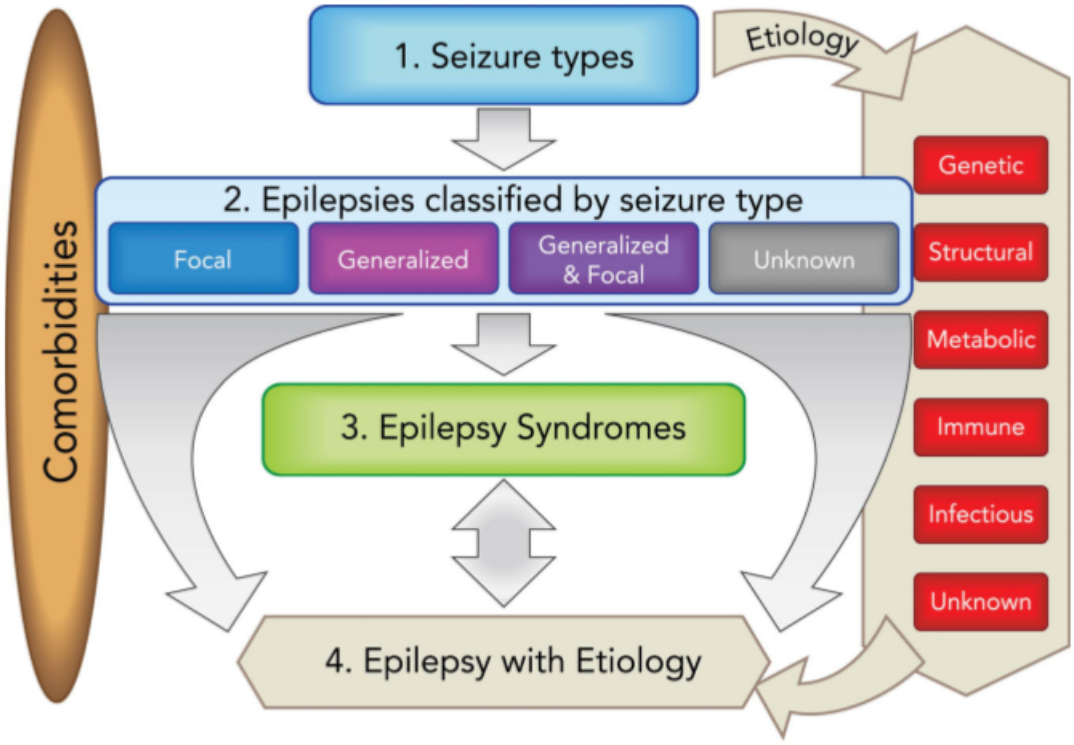
Classification

Classification of epilepsies has undergone many changes. The confusion & mis understanding of nomenclature has been going on. The ILAE has since 25 years trying to give rational classification. The current classification and the thought behind the classification is given below.

The ILAE position paper by Scheffer and colleagues describes a new classification of the epilepsies, which now incorporates a major focus on aetiology at each step of the diagnostic process (Scheffer et al., 2017). The Epilepsy classification applies to all ages. After classification of seizure type, the clinician should aim to identify the patient's epilepsy type and where possible, their epilepsy syndrome. Patients who do not meet criteria for epilepsy (ex. single seizure) should be classified as to a seizure type but classification should stop there. To classify an epilepsy type, a patient must have met the definition of epilepsy, as defined in 2014 (Fisher et al., 2014). Additionally, even if criteria for epilepsy is met, there will be patients whose seizure type is classifiable, but their epilepsy type is unclassifiable.

The epilepsy type classification is broader in scope than is the seizure classification, and considers the possibility of having multiple seizure types, and incorporates information about the overall clinical picture, imaging, genetics, laboratory tests, prognoses and comorbidities. In many instances, the syndrome and aetiology provide additional information that is critical in guiding the patient's management. Epilepsy types are classifiedas: 1) Focal 2) Generalized 3) Combined Generalized and Focal 4) Unknown. To place a patient into one of these categories one uses the classification of all types of seizures that a patient has, and then maps those in aggregate to one of these four categories. The new group of "Combined Generalized and Focal Epilepsy" has been devised in recognition that there are epilepsy syndromes, such as Dravet syndrome and Lennox-Gastaut syndrome, in which it is usual to have both generalized and focal seizures. An epilepsy type is a separate designation than an epilepsy syndrome, and the two should not be confused. Epilepsy syndromes refer to clusters of features (seizure type(s), EEG findings, imaging findings, age-dependent features, triggers and sometimes prognosis) that occur together. Many of these have well-recognized names. An epilepsy syndrome diagnosis provides more sophisticated information than does an epilepsy type diagnosis for some patients. While there are many well recognized syndromes, the ILAE has never formally classified a list of epilepsy syndromes. New syndromes are constantly emerging and further classification of epilepsy syndromes is likely to be a focus of future ILAE endeavours.

From a classification perspective, ILAE has moved from validation of history; neurological or clinical evaluation; to the proposed multiaxial classification using five levels or axes namely ictal semiology, seizure type, epilepsy syndrome, epilepsy aetiology and impairment. Even though the proponents and opponents of this classification method debate fiercely on its broad applications, the problems of definition exist in this classification and many strongly believe that it is still not best suited for population-based epidemiological studies; thus, reemphasizing the need for **case definition**, which is the central pillar of epidemiological or any other research.



Diagnosis

From a diagnostic perspective, a good history by an observant witness remains the hallmark to the diagnosis of epilepsy. Earlier, the diagnosis of epilepsy was established by non-neurologists (medical or trained non-medical staff) or through a two-step process of screening and diagnostic evaluation, which at times has given rise to fallacious results due to false positives and false negatives. Even though some investigative procedures have been used in a few studies, significant limitations exist in India as such facilities are not available in rural areas and are also not reliable in the absence of specific history.

It is important to differentiate acute symptomatic seizures from unprovoked seizures (epilepsy) in order to systematically classify cases and determine prognosis. Acute symptomatic seizures are events, occurring in close temporal relationship with an acute nervous system insult, which may be metabolic, toxic, structural, infectious, or due to inflammation. Acute symptomatic seizures differ from epilepsy in several important aspects. Unlike epilepsy, the proximate cause, temporal sequence, biological plausibility, and dose effect of acute symptomatic seizures are clearly identifiable to ascertain the cause. Acute symptomatic seizures are not necessarily characterized by a tendency for recurrence and have better prognosis, thus exempting them from the criteria of enduring predisposition to seize for epilepsy. As sophisticated skills and techniques are required to distinguish acute symptomatic seizures from unprovoked seizures, most of the epidemiologic studies relying on field surveys have included such seizures as “epilepsy”, or failed to distinguish these from unprovoked seizures. If all people with acute symptomatic seizures are categorized as having epilepsy, it would add to the burden and stigma, and hence this distinction is important.

Homoeopathic perspective-

As a Homoeopathic Physician, we have additional tasks to fathom. From convincing, counselling of patients and their relatives to give relief / cure to the patient. The challenge is more than what we envisage.

In homoeopathic philosophy, epilepsy fits into the classification of periodic diseases. The management of the disease requires specialised case taking with the help of patient and their relatives. Co-morbidities of epilepsy need to be tackled.

Most of the times in our practice patients of epilepsy come with ongoing allopathic treatment. These drugs do produce adverse effects on the patients psyche and behaviour, too. As a physician we need to know the effects, adverse effects and have to implement a plan to taper the drugs without aggravating problems to the patient. The importance of posology in relation to tapering of the allopathic drugs acquires a central importance. It has come to knowledge that various physicians use different potencies in their management. Starting with low potency in repetition to high potency in single dose is the practice. The reason behind it is the same! Susceptibility & Sensitivity!!!

Miasms play a vital role. Herbert Roberts has clearly mentioned about the Tubercular Miasm as the culprit behind epilepsies.

So in a nutshell, we need to have the…

- knowledge of the disease,
- its implication in case taking,
- understanding disease which is ‘masked’ with the allopathic drugs, the effects - side effects and drug inter-relationship of allopathic drugs,

- the tapering of the allopathic drugs,
- evaluating miasm,
- proper orientation to the patient and orientation of our own self and
- giving positive result by instituting right medicine in right potency with right repetition and
- avoiding any possible attacks of seizures/ epilepsy are few things to do for treating this disease condition.

On top of this we do not have enough and proper study/ies on this. Even in our literature, we find paucity of treated cases and paucity of conceptualization, especially in this subject. Our Materia Medica claims to have enough 'armamentarium' to tackle such diseases. The question comes up is effective & logical use of HMM after understanding the clinical entity, spectrum of the disease on larger canvas and making effective TPD+TPR.

Some studies have tried to give 'Language of Disease' as seizure is expression of aggression, pent up emotions etc. But we need more conceptualization from our studies. The Psychodynamic & Psychosomatic aspects will require more focussed studies during our deliberations & discussions on the subject during symposium.

Last but not least….

Quality of Life

The concept of Quality of Life [QOL] for patients with epilepsy [PWE] reflects a shift in focus from laboratory values to "how patients do". Patients with epilepsy have psychosocial, cognitive and behavioural issues. Therefore, QOL should be defined from the patient's perspective. We should move beyond seizures and drug side effects, which provide a limited and skewed view of the issues faced by PWE. In clinical care, question about QOL issues should become as routine as questions about seizure frequency.

As a homoeopath, we do believe in Holistic healing. Therefore, this disease poses great challenges in our practice.

Let's come to gather to fathom the depth & width of this disorder and let us try to bring order from the chaos.

So, gear up for the symposium and send your cases related to the topic. We are going to take only **8-10** cases in this symposium so that proper justice can be done to each case. Please send your case/s to

Symposium Coordinator -Dr. Chirag Shah- chirag@carewell.co.in M – 937-693-9627
Symposium Director - Dr. Mihir Parikh- drmihir10@gmail.com M – 987-952-1788

Please send your cases with follow ups up to 1-2years with RREF.

Send your cases latest by 25th August.

Reference reading-

- Adams & Victor Textbook of Neurology
- Harrison- Textbook of Medicine
- Organon of Medicine- Classification & Management of various chronic diseases.
- www.ilae.org – International League against Epilepsy

-: For Registration & Further Detail contact :-

Vadodara : - Dr Chirag Shah – 937-693-9627
Mumbai :- Dr Sachin Junagadhe – 983-313-7508
Pune :- Dr Pravin Bhalgat – 774-497-9614

-: FACULTIES FOR SYMPOSIUM :-

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-: SYMPOSIUM VENUE :-

ANJOY – THE RETREAT, Sampatrao Colony Opp. Chhappan Bhog, BPC Road Vadodara.

-: FEES :-

For INTERNS & UG STUDENTS - 2500/- **(After 15/09/18)** - 3000/-

For PG STUDENTS & DOCTORS - 3000/- **(After 15/09/18)** 3500/-

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LEARNING BY SHARING