ICR Symposium: Homoeopathic Management of Epileptiod Disorders

Vadodara, September 2018

CASE - 4

Dr. Navin/JDS

Objective:

1. To experience the impact of constitutional medicine in development of children who is having neurological insult.
2. Learning how the constitution responds to the similimum.
3. Learn that How the early introduction of homoeopathic treatment helps a child with neurological disease.

EXHIBIT 1:

Directives:

1. Share your feeling after going through the history form.
2. Go through the history submitted by parents and come to your understanding about the disease.
3. Whether you want to accept the case? Why?

EXHIBIT 2:

Directives:

1. Focus on the presentation and examination and come down to your clinical diagnosis.
2. Form your totality and come to remedy with differentiation.
3. Come down to your expectation from the treatment (TPD TPR)

Please Submit Your Working to :-

Dr Jigar Shah :- drjigarhomoeo@gmail.com

CASE - 4
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EXHIBIT 1:
History submitted by parents:(11-3-08)(History is translated from gujarati)

'Jai swaminarayan'

Preliminary Information:
Name: B.A.P. , Address: Bhimpura, Ta-Amod, Dist: Bharuch
D.O.B: 7-8-2007, Pure vegetarian

Family information:

No	Name	Age	Business	Relation with child
1	M.G.P	55 yrs	Farmar	PGFa
2	I.M.P	51 yrs	H.W.	PGMo
3	A.M.P	27 yrs	Service	Fa
4	N.A.P	23 yrs	H.W.	Mo

Children's daily schedule:
Child is 6 months old. Therefore the child doesn't have any study or games like activity.

Chief Complaints:
B has born on 7-8-2007.The delivery was done by 'Dai' at home. Child cried after her birth. Child and mother was o.k. after the delivery. Not taken any medicines from doctor.
The child had fever and cold after 1 month and 15 days. And for that we have taken medicines from Dr. M.P(child specialist).

After that on 2-1-2008 the child had fever with cold with convulsion. For that we have taken the treatment from Dr. M.P. but she was not well and so we have shown to other doctor. But from treatment of other doctor there was no improvement in fever. At last, we shown to Dr.H.M.(child specialist from Bharuch). Doctor advised us do investigation of brain and eye. The report of it is attached with this form.

The doctor told us that the child's brain nerves are drying up and so they referred us to other doctor.

So, we went to Dr.B.D of surat. Doctor has told us that the " balak ne kudarati naso ni bimari che. Janm pachini koi bimari thai nathi. So, there is no treatment for her. Do the 'seva' of the child as much as you can. The baby will not able to do any work when she will grow. Please see the letter written in file.

Other Complaints:
Child had fever, cold and convulsion on 3-1-2008. And for that she had taken treatment. The child can not able to do eye to eye contact after 3 months. The child cannot sit. We are giving her milk with glucose biscuits 1 to 2 times in a day. We are not giving him anything apart from this.

The child's developmental record:
The child was delivered at home and we have not shown him to any doctor.
Birth weight – 3 kg, Weight on 5-10-2007 – 3 kg 660gms, Weight on 3-1-2008 – 5 kg 500 gms, Dentition – not yet started Child is 7 month old now but she cannot able to sit.

Other information regarding the child:
Doctor has told us regarding the condition of the baby. So, please tell us that the baby will become alright or not?

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Report attached with history form:
Dr. B.D(M.D. D.PED): February 2008
Dear Doctor H,

I thank you very much for referring pt. She has GTC which is due to her prenatal CNS defect. She has severe hypotonia with delayed milestones, mild optic atrophy (optic nerve is direct extension of brain matter), so naturally there is brain atrophy. ***This baby has bad prognosis for useful life.*** MRI like costly investigation will not help baby, or change clinical condition. Please give

- Epival 2 ml BD
- Tonoferron drops 10 OD
- Calpol drops 10 sos

Eye hospital – Dr. Y.M., Bharuch: 5-2-2008
Baby B: Fundi (BE) - Disc: No papilloedema, pallor present.
? early optic atrophy.

6-2-2008: EEG & Brain map analysis:
History: Episodic generalized convulsions staring at one place, salivation, incontinence lasts for few mits since 2 months
Observation: The background activity consists of 9-10 Hz, 30-50 Hz microvolts of alpha activity arising from both the occipital areas and replaced in front by fats beta waves. PS doesn't potentiate any abnormality.
There are scattered that waves getting intermingled with background activity. Right hemisphere show sharp waves and spikes which occasionally become generalized. Normal sleep spindles are occasionally seen.
Impression: The sedated EEG record is abnormal showing interictal discharges arising from right hemisphere.

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EXHIBIT 2: **D/O/C :- 11.03.08**

Chief Complaints :-

NO	LOCATION	SENSATION & PATHOLOGY	MODALITY	ACCOM
1	3/1/08 Till 5-2-08 CNS After 2-3days Since then F2-3/day D- 2 min	Sneezing Watery discharge Fever with seizures Seizure clenching of teeth UREB Generalized tonic convulsion No unconscious No Involuntary urine / stool Delayed milestones No monosyllabic babbling Delayed social smile Not able to sit/turn Weakness	<1 7- 8am <1 8-9 pm (night) >2 Syp Epival(Sodium valprovate) 1.3 ml BD Calpol drop sos	

PATIENT AS A PERSON

Lean Perspiration: Partial forehead2 Excessive+

Mother's obstetric history:

Deliver FTN home delivery. Birth weight: Approximately 3kg

Lactation: N Social smile: 5 months Dentition: not yet started Turning in bed: absent

Sitting: Not yet developed

Sleep: Duration - 2-3 hrs, Deep, Keep mouth open during sleep2

Fan: W/S/M – doesn't need Covering – likes Woolen takes

Bath desire with hot water C3H2

Life Space:

A 7 month old child has come to our hospital with parents. She is the only child. Fa is working in GIDC at Ankleshwar, Mo is home wife, PGFa is retired and PGMo is also house wife. Fa & Mo are calm in nature. Pt is more attached with family especially with Mo.

By nature child calm, cool & playful. She is mixing easily with others. But if anybody teases her then she became angry and she grinds her teeth and tries to beat. But after some time she plays with that person. She startles from noise of whistle.

Observation: Baby is active and playful with everybody with calm and mild look.

PHYSICAL EXAMINATION:

Pulse: 140/min. **RR:** 34 **Wt:** 6.100kg **Head Circumference:** 42 cm

Height: 69cm **Chest:** 40 cm

CNS:

Head holding: +nt, Eye co-ordination: good, Cannot able to sit, stand. Hypotonia++

DTR: +, Parachute reflex – absent