A SURVEY OF FOURTEEN EPILEPTIC CASES

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Mr. President, Ladies and Gentlemen,

Epilepsy is a disease which has been studied and described for a long period; it is associated with a varied amount of ill health which incapacitates the patient in a greater or lesser degree. Owing to the nature of the illness and the occurrence of fits at unexpected times, the disease sets a limit to the working capacity of the patient and to his normal social contacts, and as a result he is frequently unable to take part in normal activities. Often there appears a gradual deterioration of the mental and physical health of the patient which necessitates institutional treatment in the later stages.

Epilepsy is usually considered a very intractable disease and, despite intensive research into the nature of the disease and its treatment, results are still disappointing. Consequently, it seems to me, an attitude of *laissez-faire* has risen towards the disease in the minds of the profession and the public. Since epilepsy is not a 'killing disease' like tuberculosis, cancer or rheumatism, this attitude of mind can be well understood. Nevertheless, the results which I have obtained in the treatment of a number of epileptic patients lead me to believe that much can be done to alleviate those suffering from this disease and so render them more fit to enjoy life, more able to take their proper place in the life of the home and community and to be less of a liability to their relatives and to the state from the necessity of institutional care.

In Price's *Textbook of Medicine*, epilepsy is defined as "a condition characterized by suddenly occurring disturbances of cerebral function, prone to occur over long periods of time." The exact cause and nature of the fit have not yet been determined, although it is known that changes occur in the normal electrical activity of the cortical nerve cells of the brain before and during the fit. The disturbances of the electrical activity of the cortical cells produce the characteristic fit or seizure which is typical of epilepsy.

There are two principal types of epilepsy described: (1) symptomatic, (2) idiopathic. In the symptomatic type, the epileptic seizure occurs as a symptom of certain disorders of the brain, e.g. congenital abnormalities, intra-cranial tumours, inflammatory conditions such as syphilis, head and brain injury. However, these account for only a very small proportion of epileptic cases. By far the majority of patients are cases of so-called idiopathic epilepsy. Idiopathic epilepsy in the commonly accepted view, has no pathological basis for the seizure, and the attacks occur in otherwise normal healthy-individuals. However, this view has been challenged in recent years.

Watson Williams in his book on chronic nasal sinusitis and its relation

to general medicine points out the injurious effect on mental cases of chronic suppuration of the nasal sinuses, demonstrating the deleterious effect of focal infection on certain mental disorders, exeluding epilepsy. However, Pern, in the *Medical World* of October, 1944, affirms that, in his view, idiopathie epilepsy is also caused by suppurative disease of the nasal sinuses resulting in an invasion of the meninges and brain cells by toxins and organisms.

Lennox's suggestion of the cause of epilepsy, as quoted in Price's textbook, is this: "The cause of epilepsy is never single; there is (*a*) a fundamental cause, namely an inherent instability of the brain, and (*b*) a secondary or contributing cause, and that it is a combination of the two that evokes the fit." From this description by Lennox, it seems to me that the fundamental cause may be described as the predisposing one and the secondary cause is any condition which stimulates the brain mechanism to produce the fit—the exeiting cause of the fit.

If this assumption is correct, then the toxic invasion of the cortical tissue of the brain, as suggested by Pern, may produce the "inherent instability of the brain" which is considered to be the fundamental cause of epilepsy.

It is more difficult to account for the secondary or exciting cause of the fit. The sudden onset of a fit for no apparent reason is well-known, and many suggestions as to the cause have been made. The association fits with excitement, grief, or other emotional disturbance has been recognized and it may be that any of these conditions acting either singly or in combination, is the secondary or exciting cause of the fit.

With these very brief notes on the aetiology of epilepsy, I shall now review and discuss the fourteen cases which form the basis of this paper.

Case 1. M.A., aet. 6. F.

4.12.44. Epilepsy since 2½ years old. Major attacks at irregular intervals. Frequency, 6 or 9 months interval at first, later 2 weekly. Health good before onset of attacks. Was vaccinated but did not 'take'. No history of nasal catarrh or gastritis before onset of attacks. Now susceptible to 'head colds' and gastritis. Sinuses tender. Nose now stopped. Noticed that nose was stopped with presence of seizures. Nasal discharge albuminous or purulent. Post nasal discharge purulent. Attacks of gastritis with vomiting—undigested food with mucus. Bowel costive. Nasal catarrh < in cold and damp weather. Pale complexion. Sweats < at night. Tonsils enlarged. Sleep restless with choreiform twitches. General tiredness, debility and lack of energy. Apathetic, languid, no interest in play or school.

Remedy: Thuja 30.

Results of treatment: Frequency of fits less. After 4 months' treatment, epileptic attacks at 4 weekly intervals, instead of 2 weekly. General health improved including nasal catarrh and sinusitis, susceptibility to 'head colds' >, complexion brighter, energy, both mental and physical, greater, gastritis improved.

Case 2. J.R., aet. 10. F.

18.1.38. Epileptic attacks since 7 years old. Alternate major and minor attacks. Began soon after tonsillectomy. Before operation, was very susceptible to 'head colds' and bronchitis < in damp, cold weather in winter. No vaccination. Mentally shy, timid, easily startled and fears dogs. Pale complexion. Cold sens. With cold hands and feet.

Remedies: Thuja, Tuberculinum bov.

Results of treatment: Moderately good, but after 3 months' treatment frequency of major fits very much less—at 9-weekly interval. Minor attacks less frequent also. General health improved. No nasal or bronchial infection during observation. Cold sens. >. Hands and feet warmer. Complexion brighter.

Case 3. M.McC., aet. 11. F.

23.2.38. Epileptic attacks for 5 years. Major epilepsy.

Previous illnesses: Measles, whooping cough, diphtheria, chorea. Tonsillectomy—was susceptible to 'head colds' before operation. Had vaccination.

Symptoms: Nasal catarrh with watery discharge. Choreic twitches. Rheumatic pains of fibrositis. Slight attacks of mastoiditis.

Remedies: Sycotic co. Thuja. Tuberculinum bov.

Results of treatment: Excellent. Epileptic attacks became less frequent and less severe. Finally none for 12 months. Nasal catarrh and chorea gone also.

Case 4. A.T., aet. 12. F.

9.1.41. Mother reported minor epileptic attacks of few weeks' duration at first, followed during treatment by infrequent major attacks. Health prior to epilepsy was good, but was becoming timid, easily startled and frightened and was afraid of dark.

During treatment, became susceptible to rhinitis and mild attacks of otitis media and mastoiditis. Was growing rapidly, tall and lean. Pallor. Occasionally with rhinitis had tendtr sinuses, and rheumatic fibrositis.

Remedies: Tuberculinum bov., Lycopod., Cuprum met., Calc. phos.

Results of treatment: Excellent. Tendency to both major and minor epileptic attacks gradually disappeared. Finally no epileptic attack for 4 years. General health improved. Nervous condition became more composed, fears less intense. Tendency to 'head colds' and sinusitis gone. No rheumatism.

Case 5. W.Mi., aet. 12. M.

28.4.37. History of epileptic fits sinee 3 years old. Both major and minor seizures. Had measles and was vaccinated previous to onset of fits. Is a mentally defeetive child. Dull and apathetic and takes no interest in any activities. Has susceptibility to rhinitis with thick purulent nasal discharge. Case notes show that fits are more frequent during acute rhinitis, and less frequent later when purulent nasal discharge is present; 50 per month very often.

Remedies: Thuja in all potencies. Natrum sulph., Medorrhinum, Proteus.

Results of treatment: There was no satisfactory response to remedies, and there occurred a gradual deterioration in mental and physical health, until he finally became a dement.

P. S. His twin sister also shows evidence of sycotic constitution with susceptibility to sinusitis, bronchitis and endometritis with severe leucorrhoea. No evidence at any time of epilepsy.

Case 6. M.D., aet. 15. F.

23.11.43. First notes show no evidence of epilepsy, which only developed later. On this date report of epistaxis (vicarious) instead of M. P. Bright red and easily controlled. No other signs of nasal catarrh or sinusitis. Stomach—ravenous appetite. Mentally shy, timid, easily startled, excited and frightened. No 'life'. Complexion pale. Tall and lean, growing rapidly. Chest long and narrow. Cold sens. Epileptic attacks usually associated with gastritis, having nausea and vomiting bile.

Remedies: Phosphorus, Calc. phos.

Results of treatment: Favourable. Epilepsy less frequent. General health improved. Fears and nervousness very much better. Vitality greater. Cold sens. >. More 'life'.

Case 7. B.L., aet. 15. F.

17.7.44. History of epileptic attacks for 15 months. Major in type.

Previous history: Had scarlet fever and susceptibility to 'head colds' before onset of epilepsy.

Symptoms: General physical development more mature than her age suggests—looks 18 years old. Nasal catarrh with nose stopped or dry and crusted. Discharge purulent. All sinuses tender, but left more than right. Feels better generally and less tendency to epileptic attacks when nasal discharge present. Often has choreic twitches affecting face, arms and legs. Puberty at 10½ years old—unusually early. M.P. normal and no dysmenorrhoea. Leucorrhoea, brown coloured, excoriating and having a foul fishy odour. Heat sens. Languid and tired easily. Mentally apathetic, showing no evident interest in any activities. Vitality poor. At irregular intervals rheumatic pains, fibrositic, affecting arms and wrists. Sinusitis with tenderness in all sinuses as they are affected.

Remedies: Morgan co. and Sycotic co. Medorrhinum.

Results of treatment: Frequency of fits less. Before treatment—one every 1-2 weeks. After treatment began—gradually less frequent until October 1945, and now one attack (major) each 6-8 weeks. General health improving. Vitality greater. Mentally less apathetic. More alert and showing more interest in activities. Nasal catarrh and sinusitis less frequent. Sinuses less tender. Leucorrhoea less profuse, less excoriating, and foul odour less prominent. Choreic twitches in arms and legs less severe. No rheumatism.

General improvement favourable.

Case 8. W.Mo., aet. 17 M.

22.9.39. Epileptic major attacks. Began first when 2 years old and continued with varying frequency for 9 years. Then free for 3 years and return when 16 years old after a car accident.

Previous illnesses: Had measles and vaccination before epilepsy in childhood.

Symptoms: Mentally apathetic. Languid and no energy. Bowel costive—hard and firm. Recently nasal catarrh with watery or purulent discharge. Noticed that fits were aggravated by nasal catarrh. Sweats in bed. Heat sens. at times, pain in stomach before onset of epileptic attack (?) aura.

Remedies: Thuja, Tuberculinum bov., Argent. nit.

Results of treatment: Moderate success. Fits noticed to be less frequent but still occur at least one in 10 days. General health slightly better, with nasal catarrh less severe. Mentally less apathetic, and showing evidence of greater energy and more activity.

Case 9. M.M., aet. 24. F.

6.12.35. History of major epileptic fits since childhood (approximately 20 years).

Previous illnesses: Had scarlet fever before fits began. T.B. dactylitis in childhood.

Symptoms: Fits < with M.P. which is regular and normal. Leucorrhoea, brown colour, excoriating and fishy odour, occurring between M.Ps. Bowel costive. Teeth soft and decay easily. Susceptible to 'head colds' < in damp cold weather. Associated with watery nasal discharge, profuse in heat. Cold sens.

Remedy: Sycotic co.

Results of treatment: Favourable. Only two fits reported after beginning treatment, and then none for 10 weeks—less frequent than previously. Nasal catarrh very much relieved. Leucorrhoea > less profuse, less excoriating. Vitality greater.

Case 10. M.McG., aet. 26. F.

6.3.45. History of epilepsy since puberty at 15 years of age in 1936. At first, only minor attacks, usually < with M.P. Major epilepsy began in 1942, i.e. when 23 years old.

Previous illnesses: Scarlet fever, T.B. peritonitis when 5 years old, otitis media, susceptibility to 'head colds'.

Symptoms: Nasal catarrh and sinusitis, associated with supra-orbital headaches and tender sinuses. Nasal discharge, watery albuminous or purulent. Bronchitis infrequent. Bowel costive. M.P. regular and associated with dysmenorrhoea, bearing down in character. No leucorrhoea. Complexion pale. Cold sens.

Remedies: Acute phase rhinitis, Arsenicum alb. Subacute phase rhinitis, Kali bich. Chronic (constitutional), Thuja., Tuberculinum bov.

Results of treatment: Moderately good. Major epileptic attacks less-

frequent. But after prolonged treatment, minor attacks still persist although less severe. General health varies, depending on condition of sinuses and severity of dysmenorrhoea. Major attacks once in 4 months.

Case 11. E.N., aet. 23. F.

2.6.36. Major epileptic attacks for 8 years. Began at puberty soon after first M.P.

Previous illnesses: Had susceptibility to 'head colds'.

Symptoms: Attacks usually < with M.P. M.P. irregular, at times dysmenorrhoea, bearing down in nature. No leucorrhoea. Susceptibility to 'head colds', < with M.P., associated with profuse watery discharge in cold. All sinuses tender > onset nasal discharge. Bowel costive. No indigestion, but periodically has craving for salt. Heat sens. Timid, weepy temperament.

Remedy: Natrum mur.

Results of treatment: Excellent. Had one fit shortly after treatment began, then none for 5 years. This attack was attributed to excitement of beginning new work. None since. General health good. Susceptibility to 'head colds' gone. No craving for salt. M.P. regular. No dysmenorrhoea.

This patient has recently married and become pregnant, and shows no evidence of any return to her previous state of health and no epileptic fits.

Case 12. Mrs. R., aet. 26. F.

20.1.38. Epileptic attacks, major in type, for 2 years.

Previous illnesses: Susceptible to 'head colds'. Leucorrhoea for 5 years, following confinement.

Symptoms: Feels generally < in a.m. Mentally—fears alone and becomes weepy then > with company. Apathetic. Susceptible to 'head colds' in cold damp weather, associated with nasal discharge, thick alhuminous or purulent. Tonsils enlarged. Bowel costive. M.P. regular. Leucorrhoea brown colour, excoriating, and foul fishy odour. Feet cold. Cold sens. Tender sinuses when nose stopped.

Remedies: Thuja, Nitric acid.

Results of treatment: Very favourable. Major attacks became much less frequent and finally none for 6 months. Replaced by minor attacks, which in turn became less frequent. Parallel with diminished frequency of fits, general health improved. Nasal catarrh and sinusitis less severe. Tender sinuses less. Bowel more active. Leucorrhoea less profuse, less excoriating and foul odour less intense. Mentally brighter, with fears >, and weepy >. More active, and greater vitality.

Case 13. M.K., aet. 27. F.

10.12.40. Epileptic attacks, both major and minor, for 20 years.

Previous illnesses: Vaccination in childhood. Otherwise health good prior to onset of epilepsy. Scarlet fever when 10 years old.

Symptoms: Fits began when 7 years old. Occurred every night for several years. Often three or four fits each night. Nose—frequent 'head colds' in cold damp weather, associated with tender sinuses. Followed by bronchitis

with hard spasmodic cough. Bowel costive and hard. Stomach normal. M.P. regular but prolonged to 2 weeks. No dysmenorrhoea or leucorrhoea. Epileptic attacks < with M.P. 'Head colds' < with M.P. Furunculosis with dirty skin and unwashed appearance. Mentally, fears injury from strangers, tendency to weep openly and wants company then.

Remedies: Sulphur, Kali bich.

Results of treatment: Very favourable, both as regards fits and general health. Fits, at outset of treatment, occurred 3-4 per night for prolonged periods. After treatment, became less frequent and latterly one only every 4-5 months. In August, 1945, had acute rhinitis and influenzal chill, and then sudden return of frequent fits, 15 in 3 days, becoming > with onset nasal discharge. Mentally, has become more composed. No fears of strangers, weepiness gone. Skin condition cleared. Now no furunculosis and complexion bright and healthy. Sinuses normal.

10.11.45. No fits for 3 months.

Case 14. J.N., aet. 33. M.

17.3.45. History of epilepsy for 3 years following injury to head during the London blitz.

Following the head injury he had severe concussion and coma for 13 hours. Soon after recovering consciousness he developed headaches, dizziness and difficulty in mental concentration—all after effects of head injury. What he describes as "mental blackouts" soon became evident with unconsciousness of varying duration, considered to be (minor epilepsy ?). There has been no history of major epilepsy. X-ray examination showed no evidence of fractured skull.

Previous history was negative. He was very healthy and suffered no disability.

Since his return from the Forees, he has become susceptible to attacks of 'head cold' both acute and chronic, worse in cold damp weather. The discharge was watery and later thick albuminous or purulent. With stopped nose, had supra-orbital headaches and tender sinuses. During this period the "mental blackouts" occurred, > onset nasal discharge. During this period also, he becomes mentally 'heavy', depressed and broody, > onset nasal discharge when he becomes more cheerful. Stomach: occasional nausea with flatulence. Bowel active.

Remedies: Acute, Arsenicum alb. Subacute, Kali bich. Chronic and Constitutional, Natrum sulph.

Results of Treatment: Favourable and encouraging. Minor epileptic attacks have been in abeyance so long as the nasal sinuses are kept healthy. Immediately at onset of acute rhinitis tendency to attacks recurs and he also becomes mentally depressed and 'broody'.

The total number of cases in this series is 14, comprising 3 males and 11 females. Analysis shows that the onset of epilepsy was most common in childhood and early adult life.

In the following table the numbers in each age group are given in greater detail:

2-5 years old	...	...	4 cases
5-10 years old	...	...	3 cases
10-15 years old (puberty)	...	...	5 cases
Over 15 years old	...	...	2 cases

No case of idiopathic epilepsy developed in children under 2 years old. In 7 cases (50 per cent) fits appeared during the years of childhood, and in 5 cases (35 per cent) the disease became evident during the time of puberty. Only in 2 cases (15 per cent) did epilepsy manifest itself first in adult life. In one of these cases the onset of the fits closely followed head injury which may be presumed to have been at least partly responsible for the development of the disease.

The duration of epileptic disease at the time of first consultation varied greatly—the longest period being 20 years and the shortest a few weeks. The duration of the disease is important since (1) in the majority of cases the longer the duration the more difficult it is to eradicate the disease, (2) the possibility of relief and cure is less in long standing cases. However, it is possible to obtain good results in cases of long duration, and in certain of my patients the improvement has been greater than I could ever anticipate.

Regarding the nature of the epileptic seizures, I had 8 patients (57 per cent) who suffered from major epilepsy, 5 patients (35 per cent) had major and minor attacks alternating and only one patient (7 per cent) suffered from minor epilepsy.

SYMPTOMATOLOGY OF EPILEPSY

Predominant opinion considers that idiopathic epilepsy is a functional disorder of the brain. Therefore it is not surprising to find that symptomatology is concerned principally with the local manifestations of the disease. Accurate and detailed descriptions of these local symptoms and signs are found in all standard textbooks, but those symptoms, peculiar to the patient, are absent. This, of course, is due to the conception that disease is a pathological entity. However, to a Hahnemannian such a picture is incomplete and it is one purpose of this paper to present a symptomatology of these fourteen cases as complete and as comprehensive as possible. By this means, one is able to obtain an insight into the constitutional illhealth of the patient, which I consider, as a result of my experience of these cases, to be the fundamental cause of epilepsy.

Analysis of these cases was very informative and instructive and brought to light many outstanding features. Previously, one had been led to believe that epilepsy occurred in normally healthy individuals. But from careful study of the patients it soon became evident that, far from being otherwise healthy, they had suffered, and continued to suffer, from many complaints of which

epilepsy was only one. These illnesses, as we shall see, were varied but conformed to one type, since they were chiefly catarrhal infections. The severity of these infections varied in each individual patient, sometimes being mild with no great constitutional disturbance, at other times being quite incapacitating.

Illnesses preceding the onset of epilepsy:

Vaccination	5
Sinusitis / Rhinitis	7
Bronchitis	1
Enlarged Tonsils / Tonsillectomy	2
Diphtheria	1
Measles	3
Whooping cough	1
Scarlet fever	3
Tuberculosis	2
(1 Dactylitis; 1 Peritonitis)	
Otitis media	2
Head injury	1
Fright	1
None	1

In some cases, more than one of these illnesses appears in the medical history, one patient actually having four previous to the onset of epilepsy.

A study of the medical history of these 14 patients affords valuable evidence of the nature of ill health prior to the first appearance of the epileptic seizures. I have found no epileptic patient perfectly fit and well before the epileptic disease first showed itself, although in some cases the deviation from health was only slight. The diseases noted have a profound effect on the health of the individual and in my opinion influence the causation of epilepsy. Our allopathic colleagues do not seem to lay much stress on these diseases as causative factors, but we, with a knowledge of the Hahnemannian sycotic constitution and the illnesses associated with it, appreciate their significance as probable causes in the predisposition to epilepsy. I have purposely refrained from citing these diseases as actual predisposing causes of epilepsy, since at the present moment there is no specific evidence that they play such an important role in the onset of this disease.

In analysing the symptoms and signs of ill health in these 14 epileptic patients, I have found it necesssary, for purposes of description, to divide them into two groups: (*a*) those common to all patients, (*b*) the symptomatology of the individual patient.

(*a*) Symptoms and signs common to all patients.

(1) Epileptic seizures—these were of the classical type and require no further description.

(2) All patients suffered from catarrhal infections of the upper respiratory tract—principally acute and/or chronic rhinitis and sinusitis. In addition some had also otitis media, mastoiditis, or bronchitis. These infections followed a course typical of catarrhal diseases.

In all these cases, I observed a time relationship between the onset or presence of acute nasal sinusitis and the occurrence of epileptic seizures which I think is most important. Without exception, the epileptic attacks appeared only or with greater frequency during the acute stages of the infection. Also, during the sub-acute and chronic stages when resolution was being effected, the frequency and severity of the fits gradually diminished, until finally the sinuses resumed a healthy state and no fits were reported. The association between nasal sinusitis and epileptic attacks was so common that I now attach great importance to it as an indication that the possible cause of epilepsy is the focal infection in the sinuses.

In some female cases, epileptic attacks appear for the first time at puberty and often occur at the time of menstruation. The reason for this has always been obscure and has not yet been proved, but the usual one given for the occurrence of fits at such time has been hormonal disturbance, probably ovarian, uterine or thyroid in origin. However, such cases in this series have had a history of previous catarrhal conditions such as vaccination, measles and whooping cough, and at menstruation they usually suffer from 'head colds' and sinusitis also. It seems to me possible that such cases in this series may be more liable to fits at menstruation, not from menstrual disturbances at all, but from the sinusitis. At the same time, both menstrual disturbance and sinus infection may act together in the production of a fit.

I have also investigated the possibility of other sites of focal infection playing a part in the production of epileptic attacks. In one case, I found an attack of otitis media did precede the onset of a fit. However, this patient also suffered from severe sinusitis, so that the otitis media was not the sole agent in the causation of the epileptic attack. In many illnesses, endometritis, as evidenced by the presence of leucorrhoea, is known to be a site of focal infection. I have carefully investigated three cases suffering from leucorrhoea but have no conclusive evidence in any that it is the only focus with which the production of fits could be associated.

Watson Williams in his book on chronic nasal sinusitis describes the association of certain mental disorders associated with chronic suppuration in the sinuses. I have noted that many patients in this series showed evidence of mental disturbance of varying degrees of severity which cleared as the sinusitis resolved. I observed another significant fact. The fits and mental disturbance appeared at the same time and both were relieved simultaneously when the sinusitis subsided and was cured.

(*b*) Individual symptomatology.

MENTALS

Case 1. Apathetic, languid. No interest in school or play. Averse to exercise.

Case 2. Shy, timid, easily startled. Fears dogs.

Case 4. Easily frightened and startled. Timid. Fears dark. At times cross and irritable.

Case 5. Mental defective. Apathetic and dull, taking no interest in any activities. Unable to learn anything.

Case 6. Shy, timid, easily frightened and excited. Apathetic, dull, and sluggish mentally.

Case 7. Unusually quiet and placid, apathetic.

Case 8. Apathetic, dull.

Case 10. Shy, placid, timid.

Case 11. Timid, placid, weeping.

Case 12. Placid, fears alone. Weeping, and desires company.

Case 13. Timid and shy. Fear of meeting strangers. Tendency to weep openly and then desires company.

Case 14. Dull, mentally depressed, brooding, amounting almost to melancholia. During melancholic state, sits with head in hands, staring at floor with morbid thoughts.

NERVOUS SYMPTOMS

Case 1. Choreiform twitches during sleep.

Case 3. Choreiform twitches—restless.

Case 4. Twitches face and head during sleep with snoring.

Case 7. Choreiform twitches affecting face, legs and arms < left side.

UPPER RESPIRATORY TRACT

Case 1. Enlarged tonsils. Attacks laryngitis.

Case 2. Tonsils enlarged. Had tonsillectomy performed.

Case 3. Had enlarged tonsils. Tonsillectomy.

Case 4. Had slight attack otitis media and mastoiditis but no aural discharge.

Case 12. Enlarged tonsils. Occasional attacks tonsillitis.

Case 13. Had one slight attack left tonsillitis.

BRONCHITIS

Case 2. Bronchitis in cold damp weather.

Case 13. Bronchitis.

STOMACH

Case 1. Attacks gastritis with nausea and vomiting of undigested food and mucus.

Case 3. Burning in stomach (occasional).

Case 6. Ravenous appetite sometimes. Attacks gastritis with nausea and vomiting bile, often before onset of fit.

Case 8. Pain in stomach before fit (? aura).

Case 11. Craves salt.

Case 12. Infrequent bilious attacks with nausea, flatulence and heart-burn > with warm food. Sometimes aura with ravenous appetite.

Case 14. Occasional attacks nausea with flatulence > rid of wind.

BOWEL

Case 1. Costive.

Case 8. Costive. Faeces firm and hard.

Case 9. Costive.

Case 10. Costive frequently.

Case 11. Costive.

Case 12. Costive.

Case 13. Costive and hard.

GENITAL

Case 7. Menstruation regular and normal. No dysmenorrhoea. Leucorrhoea—brown coloured, excoriating and foul fishy odour. Puberty at 10½ years.

Case 9. Leucorrhoea, brown coloured, fishy odour, excoriating occurring between menstrual periods.

Case 10. M.P. regular but associated with dysmenorrhoea, bearing down. No leucorrhoea.

Case 11. Dysmenorrhoea—bearing down pains.

Case 12. Leucorrhoea, fishy, excoriating, watery.

RHEUMATISM

Case 1. Fibrositis arm.

Case 4. Fibrositis.

Case 7. Rheumatic pains both wrists.

SKIN

Case 11. Skin pale, dirty looking, having unwashed appearance. Acne face and general furunculosis of mild type.

GENERALS

Case 1. Pale complexion. Sweats, generally < night. Cold and damp sens.

Case 2. Cold and damp sens. Cold hands and feet. Pallor.

Case 4. Pale complexion.

Case 6. Pallor. Cold sens.

Case 7. Heat sens.

Case 8. Pale. Sweats < at night in bed.
Case 9. Generally cold and damp sens. When all conditions become <.
Case 10. Pallor. Heat sens.
Case 11. Heat sens. Pale.
Case 12. Cold and damp sens. Cold hands and feet. Pale.
Case 13. Cold and damp sens. Pallor.
Case 14. Cold and damp sens.

(*To be continued*)

A SURVEY OF FOURTEEN EPILEPTIC CASES

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(*Continued from page 23*)

Mentals: From analysis of the histories of the 14 cases it is found that in addition to the functional disturbance of the brain which causes the epileptic seizures, profound mental changes occur which affect the personality of the patient. These are all of one type, namely a depressed mental outlook as opposed to the anxious high strung type of mental reaction.

The general type of mental reaction is one of apathy or mental depression which may border on melancholia in severe cases. The patient is usually listless, which is varied in degree, and he takes less interest than normal in his surroundings, particularly, in work or play. Often he has diminished energy also, so that even if he was willing, the exercise tires him out easily. Some patients are placid, shy and timid, showing no evidence of aggressive reaction, the result being that they do not 'mix' readily. Three patients had a marked tendency to weep easily with a desire for company which brought relief to the emotional disturbance. Arising from the timidity which they suffered, several patients had symptoms of fear. The fears varied greatly, the most common being fear of the dark and from being startled. One showed fear of dogs, another of being alone, and a third a fear of being attacked and hurt by strangers. All these patients had their fears allayed in the presence of friends. Finally, evidence of impending melancholia appeared in one case. At the height of his illness he was mentally dull and brooding while he sat with head in his hands, staring at the floor and absorbed with morbid thoughts.

These are the predominating mental symptoms which I found in these epileptic patients. One is not certain yet without further research that they are pathognomonic of epileptic disease, but I think it is significant that they appeared in these patients.

Now a short note on the intelligence of the epileptic patient. It is often said that intelligence is below normal. Although I did not have time available to test the intelligence of these patients, the results of clinical examination did not suggest a mental ability much below their average. It is recognized that in certain cases of long standing illness, the mental intelligence may be markedly subnormal. In this series, one patient was actually in this category, since he suffered from mental deficiency. On the other hand, however, one patient was able to undertake work in an explosives factory after being addicted to seizures of the worst type for 20 years, showing that long duration of illness does not necessarily cause mental deterioration of a severe nature. From my observations I believe that the appearance of low

intelligence may be due to apathy and inability to think and concentrate properly resulting from the toxic state in a manner similar to the mental apathy caused by enlarged tonsils and adenoids. My belief is based on the fact that in these epileptic cases when the toxic focus in the nasal sinuses is removed and the general health improved there is a parallel and comparable improvement in all the mental symptoms, with relief from the abnormal temperament and behaviour.

Nervous symptoms: Choreiform twitches were another sign of nervous disorder which I found in four patients. They affected the face, arms and legs in varying degree and often occurred during sleep. The twitches may have been evidence of slight major epilepsy, on the other hand they may have been caused by chorea, which I am more inclined to believe, since nasal sinusitis is a source of infection in the causation of chorea—a condition which was present in all cases.

Upper respiratory tract: In cases of infection of the nose and sinuses, one would expect to find frequent evidence of other catarrhal diseases of the upper respiratory tract. Four patients had enlarged tonsils and adenoids, and in two tonsillectomy had been performed. One child suffered frequently from laryngitis associated with croupy cough. Another from mild attacks of otitis media and mastoiditis, which soon healed satisfactorily and showed no evidence of active disease on examination. Other two developed slight attacks of tonsillitis which rapidly cleared with treatment.

Bronchitis: This disease was not often found in this series of cases. Only two patients gave a history of single attacks of bronchitis, which appeared to be mild and soon passed off with no recurrence.

Stomach: Although seven patients suffered from gastritis, the disease was usually never very severe nor frequently recurrent. Bilious attacks were the common type of illness in four patients, associated with flatulence, heartburn, nausea and vomiting. The vomitus consisted of undigested food in one case, bile in two cases and mucus in the fourth. Sometimes the bilious attack occurred immediately before an epileptic fit. Other types of indigestion met with included craving for salt, ravenous appetite before fit and pain in stomach as the aura.

Bowel: Seven patients complained of constipation, with hard and firm stool. Strangely enough, owing to the preoccupation with the epileptic seizures, the patient usually was never unduly distressed about the dysfunction of the bowel, and considered it a very trivial complaint.

Urogenital tract: The menstrual history of the female patients was on the whole uneventful. In most patients menstruation was regular and without incident. Two suffered from slight dysmenorrhoea with bearing down pains before the onset of M.P. In one patient, menstruation appeared first at the unduly early age of 10½ years. The usual time of onset of puberty in these patients was 13-15 years.

Three patients suffered from leucorrhoea. In all cases it was intermens-

trual in time of appearance. In each patient the discharge was similar, being dark brown in colour, excoriating and having a foul fishy odour.

Skin: Generally, the skin showed no evidence of disease except in one case. In this patient, the skin had a cachectic brown discoloration and a dirty unwashed appearance. Acne was present together with a general mild furunculosis. The whole skin symptoms confirmed the use of Sulphur as the remedy, which was administered with beneficial results on the epileptic fits and general health also. In many other patients, the skin did not have a healthy appearance, the complexion being pale and waxy in colour which seemed to be a characteristic of the disease.

Rheumatism: A tendency to rheumatism was not a marked feature in these cases. In two patients there was evidence of slight fibrositis in arms and in one slight swelling and pain of both wrists. However, these symptoms were soon relieved with treatment.

Generals: In these 14 patients, I found no particular type of physical development predominant. Some were tall and lean, especially in early adult life, while others were plump and well developed. Pallor was quite a prominent feature, 8 patients showing evidence of this appearance. The reactions to heat and cold varied very greatly. Seven patients were sensitive to the effects of cold and damp when the catarrhal symptoms were aggravated. Some had cold hands and feet and 2 of these also complained of severe sweating in bed. In contrast to these, 3 were sensitive to heat, while 4 cases showed no abnormal reaction to heat and cold.

TREATMENT OF EPILEPTIC PATIENTS

The treatment of idiopathic epilepsy varies according to the theory regarding the origin of the disease. In the predominant view, treatment is designed to prevent the occurrence of epileptic attacks by reducing the excitability of the brain cells to external stimuli. This is done principally through the sedative effects of bromides, luminal and epanutin. The action of these drugs is suppressive in nature which from the homoeopathic point of view, is undesirable. As a result of this treatment, a drug disease may be superimposed on the natural one, epilepsy, with deleterious effects on the health of the patients.

Since I have found from experience that epilepsy is closely associated with local infection of the nasal sinuses, I have primarily directed treatment towards the elimination of the sinus disease. Consequently I have developed treatment in three phases:

(a) Treatment of acute sinusitis.

(b) Treatment of the chronic constitutional ill health.

(c) Palliative treatment of the epileptic seizures as they occur.

(a) Treatment of acute sinusitis is in the nature of short term treatment in dealing with any acute catarrhal infection which may arise. I have found

that the remedies most frequently indicated were Arsenicum alb., Kali bich., Natrum mur., Pulsatilla.

(b) I have found that adequate treatment of the chronic disease is the most important object in the cure of epilepsy. This is long term treatment, the results of which appear gradually.

All the patients in this series were catarrhal or sycotic subjects and all, except one, had anti-sycotic remedies administered. These remedies included Thuja (7), Tuberculin bov. (5), Natrum sulph. (2), Medorrhinum (2), Sycotic co. (2), Morgan sycotic co. (1), Nitric acid (1). One patient made good progress on Sulphur although this is not usually considered an anti-sycotic but an anti-psoric remedy. Nevertheless, Sulphur does have a good effect on nasal sinusitis, which in this case was markedly improved by this remedy. Other less frequently indicated remedies included Lycopodium for gastritis, Calcium phos. for rapidly growing 'nervous' child, Argentum nit. in a case having gastric pain as aura of fits.

(c) Palliative treatment of fits. In a majority of patients I have found the need for palliative treatment very infrequent. With successful constitutional treatment, the frequency of fits diminishes. Also, when the fits do occur, they are usually single and at infrequent intervals so that a palliative remedy is of little avail. However, in three cases the fits did occur at certain intervals with a frequency sufficient to justify the use of a palliative. In these cases I gave Cuprum metallicum with good results in two patients and with no effect on the third.

SUMMARY OF REMEDIES ADMINISTERED

Case No. 1: Thuja.
Case No. 2: Thuja, Tuberculinum bov.
Case No. 3: Sycotic co., Thuja., Tuberculinum bov.
Case No. 4: Tuberculinum bov., Lycopodium, Cuprum met., Calc. phos.
Case No. 5: Thuja, Natrum sulph., Medorrhinum, Proteus.
Case No. 6: Phosphorus, Calc. phos.
Case No. 7: Morgan co. and Sycotic co., Medorrhinum.
Case No. 8: Thuja, Tuberculinum bov., Argent. nit.
Case No. 9: Sycotic co.
Case No. 10: Ars. alb., Kali bich., Thuja, Tuberculinum bov.
Case No. 11: Natrum mur.
Case No. 12: Thuja, Nitric acid.
Case No. 13: Sulphur, Kali bich.
Case No. 14: Ars. alb., Kali bich., Natrum sulph.

REASONS FOR REMEDIES ADMINISTERED

Case 1: Thuja. History of vaccination which did not 'take'. Susceptibility to head colds and nasal catarrh, in cold damp weather in winter. Nasal discharge albuminous or purulent in character.

Case 2: Thuja. History of susceptibility to 'head colds' in cold damp weather.

Tuberculinum bov. Timid, shy and fear of dogs. Nasal catarrh, cold hands and feet.

Case 3: Sycotic co. Intestinal nosode associated with the sycotic constitution. History of vaccination, susceptibility to head colds. Previous tonsillectomy, diphtheria and measles.

Thuja. As antidote to vaccination and in treatment of nasal catarrh and sinusitis in cold damp weather.

Tuberculinum bov. Symptomatology also suggests the presence of 'tubercular diathesis'.

Case 4: Tuberculinum bov. Susceptibility to head colds, otitis media, and mastoiditis and appearance of 'tubercular diathesis'.

Lycopodium. Nervous, fears dark, desires warm food, heat sens.

Calc. phos. Rapid growth, tall and lean, narrow chest, nervous.

Cuprum met. For treatment of fits as they occur.

Case 5: Thuja and Natrum sulph. Both remedies useful in the treatment of nasal catarrh occurring in cold damp weather, when there is also a history of vaccination. Nasal discharge albuminous or purulent.

Medorrhinum. As variant in the treatment of sycotic constitution, associated with nasal sinusitis.

Proteus. Intestinal nosode useful in the treatment of spasmodic affections.

Case 6: Phosphorus. In the treatment of epistaxis of vicarious menstruation.

Calc. phos. Growing rapidly. Tall and lean. Long narrow chest. Timid and shy. Easily excited.

Case 7: Morgan co. and Sycotic co. Sycotic history, Scarlatina. Susceptibility to head colds and nasal catarrh. Lassitude, tired easily. Leucorrhoea.

Medorrhinum. Leucorrhoea. Excoriating, brown colour, fishy odour. Heat sensitive.

Case 8: Thuja. Anti-sycotic remedy, antidoting vaccination and measles.

Tuberculinum bov. Mental apathy. Night sweats. Nasal catarrh, and susceptibility to head colds. Symptoms suggest possible 'tubercular diathesis'.

Argentum nit. Fits associated with flatulence in stomach as aura.

Case 9: Sycotic co. Fits began after scarlatina. Is susceptible to head colds and nasal catarrh in cold damp weather. Leucorrhoea, brown colour, fishy odour, excoriating.

Case 10: Thuja. History of scarlatina, otitis media and T.B. peritonitis. Susceptible to head colds and nasal catarrh in cold damp weather.

Arsenicum alb. During acute stage of rhinitis.

Kali bich. During subacute stage of rhinitis.

Case 11. Natrum mur. Susceptibility to head colds in cold damp weather. Nasal catarrh. Discharge watery. Has craving for salt especially during menstruation.

Case 12: Thuja. Susceptible to head colds in cold damp weather. Nasal catarrh with thick albuminous discharge. Enlarged tonsils. Leucorrhoea began after confinement. Feels generally worse in a.m. Weepy when alone, easier in company.

Nitric acid. Leucorrhoea excoriating, brown colour, foul fishy odour.

Case 13: Sulphur. Susceptible to head colds and nasal catarrh in cold damp weather. Tendency to weep openly, >in company. Fears personal attack. Furunculosis and generally an unwashed appearance of the skin.

Kali bich. During subacute rhinitis.

Case 14. Natrum sulph. Indicated for aftereffects of injury to head and skull. Susceptible to head colds and nasal catarrh especially in cold damp weather. Mental depression. Broody.

Arsenicum alb. During acute rhinitis.

Kali bich. During subacute rhinitis.

RESULTS OF TREATMENT

The results of treatment, as shown by an analysis of my cases, are both interesting and encouraging. In assessing the degree of improvement in each case, I have found two criteria necessary. To be satisfactory there must be

(1) Diminution of the frequency and severity of the epileptic seizures.

(2) Improvement in the constitutional health of the patient.

I have classified the results in four categories according to the degree of improvement shown by diminution of the fits.

(a) *Excellent.* Two cases have been continuously free from fits over a period of four years—cured according to the definition quoted from Price. One case who has been under observation for eight years has had one fit only during this period. On this occasion she was beginning new employment in an explosives factory and the occurrence of the fit coincided with the emotional disturbance associated with the new experience.

(b) In this category there are nine cases who have shown marked diminution in the frequency of the fits. However, the period of observation of each case has been less than the three years necessary to establish a cure. The shortest period of freedom from fits is three months and the longest twelve months, with an average of about seven months. With further treatment, it is possible that in many of these cases the fits will become gradually still less frequent and so be classified as excellent.

(c) *Fair or slight improvement.* Two cases appear in this category. Although improvement has begun in each case, it is not sufficiently pronounced for me to classify it as favourable. In one case, subject to major and minor attacks there has been a favourable reduction in the major attacks while the minor ones have continued as previously. In another patient, the frequency of fits was reduced from one every 4-5 days to one every 10 days. In the latter case the duration of treatment was too short to obtain greater improvement.

(d) *No improvement.* Only one of the 14 patients failed to benefit from treatment, even after a prolonged period. The frequency of fits was, on an average, 50 per month and no reduction in frequency was ever established. His mental condition gradually deteriorated and latterly led to dementia.

Finally, I shall summarize the results which I have obtained.

Two of the 14 cases (15 per cent.) were cured according to recognized standards. Nine (65 per cent.) showed marked recovery with a prospect of cure. So that 11 patients (78 per cent.) gave most encouraging results. In two cases (15 per cent.) progress was not sufficiently good to be more than hopeful about future recovery. In one patient (7 per cent.) no improvement whatever was observed.

PROGRESS OF THE CONSTITUTIONAL HEALTH OF THE PATIENT AFTER TREATMENT

Reduction in the frequency of the epileptic fits is not the whole story in these cases—good as that may be. Just as important is the improvement in the general health of the patient.

It is worthy of note that all patients except one showed good progress in both physical and mental wellbeing, a change which was easily seen and was most significant.

The most striking changes occurred in the two patients who may be pronounced cured of the epileptic attacks. The improvement seen in the nine patients whom I considered to be making favourable progress towards the cure of epilepsy, was definite though less marked. In the third class of patient, the two in whom the epileptic attacks became slightly less frequent, the improvement in general health was present, although less pronounced. Finally, in the case in which the epileptic fits continned unabated, the general condition of mental and physical health continued to be poor.

In the 13 cases who improved, I observed the following changes in health.

The nasal catarrh became less severe and the susceptibility to attacks of rhinitis and sinusitis gradually diminished. In other words, the patient developed a greater immunity to these infections. In the most favourable cases, the tendency to nasal infections disappeared altogether. Coincident with this improvement, there appeared an increased vitality and feeling of wellbeing generally. In the sphere of mental health, this meant a change from the apathy, mental depression, melancholia, weepiness, fears and want of confidence, and lack of interest in work and play which characterized the previous state of health. With treatment, these symptoms gradually disappeared and the patients showed greater alertness, a more cheerful disposition, keener interest in work and a desire for more mental and physical activities—all signs of a healthier vitality and a more normal mental outlook.

It is noteworthy, too, to find that the chorciform twitches, from which

some patients suffered, also became less severe and in two cases finally disappeared.

Gastritis was gradually eliminated and the patients enjoyed greater appetite for food and freedom from bilious attacks. The patient who had craving for salt lost this craving during the period of improvement.

In those patients who had constipation, the bowel function returned to normal.

The appearance of the skin improved and produced a healthier complexion. In the patient who suffered from acne and furuneulosis, the skin healed and no blemishes were afterwards found.

Those patients in whom leucorrhoea was prominent had marked relief from this discharge as health improved, it changed its character and it became less in amount, albuminous and bland and lost its foul fishy odour. Finally, in most favourable cases, it disappeared.

It is always an intriguing and interesting experience to attempt to forecast the progress of a patient suffering from epilepsy. It is unwise as it is difficult to express an opinion as to the future progress and each case must be considered individually. From my experience, I find it impossible to estimate the ultimate possibilities of progress until the patient has been under observation and treatment for at least 6-12 months. It is only then that the changes in health become so apparent that subsequent progress may be assessed. From experience, I have found that the possibilities of cure of epileptic attacks are greatest when the patient shows marked evidence of relief from the focal infection of the nasal sinuses, associated with favourable changes in the mental and physical spheres of health.

A question often asked is, is it possible to cure epilepsy? That depends on what is meant by 'cure'. In Price's textbook, cure is defined as "freedom from fits for three years after continuous treatment during this period." In this category two patients whom I have quoted should be considered cured. However, a proviso is added that occasional fits may be expected at any time depending on the circumstances. In my opinion, this definition is not strict enough and cure should mean, lifelong abstinence of fits in one who has been a confirmed epileptic. I make this statement since one cannot be certain that a patient may not suffer from a fit at any time. I have found in treating these patients, that it is only when they are fit and well that they are free from epileptic seizures. Too many adverse circumstances are in operation to prevent a patient being perfectly fit at all times. An acute infection of the upper respiratory tract involving the nasal sinuses is able to render him liable to a recurrence of epilepsy. Also, any general condition of ill health which reduces vitality or lowers resistance to disease in any way, will predispose to a return of the seizures, e.g. an acute disease or an emotional disturbance such as grief, fright, etc. However, if the deviation from health, whatever its cause, is treated immediately with the appropriate remedy the predisposition to the epileptic attacks may be overcome and their onset

averted. It is therefore important that constant and alert supervision of the patient's health be maintained to deal promptly with any infective or other circumstances which may precipitate an epileptic attack.

CONCLUSIONS

From a survey and analysis of the clinical records of these 14 cases, I noted the following features.

(1) That 13 patients were subjects having a constitutional illhealth of the 'catarrhal' type, i.e. they suffered from the Hahnemannian sycosis.

(2) These patients were particularly susceptible to catarrhal infections of the nose and nasal sinuses.

(3) In this series of cases, the epileptic fits were associated and coincident with infection in the nasal sinuses and nose.

(4) Relief from epileptic fits was obtained in these 13 cases when the nasal sinus infection diminished or cleared.

(5) In the single case who showed no strong evidence of nasal sinus infection the fits were associated with gastric derangement. This derangement may have been in the nature of an 'aura', or else evidence of catarrhal condition similar to nasal sinus infection in the other 13 cases.

(6) Finally, in these 14 cases described, I found that the absence or reduction in the number of epileptic fits coincided with improvement in the general health of the patients and also diminished severity of nasal sinus infection or complete absence of this infection. (*Concluded*)

—*The British Homoeopathic Journal*, March 1946