THE SCOPE OF HOMOEPATHY IN EPILEPSY

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IN
EPILEPSY

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PREFACE TO THE SECOND EDITION

It is indeed a matter of gratification for an author to find that his book has proved immensely useful. The need for another edition in so short a time is ample evidence for its utility and popularity.

The book has been thoroughly revised and two more case reports have been incorporated in this new edition.

I thank my readers and learned colleagues for their acceptance.

At the same time I take the opportunity of recording my obligation to C.Ringer & Co. Calcutta, who has spared no pains to publish and circulate most of my books in India and Bangladesh.

S. P. Dey

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PREFACE TO THE FIRST EDITION

Epilepsy is a common disease in India. Nearly 1% of the general population, suggested epidemiological study in India, might be affected by Epilepsy.

It is generally considered incurable. It is also common belief that life long treatment is required to keep the seizure attacks under control. That is why in the remote villages many epileptic patients live or die untreated. But the case is not so. Epilepsy is quite curable by homoeopathic medicines provided the auxiliary measures, the exciting and maintaining causes etc. are taken care of. It is also worth mentioning here that the physicians should at the same time alert the patient or the party as to the danger (e.g. street accident, drowning, accident by fire, status epilepticus etc.) that an epileptic patient may face any time, if proper precautions are being neglected.

This booklet attempts at giving an outline of the curative treatment of Epilepsy. I shall be happy if it comes in the help of those for whom it is published.

S.P.DEY

Dedicated

to

my mother

Late Raikishori Dey

EPILEPSY

DEFINITION :

It is difficult to define Epilepsy because of its several different presentations. However, it may summarily be defined as paroxysmal attacks of **cerebral dysrhythmia** due to disorganised electrical discharges from many nerve cells of the brain, characterised clinically by sudden unconsciousness (partial or complete) with or without convulsion and various post-ictal phenomena e.g., obsessiveness, automatism, hypersensitivity, disorder or perception etc. Single such episode is called a **seizure,** but chronic **recurrent seizures** are **considered as seizure disorder or Epilepsy.** Be it primary (idiopathic) or secondary (symptomatic) to some organic cause in the brain, **if the seizures themselves need treatment, it may be considered as Epilepsy .**

PATHOPHYSIOLOGY :

Abnormal hypersynchronous electrical discharges from many nerve cells, especially of the cerebral cortex, is the basic pathogenic mechanism in the production of seizures. Electrical signals are transmitted from one nerve cell to the other along the fine extensions of nerve cells meeting one another. So long the transmissions of these electrical signals continue to occur in a harmonious way, no problem arises. But if this harmony is lost due to any reason whatsoever and there is **untimely and disorganised**

discharge of electrical impulses, seizure attack takes place.

Various metabolic disturbances may take place within the brain during seizure discharges. There may be *rise in the extracellular potassium and fall in the extracellular calcium* concentration. Both of these may again excite seizure discharges. During an attack large quantity of neuropeptides and neurotransmitters may be released. There may be reduction of inhibitory mechanisms also, which again may excite Epileptic discharges. **Hereditary predisposition** plays an important role in the development of primary or idiopathic epilepsy. *Structural lesions in the brain* e.g. scars, tumors, arterio-venous malformations etc. may lead to focal seizures. The common sites of focal seizure discharges are frontal lobe, temporal lobe and limbic system.

BROAD CLASSIFICATION :

Epilepsy may broadly be classified into two groups :

A. Primary or Idiopathic

B. Secondary or Symptomatic

Primary, Idiopathic Epilepsy :

Chronic, recurrent seizure attacks **without any obvious cause** excepting the E.E.G. abnormalities, may be defined as Idiopathic Epilepsy. Here, Epilepsy itself is the disease resulting from some hereditary predisposition responsible for abnormal seizure discharges. In such cases, seizure attacks are not secondary to any primary cause in the brain, hence it is called primary epilepsy. In fact, this is the common form of Epilepsy we generally come across in our day to day practice.

Secondary or Symptomatic Epilepsy :

Recurrent seizure attacks **secondary to some primary cause in the brain** or elsewhere in the system as a whole, is called symptomatic or secondary epilepsy. Here seizure disorder is not the disease but the *result of some primary defect.* The causes responsible for secondary epilepsies include :

1. Cerebral palsy 2. **Head injury 3. S.O.L. in brain** 4. Meningitis and Encephalitis. 5. Arterio-venous malformations 6. Metabolic disturbances e.g. rise in extracellular potassium concentration in brain etc. 7. C.V. accidents e.g. cerebral haemorrhage, thrombosis, embolism etc. 8. Systemic diseases e.g. uraemia, hypoglycaemia, hypocalcaemia, cholaemia etc. 9. Alcoholism 10. **Drug or alcohol withdrawal.**

TYPES :

According to the source of origin of abnormal electrical discharges in the brain, epilepsy may be divided into two types:

A. Generalised Epilepsy and

B. Partial Epilepsy

Generalised :

If the abnormal electrical activities originate diffusely from both the hemispheres of cerebral cortex simultaneously, it is called generalised epilepsy.

Partial :

If abnormal electric activity originates from one particular part of the cerebral cortex and remains localised there or spreads to both the hemispheres, it is called partial seizure.

SUB-TYPES

According to clinical manifestations, Epilepsy may again be subdivided as follows :

A. Generalised :

1. **Grand Mal** or tonic-clonic convulsive type.

2. Petit Mal or absence (non-convulsive).

3. Infantile spasms.

B. Focal or partial :

1. **Simple partial** including jacksonian epilepsy.

2. **Complex partial** – temporal lobe epilepsy or psychomotor epilepsy.

C. Status Epilepticus.

GRAND MAL OR TONIC-CLONIC CONVULSIVE EPILEPSY :

Most of these cases belong to the primary (idiopathic) generalized group of seizures and the rest result from secondary generalisation of partial seizures. The characterisitic features of the primary generalised seizures are as follows :

1. **Age** : Generally starts after the age of 2 years and may continue all through the life.

2. **Prodromal symptoms:** In some cases, few prodromal symptoms may be noticed preceding the attack. They are insomnia, anorexia, mood change, myoclonic jerks etc.

3. **Aura** : May or may not be present. If present, they are – uneasy sensation in epigastrium, twitchings, tingling, empty sensation in head etc.

4. **Sudden loss of consciousness** with or without an involuntary *'cry'*. The patient falls on the ground, opisthotonic with tonic contraction of muscles.

5. **Stage of tonic contraction** : There is tonic contraction of muscles of trunk and limbs and remains rigid for many seconds. There may be cyanosis, *tongue biting and involuntary urination.* Pupils may be dilated and fixed.

6. **Clonic stage** : Tonic stage is followed by rhythmical clonic contraction (jerking) of muscles of all four limbs. The stages of tonic and clonic contraction of muscles last for about 2 minutes.

7. **Stage of relaxation** : Clonic stage is followed by flaccid relaxation of all muscles. This is generally associated with noisy breathing, profuse perspiration and salivation. The patient may remain unconscious for few more minutes and gradually returns to consciousness.

8. **Post-ictal phenomena** : There may be headache, fatigue, drowsiness, soreness of muscles and *mental confusion.* The patient may even *fall asleep for hours after the attack.*

9. E.E.G. : Abnormal tracing with spikes and waves or slow and sharp wave discharges originating from both the hemispheres.

PETIT MAL OR ABSENCE :

This is a variety of primary (idiopathic) generalised seizures. Its characteristics are as follows :

1. Age : Petit mal generally starts between 6 to 14 years of age. First attack of Petit mal in adult age is exceptionally rare.

2. No aura.

3. There may be **momentary loss of consciousness** for few seconds only without any loss of postural control or generalised convulsion.

4. During seizure attacks, the patient may be **inattentive** in the middle of his work ; may **stop talking** in the middle of conversation or may even **stop** in the middle of a voluntary **movement**, there may be blinking, **involuntary facial** movements and **jerking of limbs.**

5. During longer absence attack, **automatism** may take place.

6. The attack *terminates abruptly very quickly* and the patient becomes aware of the environment as before the attack. It appears as if nothing has happened and others who may be present all around may not know anything about such abnormalities in the patient.

7. May turn into generalised tonic-clonic (Grand mal) seizures in course of time. **No post-ictal manifestations.**

8. **E.E.G. :** Typical 3 Hz per second spike or slow wave discharges (Diagnostic).

INFANTILE SPASM :

This is a variety of generalised seizure-disorder in infants. Its characteristics are :-

1. **Age :** Infantile spasm starts from birth upto 3 years of age.

2. This generally results from asphyxia or **cranial injury** during **birth** which results in anoxic encephalopathy followed by seizure attacks. **Tuberus sclerosis,** a genetic disease may also lead to Infantile spasm.

3. Generally associated with irreversible damage in the brain; **mental retardation** occurs in about 90% cases.

4. *Convulsive jerking of entire body generally in flexion* is the basic character of Infantile spasm.

5. **E.E.G :** Grossly abnormal brain waves may persist in between the seizure attacks and is known as *hypsarrhythmia.*

SIMPLE OR ELEMENTARY PARTIAL SEIZURES

This is also called focal epilepsy, because the seizure manifestations are localised in a particular part or organ of the body. The characteristics are :

1. **Awareness of the environments is not lost.**

2. The phenomena may be sensory, motor, psychic or autonomic.

a) **Motor :** Recurrent focal contractions of one part of the body.

b) **Sensory :** Paresthesias, burning, tingling or numbness etc.

c) **Psychic :** Anticipatory fear, anxiety, illusion, hallucinations etc.

d) **Autonomic :** Abnormal sensation in an organ as if something experienced before ; sensation as if something rising from the stomach etc.

3. **No aura or post-ictal phenomena.**

4. **E.E.G. :** Disorganised spike discharges from the area of cerebral cortex.

JACKSONIAN EPILEPSY :

This is a variety of *focal motor epilepsy.* Rhythmic twitching *starting in thumb may slowly spread to hand, arm and face of the same side* and may lead to a generalised convulsion of tonic- clonic type. Hughlings Jackson first demonstrated it and hence known as Jacksonian epilepsy. The post-ictal manifestation is characteristic ; there may be transient paralysis of the affected limb–known as **Todd's paralysis.** The *E.E.G.* findings are diagnostic – abnormal spike discharges originate in the contralateral corresponding area of frontal motor cortex.

COMPLEX PARTIAL SEIZURES

This is also known as *temporal lobe* or psychomotor *epilepsy*. In this variety, seizure attacks present a variety of manifestations–hence called complex partial.

The characteristics are :

1. Starts at puberty or later years.

2. **Periodic attacks of behaviour changes :**

The patient loses awareness of the environment and performs various involuntary activities.

3. **Auras :** A variety of auras is a predominant feature in this type. They are :

a) Teeth grinding .

b) Chewing motion of the mouth.

c) Turning head to one side or abnormal movements of the limbs.

d) Smell of burning rubber or some other peculiar smell.

e) Drinking or pouring water.

f) Undressing.

g) Urinating or defaecating.

h) Spitting.

i) Noisy sound in ear.

j) Various illusions and hallucinations.

k) Groundless fears.

l) Sensation of a disagreeable taste etc.

4. **Ictus :**

a) The patient suddenly stops his activity with loss of awareness of the environment.

b) Prolonged staring spells.

c) Lip smacking, aimless wandering, swallowing or drinking water, laughing or crying, frequently urinating or defaecating.

d) Automatism eg., priking at one's clothes.

e) Usually lasts 1-2 minutes.

5. **Post-ictal phenomena :**

a) Well marked and lasts for about 2 to 20 minutes - may continue for hours together.

b) *Slow recovery with headache and drowsiness.*

c) Obsessiveness.

d) Hypersensitivity e.g., extreme irritability.

e) Inattention.

f) Undressing.

g) Sexual excitement.

h) *Self injury and injury to others.*

i) Religiousity and self absorption.

j) Amnesia of the events during the seizure attack.

6. **Interictal period :**

Behaviour problem may continue to persist for long.

7. **Causation :**

a) S.O.L. in temporal lobe.

b) Head injury.

c) Sequella of Meningitis or Encephalitis.

d) Developmental defect.

e) C.V. accidents.

f) Structural lesions e.g. Vascular malformations.

8. **E.E.G. :**

Disorganised spikes or slow wave electrical discharges *originating mostly from temporal lobes.*

Rolandic Seizures :

This is also known as "*benign focal epilepsy of childhood*".

The characteristics are :

1. There may be focal or Generalised seizure attacks especially during sleep .

2. Seizures disappear spontaneously as the child grows up.

3. **E.E.G.** : During sleep :

Spikes originate around the rolandic fissure of the brain.

Seizures from head injury :

Severe head injury or cerebral contusion may lead to seizure attacks both during or long after the trauma. The manifestations depend upon the site and extent of the lesion. History of injury, E.E.G. findings and C.T.scan will help to arrive at the diagnosis. Focal motor or focal sensory attacks are common in such cases, but tonic-clonic generalised seizures may also develop.

Post Meningitic or encephalitic seizures :

Seizures may develop due to an attack of meningitis or encephalitis which are easy to diagnose from the presence of fever, neck rigidity, loss of consciousness. C.S.fluid findings etc. Generalised seizure attacks may follow after recovery.

Parasitic disease - oriented seizures :

Generalised seizure attacks may result from infection with Taenia solium, schistosomiasis cystiscercosis, cerebral malaria etc.

Seizures due to cerebral tumors :

Focal or generalised seizure attacks may result from cerebral tumors. Sometimes psychological abnormality may follow. However, the signs and symptoms depend on the location, nature and size of the tumor.

Seizures due to diseases of the vascular system :

Cerebro-vascular accidents (Stroke), vasculitis including S.L.E. and vascular malformations may lead to seizure disorder. The seizures may be generalised or partial with or without mental depression, mood changes and other psychological problems.

Seizures due to metabolic disturbances and poisoning :

Metabolic imbalance due to defects in metabolism of glucose, Calcium, Sodium ; toxic products from liver, urea, nitrogn etc. may lead to generalised seizure attacks. Poisoning by lead or thallium may also lead to generalised seizure attacks. Seizure attacks at any age suggest various metabolic disturbances.

Seizures due to sudden withdrawal of alcohol and drugs :

Barbiturates, antidepressants, stimulants and other drugs if withdrwan suddenly may lead to generalised seizures. Less frequently alcohol withdrawal may also lead to the same.

STATUS EPILEPTICUS :

Successive attacks of seizures without any free interval in between, is called status epilepticus. This may occur in any

type of epilepsy, but the danger is more in **grand-mal status.This may lead to grave consequences if not diagnosed and treated in time.** *The patient may die of hyperpyrexia, acidosis and anoxia* and the mortality rate is over 10%. Considerable *permanent brain damage* may result in about 10-30% cases. **Sudden withdrawal of anti-epileptic medicines** is one of the common and important causes of status epilepticus.

Partial complex status epilepticus may lead to persistent mental confusion, automatism or other behaviour problems lasting for a long period of time.

INVESTIGATION AND DIAGNOSIS OF EPILEPSY :

1. **History of the case :**

a) In adults, history from the patient himself is to be taken as regards the duration of suffering, the mode of onset, the auras, the post-ictal phenomena, history of drug or alcohol abuse etc.

b) History from the witness and members of the family as regards the exact nature of the seizure attacks; the duration of the attacks; the various manifestations during the ictus, post-ictal and inter-ictal period ; history of drug addiction or alcoholism, history of accident resulting in head injury ; history of hypertension and heart diseases : history of using antidiabetic or antidepressant drugs etc.

2. **Age of the patient :**

a) Seizures in newborn infants *upto 2 years* of age suggest **infantile spasm** due to anoxic encephalopathy from asphyxia or intracranial birth injury; infection of the

imbalance including hereditary errors of metabolism : genetic defects e.g. tuberus sclerosis, congenital A.V. malformation etc.

b) Seizures in children from 2 to 14 years of age - Suggest Idiopathic *grand mal* or *petit mal* epilepsy, febrile seizures, injury to head and infection of the nervous system.

c) Seizures in age group between *12 to 18 years* - Suggest Idiopathic epilepsy, A.V. malformations, head injury, drug or alcohol withdrawal.

d) Seizures in young adults from *18 to 35 years* of age suggest - brain tumor, head injury, drug or alcohol withdrawal.

e) Seizures *after* the age of 35 years suggest–stroke (C.V.accidents), brain tumor, metabolic disturbances including renal and liver failure, hypoglycaemia and alcoholism.

3. **Duration of the ictus :**

If lasts for **few seconds to 2 minutes**, it is suggestive of *Idiopathic* disorder ; if lasts longer, it is suggestive of some structural lesion in the brain or other seizure disorders.

4. Prominent auras and post ictal behaviour problem is suggestive of *complex partial seizure.*

5. Large brown spots on skin or port-wine nevi on face suggests–neurofibromatosis , tuberus sclerosis or Sturge-Weber disease.

6. Sudden paralysis or speech disorder resulting from obvious infection in ear suggests brain abscess.

7. Seizures with impaired co-ordination suggest metabolic disturbances.

8. *Seizures recurring frequently inspite of anti-epileptic drugs suggest organic lesion in brain.*

9. Seizures with irregular pulse, heart murmurs, sinus pause etc. suggest cardiac involvement.

10. Seizure attacks with joint inflammation suggest S.L.E.

11. Sudden seizure attack in a patient using antidiabetic medicines suggests hypoglycaemia.

12. Elderly person suddenly losing consciousness with seizure suggests cardiac problem.

13. *Bed-wetting in adults should be investigated to exclude seizure disorder.*

14. *Persistent headache, vomiting* and a change in behaviour before seizure attack suggests *S.O.L. or subdural haematoma.*

15. **Thorough examination of the heart :**

Including E.C.G., Echocardiography, Holter monitoring etc. are absolutely necessary to exclude cardiac problems.

16. **Blood examination**

a) Serum prolactin level may be high.

b) Hypoglycaemia in patients using antidiabetic drugs.

c) Hypo or hypercalcimia or natremia in seizures due to metabolic disturbances.

17. **X-ray of Skull :** to detect cerebral tumor, fracture of the skull etc.

18. **C.T. Scan : to exclude organic lesion in brain.**

19. **M.R.I. : for visualising brain structures in detail.**

20. **P.E.T.**: may reveal metabolic changes in the brain.

21. **Angiography for vascular malformations etc.**

22. **Lumbar puncture :**

To exclude nervous system infections, sub-arachnoid haemorrhage and high C.S.F. protein concentration.

23. **E.E.G. :**

For confirmation of epilepsy and its type, E.E.G. examination is a must.

a) Spikes and slow waves indicate seizure activity.

b) *Spikes and waves* or slow and sharp wave discharges *originating from both* the hemispheres of cerebral cortex are diagnostic of *generalised seizures.*

c) *Typical 3 Hz* per second *spike or slow wave discharge* is diagnostic of *Petit mal* or absence.

d) Spike discharges originating *from a particular* area of cerebral cortex is diagnostic of *simple partial seizure.*

e) Spike discharges originating from the *corresponding contra- lateral area of frontal motor* cortex is diagnostic of *Jacksonian epilepsy.*

f) Spikes or slow wave discharges originating mostly from *temporal lobe* is diagnostic of *complex partial seizure.*

g) Abnormal electrical discharge of less than one discharge every 4 seconds is diagnostic of subacute sclerosing panencephalitis (S.S.P.E).

GENERAL MANAGEMENT

1. During seizure attacks, care should be taken to *save the patient from inflicting bodily injuries.*

2. From previous experience if the patient can understand that an attack of seizure is going to occur, he should immediately place himself in a safe position and remove his artificial teeth if any.

3. A wooden object wrapped up with sterilised gauge may be placed in between the jaws before the attack to prevent tongue biting;–not to try this during seizure attack which may cause further injury.

4. During seizure attacks, the patient should be turned to one side–holding the patient's trunk and not the limbs.

5. All articles should be removed from the reach of the patient, but the patient's movements during seizures should not be interfered in any way.

6. Constant and close observation of the patient is necessary in complex partial seizures.

7. Not to give water to drink immediately after an attack of generalised seizure.

8. Patient must take rest for sometime after an attack; he should not start working immediately after.

9. For *status epilepticus*, the patient should immediately be transferred to a *hospital* or *nursing home.*

10. Diet : high fat and low carbohydrate diet may help to prevent recurrence.

11. Reassurance plays an important role in gaining self-confidence.

12. *Risky jobs are to be avoided* e.g., working in a machine etc.

13. *Risky sports are to be avoided* e.g.,playing football, swimming, boxing, climbing etc.

14. If seizures are well under control, the patient may lead a normal life with but few restrictions e.g. to avoid going near *fire, bathing in a pond or river etc.*

15. For S.O.L. in brain or A.V. malformations, *surgery followed by medicinal treatment* should be the method of choice.

16. For seizures due to metabolic and other systemic diseases, treatment of the original disease condition is imperative.

17. Group meeting of Epileptic patients along with the physicians may help to regain confidence, to remove frustration and depression, to learn how to adjust with the disease and for future plannings of life-style.

18. Anti-epileptic drugs should not be left with the patient ; the patient may overdose willingly to commit suicide.

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THE SCOPE OF HOMOEOPATHY IN EPILEPSY.

Homoeopathy has limited scope in epileptic seizures caused by cerebral tumor, vascular malformations and other structural lesions in the brain. In such cases, surgical removal of the lesion followed by constitutional treatment may help to prevent relapse of these lesions and thereby many patients may be saved.

In Idiopathic epilepsies, most of the patients may be completely cured by symptomatic as well as constitutional antimiasmatic treatment, though it may take a long time to arrive at permanent restoration of health of the patient.

Epileptic seizures due to metabolic diseases, nervous system infections, parasitic diseases and head injuries, are easily amenable to homoeopathy if properly treated. Most of the homoeopaths have wonderful experiences in curing cases of remote effects of head injuries even if received years ago.

Seizure attacks due to after effects of cerebro-vacular accidents (stroke) are also amenable to homoeopathic treatment.

Seizure disorder due to hereditary diseases like *Tuberous sclerosis* is generally considered as incurable. Homoeopathic treatment may prolong the life of the patients, palliate the sufferings and defer the onset of various complications.

Thus it is seen that the scope of homoeopathy is to be decided on the merit of the individual case and not by the name 'Epilepsy'.

Homoeopathic concept and approach

Epilepsy itself is not considered an independent disease in homoeopathy, rather the result of some primary underlying cause. A careful anamnesis of the history of the patient from birth till the onset of the epileptic seizures, birth history of the patient, mother's history during the period of pregnancy concerned and the family history (both paternal and maternal) will give a clear clue to arrive at the basic cause responsible for seizure attacks. *Inappropriate electrical activity in the brain is responsible for seizure disorder.* This abnormality in functioning of the neurones in the brain should be considered as a manifestation of psora or Syco-psora. Lack of proper functioning or inco-ordinated functioning of the brain cells remind us of psoric or syco-psoric miasmatic state being present in the background. To treat and cure a case of epilepsy, we are to know the fundamental cause (miasmatic state) responsible for the same. This we can do only from a proper anamnesis of the whole history obtained. The symptoms of seizure attacks may help us to palliate the patient during such attacks but eradication of the seizure dyscrasia is not thereby possible. Unless the basic miasmatic state is included in the symptomatology of the patient and an appropriate antimiasmatic medicine is selected constitutionally, no cure of epilepsy is probably possible.

Sometimes (though rarely), hereditary neuro-syphilis may result in seizure-disorder in a child or young adult. Here also, a careful anamnesis will help to elicit this. Ordinarily it may be very difficult to arrive at the diagnosis as such. Careful observation, special tact and thorough knowledge of pathology are essential to discover such miasmatic

blending. But once it is arrived at, the result of the remedy administered appears to be miraculous.

Grand mal and Petit mal epilepsies are to be treated with **Constitutional antimiasmatic medicines** for complete cure. Acute episodes need symptomatic medicines to take care of the seizures and to minimise their severity and duration.

Infantile spasms should be treated according to the totality of symptoms including *causation.* If causation is not covered, the medicine selected may fail to produce any desired result. If along with spasms, mental retardation is a prominent feature, prolonged constitutional treatment may result in cure of the seizure attacks and considerable improvement in mental sphere.

Elementary, partial, Jacksonian and Rolandic seizures should be treated constitutionally with antimiasmatic medicines covering both psora and sycosis.

Complex partial seizures generally need **syco-syphilitic** medicines or *complex miasmatic* medicines covering predominantly all the three miasmatic states. These cases are comparatively difficult to tackle because of considerable psychological involvement.

In cases of **post-traumatic** seizures, the exact nature of *head injury* is to be noted. The particulars relating to trauma are essential in the correct selection of medicine. For example, whether the trauma was due to a blow, injury by blunt instrument like a bamboo-stick, a fall from a height, a cut wound, car accident, street accident and so on. Routine use of Arnica or Natrum Sulph may not be sufficient. Miasmatic anamnesis is not necessary in such cases excepting if and when the latent miasmatic state

flares up due to trauma. But whether the seizure attacks are the direct result of trauma or due to remote effects of contusion, are very much essential to take cognizance of. In post infective seizures, symptomatic medicines covering the symptoms of illness should be selected first. Later on, constitutional medicines are to be selected to remove the after effects or the dyscrasia caused by the infectious disease.

In parasitic disease oriented seizures, constitutional antimiasmatic medicines are to be selected. In most cases, Psora is the basic cause, but at times a mixed miasmatic state may be responsible.

In **tumor related seizures**, antisycotic medicines covering the totality of symptoms are to be selected. Rarely, mixed miasmatic medicines may also be necessary. We must not forget the scope of surgery in such cases. **Surgical removal of the tumor followed by constitutional treatment should be the method of choice.**

Seizures due to vascular diseases: antisycotic medicines may be helpful in such cases to arrest the progress of the condition and to cure wherever possible. But we must keep in mind that vascular malformations are not generally amenable to medicinal treatment and surgical interference may have to be suggested as and when necessary. **In seizures due to metabolic disorders**, medicinal treatment is the only way out. Anti-psoric or anti- sycotic medicines are frequently found to be effective in such cases depending on the fundamental cause assessed.

Plan of treatment :

The first step is to diagnose the type of epilepsy the patient has been suffering from. Then if it appears to be amenable to medical treatment alone, homoeopathic treatment may be started as follows :

a) If the patient comes to us *without the history of using any anti-epileptic medicines* till that time, *constitutional homoeopathic treatment may alone cure the patients. Of course, symptomatic medicines may have to be given from time to time to palliate acute episodes.*

b) If the patient gives the history of using anti-epileptic allopathic drugs for fairly a long time past, *it is not wise to withdraw the drug immediately.* Because it may lead to Status - Epilepticus and the patient's life may be in danger. In such cases, gradual withdrawal of the allopathic drugs along with simultaneous homoeopathic constitutional treatment should be the method of choice. If the patient remains completely free from seizure attacks for few months, then only the allopathic medicine may be completely stopped.

E.E.G. tracing should be repeated before homoeopathic medication is discontinued. Because, it may so happen that the patient remains symptom-free for years together but the E.E.G. tracing remains abnormal. In such cases, possibility of relapses is always there especially if the patient is exposed to worries, anxieties, tension, physical and mental exertion etc.

List of possible medicines for acute episode of seizure attacks :

Bell, Cicuta, Cupram met, Oenanthe croc., Artemesia vul., Absinthium, Aethuja, Opium, Calc ars., Zincum met. Helleborus, Stram, Nux vomica, Kali phos, Kali brom. Arnica etc.

List of possible medicines for constitutional antimiasmatic treatment :

Calc carb, Kali carb, Nat c., Nat sulph, Thuja, Caust, Silicea, Lyssin, Kali brom, Ars alb., Medorrhinum, Syphilinum, Tuberculinum, Plumbum met, Phos, Staph., Mezereum, Aur met., Nit acid etc.

ILLUSTRATIVE CASES

CASE NO. 1

A boy aged 13 years was brought by his father on 30-8-89 for treatment of his epilepsy. He had been suffering from grand mal type of epilepsy for five years. He was cured of his ailments with Natrum sulph alone, prescribed on the basis of repeated head injury.

A) **Present complaints (as on 30-8-89) :**

1. **Repeated seizure attacks** - preceded by vertigo. Vertigo is immediately followed by unconsciousness and rigidity of the whole body. The limbs get flexed ; head deviates to right side ; mouth also deviates towards right side.

There may be foam at the corners of mouth and occasionally tongue biting may be present. The whole attack lasts for about $1\frac{1}{2}$ minutes to 2 minutes.

Post-ictal phenomena : profound and prolonged sleep ; heaviness of head persists for about 4 hours.

Time of occurence : The attacks may occur at any time but commonly between 10 to 11 a.m. or p.m.

2. Urticaria occasional for 5 years. No causative factors or modalities are available.

3. Dry dermatitis right hand especially the tips of fingers - 4/5 years ; persistent - all through the year, no definite modalities.

4. Habit of spitting here and there - since childhood.

B) **Past history :**

History of cut injury on left parieto - occipital region due to fall from a chair at four years of age ; six months after the said incident, again fell down from bed. History of measles at 3 years of age.

C) **Family history :**

1. Hypertension and P.T. (Paternal side)
2. Urticaria and Epilepsy (Maternal side)

D) **Generalities :**

Hot patient ; desires meat, salty food, extra salt : aversion - onions, sweets, milk ; Thirst + likes cold water ; sweat moderate in axillae, face and chest ; jerking of a limb or whole body at the commencement of sleep ; somnambulism ; cat-nap sleep ; mind–very much punctual in all

activities , intelligent , merit sharp , very tidy , likes to be alone , jealous , no fears.

E) **Clinical findings :**

E.E.G. report dated 8-4-86 : Seizure disorder.

F) **Anamnesis and Synthesis** :

The family history and generalities are suggestive of a mixed miasmatic state. The exciting cause was repeated head injury. Hence, a medicine is to be selected which covers the head injury as also the basic miasmatic state.

G) **First prescription** :

30-8-89. Natrum sulph 0/2 twelve doses. One dose to be taken every alternate day.

H) **Follow-up** : 9-6-90.

Natrum sulph was continued upto 0/10 till this date. In the meantime , he had occasional attacks of seizures though at longer intervals and of less intensity. Last such attack was on 31-5-90.

Considering the possibility of medicinal aggravation due to repeated doses of 50 millesimal potency, a single dose of centesimal is being preferred now.

Natrum Sulph 200/ one dose only in diluted form.

30-12-93 After Natrum sulph 200/ there had been no seizure attacks till this date. In the meantime his dermatitis and urticaria also did not relapse and he is leading a normal health at present.

E.E.G. report dated 30-12-93 **Normal tracing.**

Comment and conclusion :

Natrum sulph is a unique medicine to remove the after effects of head injury. Incidentally, it also covered most of the constitutional features of the patient. Hence his urticaria and dermatitis also responded nicely to Natrum sulph. The patient is still under observation and may need some antipsoric medicines before the treatment is concluded.

Latest Note : January 1998 - the patient is leading a normal life and till now he never had any further attack of convulsion.

CASE NO.2

"*Homoeopathy removes the symptoms but the disease remains*" – is the allegation which one can claim only when the true homoeopathic instructions are improperly implemented. The following case will justify it.

A boy aged 7 years was brought on 11-1-92 for treatment of repeated seizure attacks recurring at an interval of 1-2-3 months since his age of $1\frac{1}{2}$ year following a surgical operation of cleft palate. His uncle also had cleft palate.

However, his E.E.G. report on 22-10-84 confirmed convulsive disorder suggesting *idiopathic generalised epilepsy.*

The patient was chilly, restless and intelligent. He had scanty thirst, profuse salivation ; craving for sweets, meat, milk and warm food ; aversion to fish ; delayed healing of wound; **stool very hard, ball like** with difficult evacuation.

This case from the very history (including family history) and generalities presents conspicuously a mixed miasmatic state with predominance of syphilis. As such, he was administered Plumbum met in 50 millesimal potency starting from 0/2. The first month was event free but he had three seizure attacks within two more months, the intensity being lesser gradually. However, anticipating hindrance by Psoric block Sulphur - 200, one dose was administered which kept the patient event free for three more months. Then again he had a major attack for which Lyssin - 200, one dose was administered. The patient had not only the miasmatic state of Lyssin, but also the characteristic symptoms of stool, salivation etc. Moreover, the profound action Lyssin has in the central nervous system having stupendous power to curb the degenerative process, inspired me to administer Lyssin in this case.

The boy had no further attacks of seizure after the administration of Lyssin on 8-8-92. On 11-12-93 finding no attack of any seizure for more than 16 months, the party showed unwillingness to continue treatment. However, he was given a dose of Sulphur-200 to conclude the case but was advised to get fresh E.E.G. done and report if it is not normal. The second E.E.G. done on 15-1-94 revealed "*interictal neuronal hyperexcitability*" for which he was advised to continue treatment again. On 15-1-94 he was administered Cal. carb 200, one dose as a complementary to Sulphur. On 12-3-94 he again had, as I assumed, a mild seizure like incident with high fever. This may not be a convulsive or epileptic attack but possibility of recurrence of seizures after physical or mental abaressions we cannot rule out till the E.E.G. tracing becomes normal.

This case proves, if we take only subjective symptoms as the indicator then we are prone to err, as their

disappearance may often be doubtful about a cure. In fact. Hahnemann wanted to consider not merely one or two symptom similarity but the totality of symptoms which include all objective and clinical even the laboratory investigation findings. We can declare a case cured when all the abnormalities including the laboratory data become normal.

Obviously, the patient is still under treatment which shall be continued till the E.E.G. tracing becomes normal.

Last report dated 26-8-95 :

The party came for the last time and decided to discontinue treatment as he was not having any trouble for about one year and 4 months. Inspite of my repeated advice, they did not agree to have another E.E.G. of the patient as they considered it unnecessary. However, they were advised to report immediately if any further attack of fit recurs . But till now (January 1998) they did not turn up for further reporting.

CASE NO 3

A male patient aged 20 years came for homoeopathic treatment on 21-11-90. He had been suffering from seizure disorder for 11 years.

Along with the seizure disorder he also had chronic orchitis persisting for 4 years and susceptibility to catch cold easily since childhood days. His father had insanity.

He was a hot patient with tendency to offensive sweat all over. He had enough of thirst and much craving for

chillies. He had causeless irritability of mind but no outbursts, used to suppress his anger.

His last attack of seizure occured one and half months back following an attack of parotitis with fever and orchitis.

The patient was considered as mixed miasmatic with predominance of sycosis. But no medicine was given on the first day as the patient received one dose of Pulsatilla - IOM given by the previous physician one and half months back.

On 18-12-90, the patient reported another major attack few days back without any apparent cause. This time Medorrhinum-200, one dose was given.

Since then the patient never had any seizure attack and it may be presumed that Medorrhinum alone cured the patient of his epilepsy. But still he was subsequently given parotidinum for removing the after effect of fixed miasmatic state (Mumps), Syphilinum to eradicate the syphilitic orientation (insanity of father) and Sulphur, the King of anti-psorics with which the treatment was concluded.

E.E.G. report on 7-4-1980

Epileptiform activity emanating more often from left cerebral hemisphere anteriorly. The patient last reported on 14-2-1992 when a fresh E.E.G. was advised but the party did not get it done, probably considering the patient as cured having no complaints whatsoever.

CASE NO.4

A boy aged 11 years was brought on 23-1-84 for treatment of idiopathic generalised epilepsy (confirmed by E.E.G. on 22-2-82). He had been suffering from seizure disorder, the onset dating back to 6th year of life after six months of receiving antirabies injection for an episode of dog bite.

The attacks invariably used to take place at the beginning of sleep. Moreover, he would suffer from vertex headache from time to time. His mother suffered from Jaundice when he was in mother's womb. There were instances of piles and Bronchial asthma in many members of the family both paternal and maternal.

He was ambithermal patient with much sweat all over. He was thirsty desiring ice-cream, raw onions, sour and warm food with aversion to fish. He used to evacuate hard stool irregularly and profuse, pungent urine especially during day. He had profuse salivation during sleep. He was a fearless boy with forgetfulness and tendency to be irritated easily but cooling down soon.

On anamnesis, the patient was considered as mixed miasmatic with predominance of Syco-Psora. The generalities and the peculiar time of attack only at the commencement of sleep led me to think of Causticum which was administered on 23-1-84 in 50 millesimal potency (0/5-16 doses), one dose to be taken every alternate day. Gradually the potency was raised upto 0/18 by the time of which the attacks disappeared for more than three months, when considering the half-acute miasm lurking behind, Lyssin - 200, one dose was administered. An attack of seizure came after nearly two months of administering Lyssin. Hence Causticum again resumed

and continued upto 0/27 during the period of which he was completely free from seizure attacks but twitching and jerking in the limbs used to occur from time to time for which Agaricus and then Zincum Met was administered. However these jerkings completely disappeared by Bufo R.200, two doses given on 7-2-88. Afterwards he got treated for nearly two years more for some minor ailments like pain in neck, head etc.

E.E.G. report dated 22-2-82.

Occasional, *bilaterally paroxysmal dysrythmia* recorded throughout.

Impression : Convulsive disorder.

E.E.G. on 3-1-90 : Report says **Normal E.E.G. record.**

CASE NO.5

This case is interesting because here, even after E.E.G. report being normal the patient could not become free from transient attacks of black out or reeling after strenous physical and mental exertion. It may be due to inherited hypersensitivity of nervous system and may persist for fairly a long time even after apparent cure of her seizure disorder. This hypersensitivity may also be cured spontaneously afterwards. But the fact is that I have not yet been able to cure the patient completely, though frank seizure attacks are not there any more. I would be pleased to see the patient cured by any of my colleagues but the patient's reluctance to go anywhere else stands here as impediment. However, she is going to marry soon confident of a feeling that she is cured.

Here, there were seizure attacks from the 9th year of life preceded by an attack of chicken pox which again was preceded by an attack of rheumatism. She used to have

unconsciousness for 2-3 minutes without any convulsion. In the family, there was history of pulmonary tuberculosis. Diabetes mellitus. fainting spells in many members and rheumatism.

She was a hot patient with canine hunger and craving for onions, warm food, eggs and sour food. She had burning sensation during micturition from time to time. She also had much acne simplex on her face. It was no doubt a case of mixed miasmatic state with predominance of Sycosis as evidenced by the history of the patient, the family history and the generalities. Obviously, it was **Thuja** occ. which covers the miasmatic back-ground as also the other symptoms of the patient, **was administered on 11-8-83** in 50 millesimal potency starting from 0/1 - 16 doses, one dose to be taken daily morning. She remained free from attacks for a fairly long period but after one dose of Sulphur 0/5 for exacerbation of acne and flared up psoric state, there was one more attack. Again Thuja occ. was administered in 200th, only one dose. The patient improved steadily and gradually. Thereafter she was administered Bacillinum -200, Medorrhinum -200 and Syphilinum 1 M - all in single doses to remove the blocks as and when seemed necessary, considering the then existing symptomatology.

The patient reported for the last time on 14.1.93 . Another E.E.G. on 25.9.92- recorded normal tracing. I must admit here that the patient should not yet be considered as cent percent cured, owing to the fact as stated in the beginning of the case history. She is advised to report me immediately after any untoward incident supervenes.

Latest report :

The patient did not turn up till now (January 1998) for any further reporting.

E.E.G. dated : 07/09/83 :

Occasional bilateral and paroxysmal discharges of high amplitude sharp waves recorded mainly during activation procedures.

Impression : Convulsive disorder.

E.E.G dated 17-4-87

Impression : Minimal paroxysmal features

E. E.G. dated 25/09/92

Impression : The E.E.G. record is within normal limit.

CASE NO.6 :

Temporal lobe Epilepsy (Cerebral Aneurysm ?)

A male patient aged 36 years came for consultation on 25-7-81. He had been suffering from epileptic convulsions for about 1 year and the last attack was on 18-7-81. He did not have any further attack of convulsion following constitutional homoeopathic treatment. It is interesting to note that he was cured of his convulsive attacks by Thuja and Thuja alone.

Present complaints (as on 25-7-81) :

1. Epileptic convulsions from august 1980. Till now five convulsions occured; the last one on 18-7-81.

Before attack, the toes of the left foot start twitching followed by twitching and stiffness of the left leg ; this is followed by unconsciousness with foam in mouth and

redness of eyes and face. No locking of jaw or biting of tongue occurs.

2. Stammering since first attack of convulsion.

3. Progressive loss of weight.

4. Falling of hair + +.

History :

First attack of unconsciousness occured suddenly while stepping stairs in August 1980. The second attack took place the next morning in bed at 8-30 a.m.

Past History :

Whooping cough, typhoid, pneumonia and cholera; scabies treated by ointment; worm trouble; occasional vaccination. Paroxysmal tachycardia - 5 years back.

Family history :

1. Father had syphilis ; died of heart attack.

2. Father's sister - Bronchial asthma.

Clinical findings :

1. Pulse 72 p.m.

2. B.P. 110/90 mm. Hg.

3. Heart - aortic 2nd sound accentuated.

4. Tall, slim patient.

5. E.E.G. dated 3-8-81.

Focal pathology (right).

6. P.P.B.S. 30-7-81 - 130 mgm %

Generalities :

1. Chilly .

2. Stammering since first attack of convulsion .

3. Sweat-scanty, feels uneasy after sweating.

4. Thirst + + even at night when wakes up from sleep.

5. Stool - semisolid, offensive , itching in anus due to worms.

6. Urine - 2/3 times at night; becomes offensive before attack of convulsion.

7. Desire : sweet + +, salt + +, meat, warm food.

8. Aversion : potatoes.

9. Intolerance : meat, causes indigestion.

10. Sleep : disturbed , lies on right side.

11. Mind : fearful, especially of darkness, snake, ghost, of being alone ; fond of music, travelling .

Treatment :

25-7-81 - ℞ Thuja occ. 0/1/12 doses.

One dose to be taken every alternate day.

20-8-81 - Sleep disturbed at night ; no further convulsive attack.

℞ Thuja occ. 0/2/12 doses.
Direction - same as on 25-7-81.

12-9-81 - Occasional jerking of limbs, otherwise no troubles.

℞ Thuja occ. 0/4/12 doses
Direction - as before.

03-10-81 - Only once had palpitation at night : no other troubles.

℞ Thuja occ. 0/5/12 doses.
Direction - as before.

30-12-81- Trembling and weakness of left leg occasional, aggravates morning ; no convulsions or any other complaint.

C.T.Scan of brain at Madras :

Slice no. 7 shows a circular area of enhancement in the middle line just anterior to the lateral ventricle could be due to Aneurysm of anterior cerebral artery.

E.E.G. dated 16-11-81 at Bangalore :

E.E.G. is mildly abnormal and suggestive of possible right T.L.E.

	℞ Thuja occ. 0/8/16 doses. Direction as before.
29-1-82 :	Occasional jerking of limbs during sleep.
	℞ Thuja occ. 0/10/16 doses. Direction - same as before.
29-3-82 :	Occasional jerking during sleep persisting.
	℞ Thuja occ. 0/12/8 doses. One dose to be taken every 4th day.
10-5-82 :	Jerking of left hand and leg during sleep ; occasional bleeding gums.
	℞ Lachesis 0/2/12 doses. One dose to be taken every alternate day.
21-6-82 :	Had no troubles till few days back : now jerking of limbs tending to reappear.
	℞ Lachesis 0/4/12 Direction - same as before.
31-7-82 :	Occasional jerking of limbs -
	℞ Lachesis 0/5/12 doses. Direction - same as before.

1-12-82 : Had no troubles in the meantime including jerking of limbs ; now jerking has reappeared.

℞ Lachesis 0/8/8 doses.
One dose to be taken every 4th day.

13-1-83 : Trembling and jerking much less and very rare.

℞ Lachesis 0/12/8 doses.
One dose to be taken every 4th day.

12-1-84 : The patient did not report any further after 13-1-83.

Today I have received one letter from him informing me that he has had no troubles since his last visit on 13-1-83.

CASE NO. 7

A girl aged 17 years was brought on 3-9-82 for treatment of her epileptic convulsion which started since 2 years of age. She had only one attack of convulsion after withdrawal of anticonvulsive allopathic medicines, after which she became free from convulsive attack though her E.E.G. findings did not turn to normalcy.

Present Complaints (as on 3-9-82) :

1. Epileptic convulsions since 2 yrs of age, last attack was on 22-10-81 when she was put on anticonvulsive allopathic medicines and since then till now the allopathic medicines are being continued and the patient remains free from convulsive attacks.

Attacks of convulsion occur during sleep, during menstrual period and occasionally during febrile attack.

Series of events :

Before the attack - the patient feels a black shadow before her eyes for which she screams followed by vertigo and tendency to fall, but she cannot talk or express her feeling.

During the attack - foam accumulates in mouth; eyes remain staring and directed upwards ; biting of tongue takes place and limbs remain extended.

2. General weakness all the time.

3. Menses - regular but very much painful - pain in lower abdomen only.

4. Leucorrhea - thick, bland < s before mense.

5. Anorexia + +

Past History :

1. Susceptibility to cold in childhood.

2. Scabies > d by ointment.

3. Measles.

4. Anorexia from the very beginning.

Family history :

1. Paternal side - Rheumatism and arthritis.

2. Maternal side - Diabetes mel.

3. Mother suffered from severe anorexia all through the pregnancy.

Generalities :

1. Ambithermal

2. Sweat scanty, offensive < s.

3. Thirst - scanty.

4. Desire : salt, sour, cold food and drinks.

5. Aversion - milk.

6. Burning , sweating and heat of palms.

7. Mind : easily angered, likes company, likes music, fear of dogs.

Clinical findings :

1. Excess of hair all over the body.

2. **E.E.G. report** : dated 22-4-81 sub-cortical seizure discharge.

Treatment :

3-9-82 : ℞ Thuja occ. 0/1, 0/2/12 doses each. One dose to be taken daily morning one after other.

21-11-82 : The patient was on Thuja upto 0/7 till this date with progressive improvement in all respects. But she had one convulsive attack on 5-11-82 after withdrawal of all allopathic anti-convulsive medicines.

℞ Thuja occ. 0/8, 0/10/8 doses each. One dose to be taken every alternate day one after other.

15-9-83: No further attacks of convulsion so far ; no remarkable troubles. She was on Thuja upto 0/20 till this date.

℞ Thuja occ. 200/2 doses only. To be taken at 6 a.m. and 6 p.m. the same day.

16-1-84: No convulsions so far. She was on placebo in the mean time. Now she complains of excessive hair falling in bunches and pain in left leg.

℞ Syphilinum 200/1 dose only.

7-1-85: The patient was followed upto this date with no return of convulsive attacks. But her E.E.G. findings dated 21-4-84 still reveals convulsive disorder. The party did not like to continue treatment any more even though her hair falling was not stopped completely and she had dandruff as well. They also did not like to have a fresh E.E.G. done.

As such, we cannot claim that the patient has been cured, but the result of constitutional homoeopathic treatment in this case was far beyond our expectation.

OTHER WRITINGS OF THE AUTHOR

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