Cerebellar Degeneration

[Editor: From this issue we are giving the general article by Dr CH Asrani along with the relevant case. We hope this will make more comprehensive reading.]

GENERAL WRITE-UP:

What is Cerebellar Degeneration?

Cerebellar degeneration is a disease process in which neurons in the cerebellum - that controls muscle coordination and balance - deteriorate and die. Diseases that cause cerebellar degeneration can also involve areas of the brain that connect the cerebellum to the spinal cord. Genetic mutations alter the normal production of specific proteins that are necessary for the survival of neurons.

Cerebellar degeneration is one of many diseases that produce ataxia-disturbance of the accuracy and speed of voluntary movement.

Neurological diseases that feature cerebellar degeneration include:

- **acute and hemorrhagic stroke**
- **cerebellar cortical atrophy** - progressive degenerative disorders in which cerebellar degeneration is a key feature.
- **Friedreich's ataxia, and other spinocerebellar ataxias,** caused by inherited genetic mutations that progressively destroy neurons in the cerebellum, brain stem and spinal cord.
- **transmissible spongiform encephalopathies eg** "Mad Cow Disease" in which abnormal proteins cause inflammation in the brain, particularly in the cerebellum.
- **multiple sclerosis,** in which damage to the insulating membrane (myelin) that wraps around and protects nerve cells can involve the cerebellum.

Other diseases that can cause cerebellar degeneration include:

- **endocrine diseases** that involve the thyroid or the pituitary gland.
- **chronic alcohol abuse** that leads to temporary or permanent cerebellar damage.
- **paraneoplastic disorders** in which tumors in other parts of the body produce substances that cause immune system cells to attack neurons in the cerebellum.

Symptoms: The most characteristic symptom of cerebellar degeneration is a wide-legged, unsteady, lurching walk, usually accompanied by a back and forth tremors in the trunk of the body. Other symptoms include slow, unsteady and jerky movement of the arms or legs, slowed and slurred speech, and *nystagmus* - rapid, small movements of the eyes.

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THE HOMOEPATHIC CASE

INTRODUCTION BY Dr S K MAMGAIN: Every homoeopathic physician knows well that homoeopathic prescribing is not based on clinical pathology alone, rather it is based on the personality of the patient. This personality is based on certain factors, viz (1) location (2) sensation (3) modalities (4) concomitant, along with the inherent Miasm and causation, etc.

In the present case there are some factors due to which the detailed history of the case could not be elicited.

(1) The patient being very much handicapped, could not relate himself clearly.

(2) Regular personal rapport was not possible as the patient used to live far and communication was done by post only.

Our Materia Medica is a storehouse of the personalities of drugs and diseases as well. So, based on whatever symptoms were available, I prescribed for him according to my own logic (even though may be a lame

one). But my prescriptions worked. Therefore I present this case to demonstrate how homoeopathy works in a difficult situation.
(Just for your information, I use 4 – 5, No 10 size globules saturated in the remedy potency as one dose.)

Dr R Asthana, 43 yr First visit 7 – 3 – 1996.
The patient is a Senior Medical Officer in Punjab, posted at Hoshiarpur, far from my place, hence treatment was continued through post. The patient has Bronchial Asthma since 1973 with attacks precipitated by change of climate. Attack was mostly preceded by acute coryza and sneezing bouts followed by breathlessness < night. He is also a chronic patient of Amoebiasis passing mainly mucus in stools.
In 1983 he started complaining of awkwardness of speech, many words would be un-intelligible→followed by gradually increasing awkwardness in gait and movement of the hands. Going up or down the stairs and getting in and out of the bus became difficult; his writing became very shaky, even when writing very cautiously, letters would get intermingled. All this was almost painless.
When he visited me on 7–3–1996, he was staggering so much that he could only walk with support of two people. His speech was un-intelligible. The movements of arms and hands were very awkward.
Report Proton NMR imaging of brain and cervical cord done with T1, T2 and proton density SN sequences in axial and sagittal planes:
There is evidence of cerebellar degeneration with prominent folia. Dilated 4th ventricle and giant cisterna magna seen. No focal lesion/abnormal signal intensity seen in brain parenchyma. Junction and cervical cord normal. (I simply copied the report as it is)
Impression: Findings consistent with cerebellar degeneration.
No associated pathology in brain parenchyma seen.
The Finding were with PGI Chandigarh, However the findings, informed was as under:

- All the jerks were exaggerated.
- Finger nose test was negative.
- Dysdiodokinesis, positive.
- Speech – scanning type.
- Straight line test – positive.

The other symptoms he related were:

- Great mental depression.
- Sleepless nights.
- Legs/ feet remain cold.
- Feels aggravation in all the complaints during change of weather.
- Temperament very irritable.

Family history:

- He was brought up under strict discipline, by his very strict father.
- His brother and sister suffer from Bronchial Asthma.

Previous to the commencement of Homoeopathic treatment he had undergone Allopathic, Ayurvedic and Tibetian treatment with no avail, rather his condition went on deteriorating.
The treatment was started has 7–3–1996 with one dose of *Syphillinum* 1M followed by one dose of *Carbon-sulph 30* one dose daily.
Clarke Dictionary of Practical MM: *Carbon-sulph* causes tremor, giddiness, muscular weakness, more or less ataxia. Strong increase of mechanical muscular irritability, etc.

He immediately started feeling better in the symptoms of Cerebellar Degeneration.
24–5–1996 ie after 21/2 mths: progress stalled in Cerebellar Degeneration.
Felt slight > in Amoebiasis. No > in Bronchitis.
Syphillinum 1M one dose followed by *Carbon-sulph.* 200 at long interval.
11–6–1996 ie After 3 weeks: No further improvement. *Bufo-rana* 200 bi-weekly. **Indications:** *Bufo-rana* causes softening of brain.
21–11–1996: Gradual > in the symptoms of the Cerebellar Degeneration and in Amoebiasis. Winter set in which < Bronchitis. *Bufo-rana* 1M followed by *Ars-alb* 30 intercurrently for Bronchitis. *Bufo* 200 had re-

sponded well. After this long period of 5 mths, I felt he would react better to 1M, single dose, which was followed by *Ars-alb* for his bronchitis.

14–6–1997: In last 7 mths, pt feels much improvement in all respects. Bronchitis improved. Normally bronchitis < March and September due to pollens. He fears < now during flowering season. Recently has been under much mental stress yet not <. *Bufo-rana* 1M continued at long intervals. A few times when he developed some trouble in his breathing during the past winter season a few doses of *Arsenicum* 30 given. When not better based on bronchitis agg by cold he was given. *Carbo-veg* 30 at different times according to the symptoms he reported.

17–7–1998: AFTER 1 YEAR: He reported a relapse in the symptoms of cerebellar degeneration. This is in spite of *Bufo-rana* conintuing periodically. So case reviewed. *Phosphorus* 1 M at long intervals.

INDICATIONS: 'Repertory of Hering's Guiding Symptoms of our Materia Medica' by C. B. Knerr: *Phosphorus* was given under the rubric brain softening

24–10–1998: Reported good improvement. *Phosphorus* 1 M continued as before at long intervals. He used to write to ask for medicine at an interval of generally one month.

9–3–1999: Reported that he is again feeling instability while changing posture.

Phosphorus 10 M at much longer intervals.

12–6–1999: Improvement has set in and he went on improving. But this time he felt some < in his bronchial asthma during summer.

Ipecac 1 M gave him prompt relief(*Ars-alb* did not help so *Ipecac* was given.)

14–7–1999: Reported Nasal allergy. Frequent urination. Great weariness, feels easily tired.

Phosphoricum-acidum 200. (as an acute phase medicine?)

6–6–2000: He wrote this report: the improvement in all respects continued well.

Now for the past few days finding difficulty in controlling the movements of his hands and the head. Temperament has become quite irritable.

Nux-vomica 1M

13–9–2000: *Nux-vomica* 1 M improved him a lot but for the past few days he again felt some agg in his movements. *Baryta-carb* 1M

27–10–2001: After *Baryta-carb* improvement again set in. But an attack of acute bronchitis was precipitated as such allopathic help was called (being at a far of place). He was given steroids to control the Bronchitis. After this attack he again felt agg in his condition. *Syphillinum* 10 M one dose followed by *Carbon-sulph* 200 occasional dose.

He again set on the path of improvement.

12–8–2002: As already stated, he was brought up under strict control of his father as such he often feels great psychological stress and mental depression; and he often feels greatly perturbed by this state.

Carcinocin 1 M one dose followed by occasional dose of *Natrum-mur* 200.

4–10–2002: Reported that he felt much improvement in his mental state.

Natrum-mur 1 M which improved him a lot. (why change **R** now ?)

Last communication with him so far was on 30–4–2003. He was busy with the construction of his new house. He is very much normal now with respect to his body balance, movements of his limbs.

EDITOR CONCLUSION: *This is a zig-zag cure. Did each medicine work.? Were these changes required according to the phases? Was there a pattern in the selection like related remedies etc.*

This kind of treatment will produce what kind of learning in the younger Homoepaths and students? We senior Hom have that responsibility too. And also since this pt-doctor is so convinced, can we not have proof /evidence of improvement through investigations?

AUTHOR REPLIES: Yes it is a zig zag cure of course. But in absence of detailed report we have to resort sometimes to circuitous route. But we must go on through

our MM regularly. I had many times asked the patient to get NMR done but he did not comply even being a senior Medical Officer.

For your information Dear Editor the patient recently visited my place and he is almost normal except slight awkwardness in walking. I have taken his video clip.

During this period from 7–3–1996 to 30–4–2003 he visited me thrice. When he visited me in March 2000 (his third visit) he had regained his controls nearly 80%.

During June, 2002 he sent me the following note/certificate:

I am a doctor serving as Senior Medical Officer in P. C. M. S. & suffer from Cerebellar degeneration. After reading about Dr Mamgain in a reputed journal, I opted for his treatment. His drug worked like miracle. My speech, imbalance & coordination of muscles improved & the progress (of the disease) has considerably slowed down.

I shall request my brothers & sisters who are suffering from Cerebellar degeneration, Parkinsonism, Alzeimer's disease etc., to try homoeopathy.

Sd – Dr. Rajiv Asthana, Hoshiarpur. ❑

Mystery of Disappearing Brain Tumour

Shirish Agrawal, 12 years, came on 17-08-2000, in the early morning, even before the clinic hours with complaint of throbbing headache worse from movement and light,but better by closing eyes; he also had projectile vomiting with headache and was not relieved by vomiting. On this short acute history, I gave him *Belladonna* 30 and asked them to report after one hour.

After one hour attendant reported that there is no relief, and condition is worse , so without wasting much time, I gave him *Bryonia* 30. Patient still had no relief and he went to consultant Neurologist who diagnosed it clinically as Vascular Headache.

Neuro physician asked for C T scan.

The Report of CT scan—Dated 19-07-2000:

HYDROCEPHALUS

The sulci and cisterns are completely obliterated. The 3rd and both lateral ventricles are dilated.

AQUEDUCTAL STENOSIS.

Patient referred to Neurosurgeon who advised MRI.

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Report of MRI 22-07-2000

A small, well-defined, nodular, non-enhancing lesion in the posterior 3rd ventricular region appearing inseparable from the pineal gland producing marked narrowing of the proximal end of aqueduct of sylvius, suggestive of a pineal neoplasm ? Germinoma.

A follow-up examination after eight weeks was suggested for further evaluation.

Mild to moderate obstructive enlargement of the lateral and 3rd ventricles with mild enlargement of the 4th ventricle.

Then patient was referred to Mumbai for further investigations.

At Mumbai, he consulted Dr C E Deopujari who investigated Shirish Agrawal by all possible means and various reports are normal except report of MRI. He also repeated MRI using contrast media.

Dr C E Deopujari explained to relations that the tumor is within proximal aqueduct causing obstructive Hydrocephalus.

He advised for 3rd ventericulostomy and biopsy / excision of Tumor. He also warned that in posterior 3rd ventricular region it is difficult to operate and surgery is not without risk. Relatives were not ready to take the

risk.
Ultimately shunt was placed to drain the hydrocephalus. The pathology was left untreated.
Neuro-surgeon at Mumbai further explained to relatives (04-08-2000), that it is best that you should consult Neuro-surgeon in USA

After Shunt operation, Shirish Agrawal came to me on 21/08/2000 with following complaints.

- Weakness
- Lack of concentration
- Impaired memory
- Indifferent
- Grief about shunt and disease
- Despair
- Sensitive to noise
- Anxiety about studies
- Craving for sour
- Thirst for cold drink
- Chilly

O/E Lips dry and cracked. Shunt in place. Myopic. Looks indifferent

21/08/00: *Alfalfa q.* 10 drops TDS
Report after one week
01/09/00: No change in condition of patient
On basis of totality *Nat-mur*-30
15/09/00: No change Rx.*Nat-mur*-200
01/10/00: Rx *Sepia*- 200
15/10/00: Appetite < weakness >
Weight <. Cheerful Rx *Sac-lac.*
Aphorism 281 came to my mind.
In order to be convinced of this, the patient was left without any medicine for 8, 10 or 15 days, meanwhile giving him only some powder of Sugar of Milk.
01/11/00: Eruption on skin . Rest –OK Rx *Sac-lac*
17/11/2000: Patient went for follow up to Mumbai and Neuro surgeon asked for repeat MRI.
They were surprised, as there was no tumor mass in aqueduct.
They repeated MRI. with contrast media and again they were surprised that it was normal! ❑

The Angry Child with Glioma

Course of Ms F, 13 year old, illness before she was referred to us: she was admitted to Nair hospital on 7/1/03 with c/o headache since 7 days. She was apparently alright prior to that. She had projectile vomiting when in school, followed by giddiness and subsequently unconsciousness lasting for 30 minutes. Her headache was generalized, intermittent and throbbing with no definite aggravating or relieving factors.
On admission there was
No H/O blurring of vision/ diplopia

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No H/O sensory or motor deficit
No H/O sphincter involvement
No H/O K/ KC
No H/O BA, Jaundice
Birth history was normal
O/E GC – fair; Pulse 84/min; BP 90/70 mm of Hg
General and systemic examination were essentially normal.

MRI of Brain on 7th Jan 03.
A fairly large ovale heterogeneous predominantly hyperintense lesion is seen on both T1WI and T2WI involving the superior portion of the left thalamus and adjoining portion of the septum pellucidum, trigone and corpus callosum. It measures approximately 4.76 X