



Breath Holding Spasms or Epilepsy?

Master M **Birth Date:** 28/08/92 Hindu, Veg from Baroda

Fa 32 yrs, SYBCom. Tobacco business. Mo 27 yrs B.Com. Brother - 2yrs

Date of consultation: 11/04/96

CHIEF COMPLAINT

LOCATION	SENSATION	MODALITY	ACCOMPANIMENT
CNS 3 rd month of life OD 2-6/d x 3-4 mins with occ gaps of 2 d FACE to CNS	Bluish Discoloration+ ↓ Tonic and clonic spasm ³ Foam occasional ↓ urinary incontinence ↓ p fall down. o occ screams s sleepiness ³ t forget episode Watery stools offensive ³	A F Crying ³ < fall down/ Injury < Fasting ²	
Rectum since 1 week 10-15/ day Abdomen	Pain ² Mucus+ Involuntary+ Ineffectual urge ² Stool Report-NAD	< 3 Food after not > Allopath Rx x 1 wk >3 stool after.	
H/O Since 1 st - 3 rd yr of life Rectum daily	Stool 4-5/day semi-solid. occ mucus. Offensive. Involuntary. Wt - maintained Unusual behavior.	Not better by any medicine No < modality available	
3) MIND	Aggressive Beating ³ Biting ³ ? MR? ADHD		



PHYSICAL CHARACTERISTICS

WEIGHT: 12 kg.

PERSPIRATION: Partial: Head², Palms- soles

THIRST: ++1½, glass, every ½hr. Desire for cold water³

CRAVING: Indigestible Things¹, sweet¹, ice cream²

SLEEP: Startles during sleep. Fasting < 2

THERMAL STATE: Chilly (C3H2)

DEVELOPMENTAL LANDMARKS

Birth: FTND. Birth wt: 2.2kg. Crying: Immediately after birth

Mother's Health: At 3rd month - Elder Son 4 yrs old, expired due to accident. Grief³ and now Anxiety³ of this precious pregnancy. Low blood pressure, hyperemesis gravidarum for 3 months

PHYSICAL DEVELOPMENT: Delayed. Wt gain- N

MENTAL DEVELOPMENT: Delayed

Recognition-persons: 2 yrs of age

Teeth: 1¼ month. Sitting: 8 month. Walking: 1½ yr

Speech: Retarded → 3½ yr

Breast Feeding: 6 months

F/H: Mother: convulsion-childhood during

O/E Nail-Pink Tongue- yellowish coated Wt-12 kg

CNS-NAD Neurologist. Dr K Buch opinion: Epilepsy- EEG: Abnormal.

OBSERVATION: Patient was restless and difficult to control by parents. Required time to answer simple questions.

LIFE-SPACE INVESTIGATION

This case was referred by family physician for c/o recurrent diarrhoea and convulsions. Parents were worried about recurrent convulsions.

Pt entered with parents in the consulting room. He appeared irritable, demanding chocolates and cold drinks. He did not listen to parents and started beating mother. Father gave Rs 100/- note to the driver and asked him to get whatever he wanted. I requested father to take him out for 30 minutes, which he readily agreed.

It is equally important to know about the family circumstances. They are belonging to Charoter Patel community. They have a family business of tobacco and

supply raw tobacco to ITC. Pt's grandfather is known as a tobacco king- a rich family. Pt's father is the eldest son and generally remains busy³ traveling between Baroda ← → Calcutta. During tobacco cultivation he stays out for months together.

Pt was the 2nd male child in family. 1st child expired (when pt was in womb). Mo passed through Anx³, grief³+. Pt was pampered³ / over protected³ by the family members. Grandfather fulfilled each and every demand, as if money is solution of all the problems! Later on father, as a compensatory mechanism, fulfilled demands. If demands were not fulfilled it resulted into crying → convulsion or burst out into anger, throwing and breaking things. It became a defense mechanism for the child to get whatever he wanted.

Gradually the child grew up in an environment where nobody scolded him. Later on mother noticed delayed development, and assistance in all routine activities. Even after repeated instructions he did not understand. Mother became worried when pt did not learn toilet training properly.

The child has been described as irritable³, losing temper easily. When somebody comes home, at times he throws whatever things he has in his hand or grinds teeth. He behaves in the same manner (throwing things) while playing with other children. He talks to his elders in a loud voice and rough manner. He prefers to play alone; if plays with younger brother and his friends, it often ends in a fight.

At the same time he is a sensitive fellow, who misses his father and if somebody is ill in the family, he becomes calm and cool. Mother tried to put him in play group 2-3 times but in vain, as he used to fight with other children, did not listen to the teacher and used to break toys. Even private tuitions did not work out as he became rough and at times abusive to the teacher. He is fond of roaming in car and often stops crying when the driver takes him for rides 3 to 4 times. Mother caught him for smoking bidi. Whenever scolded he responded by violence breaking T V/Radio/glasses etc. Father is a cool and business³ oriented person. It ap-



pears that child does not have a fear of father; father does not have time for child.

Mother is a strict³ / disciplinarian¹ lady who does try to improve child by various method but grand parents are a major block. Mother did not like grand parents' behavior but *Charotar Patel* have no choice. When PP explained his parents about this likely diagnosis and that investigations were required, they doubted that best Pediatrician had never said about Epilepsy. I explained about the treatment and impact on development of the child then only they agreed for it.

My compunder said that his father had difficult time controlling the pt outside. A bribe of chocolates and soft drinks was given. Also passed urine in waiting room and soiled his underwear.

As a physician our first duty is to understanding pt at clinical level.

Either this child fall in category of

INFANTILE SPASMS OR BREATH HOLDING SPELLS/ GENERALISED SEIZURE.

It appears majority of Physicians took it likely diagnosed it as a breath holding spasm.

Criteria

- 1) Age of 6 month & 3 yr.
- 2) AF: crying/ppt factors: fear or minor injury.
- 3) Cyanosis then tonic, clonic spasm
- 4) If hypoxia persist more then 15 seconds then convulsion may occur.
- 5) Other phases of convulsions are absent.

Following data was available from the case:

Pt presented with symptoms of ictal and post ictal phase. Attacks also present when child was alone. Symptoms + incontinence of urine, falling on ground and post ictal sleepiness favour **Epilepsy**.

HISTORY OF MOTHER: suffered from epilepsy in childhood suggestive of genetic transmission.

I took help of neurophysician (Dr. K.R.B) & he wrote, 15/4/96

Dear Dr Purohit, Thanks. Master M.P has severe epilepsy—confirmed on EEG.

I advised to put him on syp. Tegratol. With regards. Dr. K.R.B

EEG report of 15/04/96

Sedated EEG record is abnormal: **Consistent with inter-ictal record of generalized seizures.**

How do we understand his behavioral pattern?

Either it is normal in pampered child or it is abnormal. Psychologist report helped to understand pt better.

PSYCHOLOGICAL TEST REPORT

Master MP M/ 4.6yrs. Education: Nursery

Tests Administered: VSMS, BKT, Goddard form Board Observation and Test Report: Patient was brought for assessment by his parents with h/o seizure? Breath Holding Spasms -on and of only when he cries. EEG also supports generalized seizures.

During both testing sessions, Patient was very restless, hyperactive, destructive and very attention seeking.

On Social-Developmental scale, his social maturity level is at 3 years level. He is unaware of any obstacles, shows no fear, and is partially dependent on mother for most ADL activities like toileting, dressing, bathing. He can learn given an opportunity, but he is not given a chance either because he is overprotected or that he is distracted and impulsive.

SQ=80 points-Dull Average Range

On BKT Tests of Verbal Abilities -- his **Mental Age=3 years-Verbal JQ being 72 Points- Dull Range:**

His level of verbal comprehension is good, he can grasp easily but due to hyperactive behavior, his performance is affected. He can identify object body parts very well. His picture vocabulary and matching, recognition is good but it's just that he fails to benefit from any learning due to distracted behavior. He has good concept in shapes and a few colours.

He is still at a scribbling stage. His adaptive functions are poor; probably diffuse brain pathology because of epilepsy could then manifest attention deficit disorder.

Superseding that over protection, overindulgence by parents and grandparents have probably spoilt child's habits such that mother cannot control his stubborn behavior. Parents are very anxious and apprehensive



about his fits, hence they fail to control his behavior and fulfill all his demands and tolerate all his mischief.

Father keeps away from child for days together on business trip and tries to compensate by over-pampering, when returns.

Mother tries to be overprotective vs strict disciplinarian yet cannot control him because of indulgence from grand parents.

Both parents are counseled. They feel putting him in a hostel might be a better solution. That should be their decision, may be later on

DIAGNOSIS: Dull average Intelligence (75 to 80 point) with Epilepsy and ADHD (Attention Deficit Hyperactivity Disorder) Normal IQ range = 90+ points.

Recommendation: medication, parental counseling, regular schooling, re-evaluation every 6 months.

Once the understanding of the patient is clear at clinical level, then our job is easy & we can plan out homoeopathic management without difficulty.

REPERTORIAL TOTALY. KENT APPROACH

1. Convulsion crying from: AF & <. Crying: Synthesis 205
2. < alone: Synthesis 30
3. Irritability: violent, rage: Synthesis 202
4. Learning with difficulty: BTP 52
5. Foolish, childish behaviour: Synthesis 110
6. Obstinate: Synthesis 154
7. Delayed development: Synthesis 1580
8. < fasting
9. Cr: indigestible
10. Cr: sweet
11. Cr ice-cream

Following drugs emerge from repertorial filter. *Calc-carb, Baryta-carb, Nat-mur, Tarentula.*

CALC-C comes near but basically *calcareo* child is capable of doing work but his sluggishness at level of mental & physical prevents him to do work.

NAT & TARENTULA comes near at level of expression like irritability, destruction, violence etc & obstinacy but

both these remedies do not cover the core of pt.

Baryta-carb: identification usually starts with delayed development or certain syphilitic expression present since birth. As the child grows up, shyness, non-cooperativeness, sluggishness and obstinacy develops because of dullness. As our pt grew up, he faced difficulty in school due to poor perception → shyness/anxiety or frustration expressed by irritability and violence. Our pt's journey really began from fetal life where elder brother died due to accident resulting in a tremendously anxious state of mother → **over-protection and over-pampering**. So the second defect was in poor initial training of pt. All demands were fulfilled → **Obstinacy**. Development delayed and **Dullness**-school tuitions became essential. High degree of **Freedom** → **Strictness** resulted in difficulty in **Adaptations, Low Tolerance** → **Aggressiveness, → Violence, → and Internal Restlessness**

This understanding at level of mind + Body helped to come to. *Baryta-carb*

INTERCURRENT REMEDY: Tuberculin bovinum:

Tuberculinum: Seizure is basically an expression of aberrant electrical discharges. viz, hyper-excitability and erraticity. Genetic H/O mother also spells Tubercular miasm. Same time expression level of mind speaks of Tub-syphilitic zone.

FOLLOW UP CRITERIA:

A]

- | | |
|-------------------------------|------------------------|
| 1) Epilepsy A/F crying, Alone | 6) Tonic/clonic spasms |
| 2) Intensity | 7) Involuntary urine |
| 3) Frequency | 8) Falling on ground |
| 4) Duration | 9) Sleepiness |
| 5) Ictal phase cyanosis | |

B]

- | | |
|-------------------------|-----------------------------------|
| 1) Involuntary stool | 5) Mind in gen / parents behavior |
| 2) Irritability | 6) Diet/app/wt |
| 3) Obstinacy | 7) EEG |
| 4) Abnormal development | 8) IQ |



Date	1	2	3	4	5	6	7	8	9	OBS/IN	Remedy
11/4/96										Acute gastritis	<i>Nux-v</i> 200 4 hrly
15/4/96										Acute over	<i>Baryta-c</i> 200
22/4/96 A]	S	>	>	>	S	S	S	S	S	Plays with children	<i>Baryta-c</i> 200
B]	S	2	2	2	2						
2/5/96 A]	S	>	<X2D then >	er- ratic	S	S	S	S	S	Inadequate control. Freq rep + IR requirements	<i>Tub-b</i> 1M <i>Baryta-c</i> 200 3P/ HS
B]	S									26 th -31 st 5-6 times attack	
9/5/96	>	SI>	SI>	>	S	S	S	?	0	Freq repetition. All the time crying. No <	<i>Baryta-c</i> 200 2P
B]	S									Cr:Indigestible	
16/5/96 B]	S 0	>	>	>	L7	L7	S	>	0	Cr: indigest3	<i>Baryta-c</i> 200 7 HS
31/5/96 B]	>/0 S	> ++	> ?	> ?		S	S	0	0	Attacks after fighting. 2/2W. Mind same	<i>Baryta-c</i> 200 BD
5/6/96										Loose stool	<i>Nux-v</i> 200 4 hrly. <i>Baryta-c</i> ctall
12/6/96	+++									overstimulation	SL
24/6/96 B]	> ?	> ?	> ?	> less	S >	S	S	0	0	< passed of	<i>Baryta-c</i> 1M/1D
8/7/96 B]	> >2	>	1/5D	>	S	>/> 14	>	0	0	>	<i>Baryta-c</i> 1M 1D
30/7/96 b]	0/0	>2	>2	>2 >	S	S	S/S	0	0	No attack since 5 days	Ct all
16/8/96 B]	0/0 >2	>2 ?	>2 >2	>2 >	S >	>	S/S	0	0	Initial 2 d attack, then no attack for 15 D. no problem in school	<i>Tub-b</i> 1M 1D <i>Baryta-c</i> 1M 7 HS
22/8/96	++									Med <	SL
26/8/96 B]	>				>3	>3				< → >but disease activity constant	<i>Baryta-c</i> 1M 1D wky
9/10/96 B]	>2 >3	>2+ >	>2+ >	>2+ >	0	>2+	0	0	0		Ct all x 2 wks



Cases

2/11/96 B]	S	0	3/ 2W >3	> ok	>0 >2	L5	0	0	0	Plays with other children. Good control	Ct all x 3 wks
27/12/96										Irregular drugs. Attacks ++. Requires I.R	<i>Tub-b</i> 1M 1D <i>Baryta-c</i> 1M 1D
11/1/97 B]	+/0 0	>2+	3/	>2+	0 15	0	0	0		Good control	<i>Baryta-c</i> 1M 3p x 4wks
12/2/97			15D							Attacks>2+	<i>Baryta-c</i> 1M 1P x 4 wks
27/2/97			3/ 2							Good control. needs freq repn	<i>Baryta-c</i> 1M 3P
13/3/97	++		wks ++							Need of I.R	<i>Tub- b</i> 1M 1D <i>Baryta-c</i> 1M 3P
5/4/97										Acute GI with fever. Acute followed by C	<i>NV</i> 200 4 hrly → <i>Tub-b</i> 1M → <i>Baryta-c</i> 1M 3P
27/5/97										Out of station. Acute infection	<i>NV</i> 200 4 hrly → <i>Tub-b</i> 1M → <i>Baryta-c</i> 1M3P x 3wks
7/6/97	++	>	>	>						CR req more freq	<i>Tub-b</i> 1M <i>Baryta-c</i> 1M 3P
17/10/97										Good control Mind at rest	<i>Tub-b</i> 1M <i>Baryta-c</i> 1M 1D
26/11/97										No attacks.	<i>Tub-b</i> 1M <i>Baryta-c</i> 1M 1D week x 2 wks
15/12/97										EEG > Attack once	<i>Baryta-c</i> 1M 1D week x 2 wks
2/1/98										due to fall	<i>Tub-b</i> 1M → <i>Baryta-c</i> 1M 1D
20/1/98										Good control	<i>Baryta-c</i> 1M1P
25/3/98 B]	Mild 0	Mild +	Twice N	1/2 N	0 >	+	0	0	0	Good control Skin+	<i>Baryta-c</i> 1M 1D
7/4/98			4/w		0	+	0	0	0	Good control but ppt factor+ skin++	<i>Psor</i> 1M 1D <i>Baryta-c</i> 1M 1D
21/4/98										Skin >3	<i>Baryta-c</i> 1M 3P
20/6/98										No attacks. Passed	<i>Baryta-c</i> 1M 1D



		entrance exam in Panchagani	
17/7/98		Stability	<i>Baryta-c</i> 1M 1D
	Child now under observation only		

EEG report of 15/12/97

Awake EEG record is minimally abnormal- to be clinically correlated.

Present EEG shows less epigenocytosis as compare to EEG done on 15/04/96. EEG report: 20/06/98

Awake EEG is within normal limits.

LEARNING FROM THE CASE:

MANAGEMENT GENERAL ENVIRONMENT-INDIVIDUAL:- Initially problem started with clinical diagnosis. Physician should have a clarity what he is treating. And how cure is going to take place in this individual case. The way paediatrician took it loosely about infantile spasm tested physician's knowledge and confidence. Sensitive handling of parents about clinical diagnosis removed agitation from their mind. Involving neurophysician at right juncture sorted out problems. Physician should not have any restriction in taking help from other sciences when better facilities are available. All "Specialist" should be used with "respect and care". They become asset if properly used. Cure is only possible when we totally abolish disease process, while equally taking care of precipitating and maintaining factors. In this case family environment was playing a big role, crying used to <. Crying, mostly, become a defense mechanism for the child to fulfill all his demands. Overindulgence of grandparents and father lead to spoiling the child. If this environment was not corrected then chances of improvement was remote. They were explained about impact of over protectiveness/ pampering on development of the child. Further environment of child on intellectual and behaviour level was done by psychologist. Involving psychologist in process of cure was of an asset. Psychologist plays important role in assesment of pt and hence clear cut diagnosis were available. Same time she was able to give feedback to parents about their handling in a precise manner. **All this provided, crystal clear clarity to the physician about his role not only limited to treatment of epilepsy but to change child's adaptive-reactive pattern so he can adjust well and life may become**

more meaningful.

This type of cure is only possible when clinician perceive pt as a whole and does not treat parts.

Frequent repetition of medium potency was administered to control neuronal discharge (neuronal excitability with heightened sensitivity). Miasmatic care was taken in terms of infrequent to frequent repetition of *Tuberculinum*. Gradually response started in both signs and symptoms and improvement found in EEG. Later on both came normal within stipulated time. General derivation occurred in form of use of medium to higher potency in frequent repetition, which is essential for rapid and permanent cure. Timely used of intercurrent remedy proves an asset in rapid resolution of case.

Slow but steady improvement occurred- first in behavioural pattern and later on intellectual pattern. Pt adjusted well and lastly he was accepted in boarding school at Panchgini. Pt was confident in acceptance of new environment yet further clarity will come later on as how he keeps balance in demand à capacity à expectation with limited resources.

Importance of detail follow ups, repeated investigation were advised to understand role of IR+CR. Frequent repetition of CR was used to control erraticity and hyper excitability of mind and neurons. Once potency exhausted à next potency used and result achieved. Importance of *Tuberculinum* as IR was felt. Further recovery only occurred after introducing IR at the right time. During follow-up also, whenever frequency was decreased, vigilance was maintained and SOS advice was given. (It was felt that sending out from environment might work as a resolution, so once pt has improved, green signal was given by the physician.

REFERENCE READINGS:

Books on pediatrics: Nelson, Forfar & OP Ghai.
Books on Neurology: Adams & Victor.
Principle & Practice: Dr ML Dhawale
Symposium Volume F & G: ICR Publication

