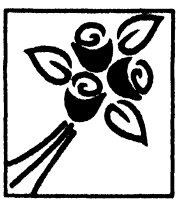
Parkinsonism

A clinical syndrome caused by lesions in basal nuclei of the brain, manifesting with the triad of Hypokinesia (impairment of voluntary movement), rigidity & tremors. The nigrostriatal pathways utilize dopamine as a neurotransmitter; thus Parkinsonism is associated with dopamine deficiency. The exact pathophysiology is not completely defined. 3/4 cases are paralysis agitans (also called idiopathic Parkinsonism or Parkinson's disease of unknown origin). Parkinsonism is often erroneously attributed to cerebral atherosclerosis. Most patients with Parkinson's show signs of cerebral atherosclerosis but it is essentially co-existing.

It may sometimes follow a single head injury; most often a complication of repeated head injury (as in boxers). Other infrequent causes: cerebral tumors, meningiomas, meningovascular syphilis, carbon monoxide poisoning, etc.

CLINICAL FEATURES:

1. Tremor is the first complaint for which the patient seeks advice. It first involves fingers and spreads proximally. It may extend to tongue and legs. Tremor at rest and often reduced during purposive activities. Stress and embarrassment aggravate the amplitude of tremor. Tremor of head is rare.
2. Rigidity: Resistance to passive movement is increased throughout range of movement of a joint. The patient is ultimately flexed at neck, hips, elbows & knees.
3. Hypokinesis: It is the most disabling feature and comprises a delay in initiation of movements together with paucity, slowness & lack of precision. The insidious onset often manifested by illegibility of the handwriting and gradual reduction in size of letters, then fastening buttons & laces and feeding get impaired; even turning over in bed, rising from chair & starting to walk becomes difficult for the patient. Loss of normal arm swinging when walking is a very early sign. Next change is in gait. Steps short and shuffling, walking slow; periods of uncontrolled acceleration when walking downwards (festination gait).
4. Normal emotional movements of the face start changing to mask facies: Blinking reduced; accommodation reflex of pupil impaired; changes in speech-Dysarthria, delayed initiation of speech and loss of voice volume.



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CASE :

Sr R, 60 yr, a nun in St Mary's Convent, Orissa, visited our college OPD on 12-05-99 with weakness[3] in both Rt upper & lower extremities since 1 ½ yrs. Initially, it started as the trembling of the Rt big toe, then numbness of other toes, then weakness of limbs started ascending upwards with difficulty in walking. She was not able to wash clothes, had difficulty in writing, lifting objects and combing < physical exertion[3] and better at night and rest[3]. She had to drag her Rt leg while walking, had tremors in hands and feet, numbness in 2nd and 3rd toes. Gait was slow. Occasional Rt sided headache. Upper limb: started with trembling of the fingers since 7 months followed by weakness of Rt hand and difficulty in writing. Trembling of hands and feet and headache aggravated traveling and better rest. There was no urinary or bowel disturbances.

Past History:

H/O Fall into a ditch 2 yrs back- injured Rt ankle joint-immobilization for 21 days. She had scalp laceration from a fall from a motorcycle.

Family History:

Father had hemiplegia; now dead. All three brothers died of heart attack.

PHYSICAL GENERALS:
DESIRE: Fish[3], Fruit[3], Milk[2]
AVERSION: Meat [2], Chicken
PERSPIRATION: Increased on chest and back.
MENSTRUATION: menopause at 52.
Reaction: likes winter
Thermal Reaction: Likes cold bath and fanning
INTELLECTUAL STATE:
Writes articles in magazines, translates books (English to Oriya). She studied BA (Theology). She has no weakness of memory.
EMOTIONAL STATE:
Anxious[3] about health. Perfectionist in work area. Likes company.
SYSTEMIC EXAMINATION:
CNS: Cranial nerves - normal
Mask like face. Reduced blinking, Muscle tone increased on Rt side with coarse tremor Rt hand and feet.
No H/O cognitive defect, ataxia, motor sensory deficit, autoimmune dysfunction.
CLINICAL DIAGNOSIS: Right Hemi Parkinsonism Disease
FIRST PRESCRIPTION:
12-05-99: Causticum 1M-1P + Placebo (If the author had given the reportorial rubrics, -physical and mental and discussed the basis of selection of Causticum and also the choice of potency., it would have made it a comprehensive presentation. Was an Intercurrent not required in a case of such miasmatic dimensions? Our experience shows otherwise. Of course the result vindicates the approach-Editor)

FOLLOW UP

13-05-99	Feeling better generally	Placebo
14-05-99	Weakness is reduced	Placebo
15-05-99	Generally better	Placebo
18-05-99	Better	
19-05-99	Gait improved, trembling of hands reduced	
Patient was discharged with *Causticum* 1M/2p 1/15 d + Placebo 40 pills X 1 month		
05-07-99	All complaints are better. *Causticum* 1M/4p 1/wk + SL x 2 month	
13-09-99	Weakness better. *Causticum* 1M/2P1/15days Placebo x 2 months	
	Trembling much better	
	Numbness and tingling – same	
	Difficulty in walking – same (Why same potency repeated and why not higher-Editor)	
26-11-99	Weakness & Trembling – much better. Rpt same Rx 2 months	
	Difficulty in walking same.	
09-02-2000.1	Complaints much better. Writing regularly. Placebo1M1/15d.	
	5 *Phos* 6 x BD	
03-04-2000	Generally better. Weakness slight. *Causticum* 10M/4P 1/15 d.	
	Placebo 5 Grain tab 1-0-1 x 2 months	

Patient was admitted in the hospital. Patient is happy that she is continuing her main job of translating different articles from English to Oriya on spiritual themes.

CONCLUSION:

Medicines prescribed on the basis of total correspondence (totality of symptoms) not only can stop further deterioration in degenerative disorders but also improve to a greater extent.

REFERENCE:
Davidson's Principles & Practice of Medicine
14th Edition, 1986 (reprint)