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

2.91 X 2.59 cm in dimensions and causes mass effect on the left lateral and 3rd ventricles. There is minimal contra- lateral extension. The lesion causes mild early hydrocephalus. Heterogeneous signals are seen within the lesion. A few abnormal vascular channels are also visualized. No skip or satellite lesions are seen.
There is no shift of the mediastinal structures.
The visualized orbits, Para nasal sinuses and calvarium appear unremarkable.
CONCLUSION:
MRI scan reveals
• A large heterogeneous hemorrhagic lesion involving the superior portion of the left thalamus and adjoining portions of the septum pellucidum, trigone and corpus callosum. its described above. Possibility of a hemorrhagic neoplasm is likely. It causes mild early hydrocephalus.

FOLLOW UP CT SCAN DONE ON 13/1/03
Plain and contrast enhanced scans of brain performed by taking 4mm and 8mm sections. 3D coronal and sagittal multiplanner reconstruction images given.
Serial Scans reveal:
There is a mixed density enhancing soft tissue lesion seen in the region of the body of the corpus callosum, involving the body of the left lateral ventricle. It measures 2.1 x 1.9x 2.0 cms. There is marked enhancement in the periphery of the lesion. The lesion is pushing the choroid plexus laterally.
There is asymmetric dilatation of the left temporal and occipital horns.
The rest of the neuroparenchyma appears normal.
Dual venous sinuses appear normal.
IMPRESSION: Above CT findings are suggestive of:
A neoplasm involving the left lateral ventricle and adjacent body of corpus callosum.
The following different diagnosis can be considered:
1) Ependymoma.
2) Glioma.
[Co-ordinating Editor: The reduction in size mass is due to the resolution of haematoma.]

On 18/1/03, Ms F was referred by Dr R. Pt came in lean, thin, supported by relatives, could walk with difficulty, could not sit, had profound weakness, and was asked to lie down on examination table. Voice low, lethargy, dull, lying quietly on examination table but responding to questions.

Her uncle gave the following history:
On 28th Dec 02 she got upset because her younger brother spoiled her dress (passed stools on it). She started crying loudly, got very angry, asking her parents to tear off the dress and throw it out. After that she developed headache, cold and a swollen eye. Next morning, she went to school, inspite of having headache as she had exams. When she sat in the jeep to go to school, her headache increased and became severe. She felt giddy, vomited and became unconscious. Headache was so severe that she started hitting her head on the wall, pulling her hair and not allowing anyone to touch her head. Constant nausea. She remained unconscious for four to five hours. She was given IV Glucose and regained consciousness. Once again severe headache started which was continuous and she would hardly get relief for two minutes. She had a painful cry. People listening to her cry would feel sympathy for her. 6th Jan 03 pain became less. But dull pain persisted with heaviness.

Prior to this attack, she used to complain of pain in the spine after taking bath. Headaches often but not so severe.

PAST HISTORY
Typhoid at the age of 3 yr and 10 yr associated with headache and back pain.

On 7th Jan 03 MRI scan head was performed and evening (6 pm) she complained of headache (1am to 2 am). The patient was put on Tab Diamox 1 TDS.
18th Jan 03 the condition of the patient as follows:-
1) Profound weakness cannot walk without support.

2) Severe nausea, cannot eat any thing; takes liquid, which also nauseates.
3) Lying quietly on examination table with knees drawn chest.
4) Dullness. Eyes closed, respond to question with low voice.

Most of the information was collected from the relatives-from grandfather and maternal uncle. Mother was in Lucknow (UP)

O/E

CNS: Mental state: Dullness, orientation to surrounding less. Present speech clear but low, responding to question well but again goes back to dullness. Eyes closed. While answering, remains awake, otherwise most of the time sleepy.
Motor system: Can walk with support.
Nutritional state of muscle: Normal. No S/O emaciation.
Reflexes: Planter, knee, ankle reflex: Adequate.
Sensation: Touch, Heat and Cold appreciative.
Cranial Nerves: No involvement of cranial nerves.
Pupils: Bilaterally equally reacting to light.
CVS/ RS/ PA – Normal.
BP: 100/70. **Pulse:** 70/mim. Afebrile.

LIFE SPACE

She is a Muslim woman hails from Lucknow. She belongs to Muslim girl. Father is 42 yrs old, working. Mother is 38 yrs old, housewife. Elder brother (16 yr), studying in 9th std and Younger brother who is just two months old. They stay in a joint family. Grandfather is 70 yrs old and grandmother is 65 yrs old.
Since childhood her nature is irritable, excitable, gets angry easily and is very obstinate. If anything goes against her, she starts crying. If consoled, she cries even more. When she gets up in morning her mood remains irritable. If anybody admires her elder brother, she starts crying loudly.
Her relation with family members is cordial. She is average in studies and likes shareshagari music.

PHYSICAL GENERALS: Lean and thin from the beginning.
CRAVINGS: Salty and sour things.
AVERSIONS: Sweets and milk.
THERMALS: Likes winter season.

HOMOEOPATHIC MANAGEMENT:

The foremost question is whether to accept case for Homoeopathic management or not?
The patient consulted Neuro-surgeon who suggested surgical intervention and a biopsy first to establish tissue diagnosis. But patient was not fit (physically, mentally and financially) to do that; therefore she was put on conservative line of treatment. Symptomatic treatment was suggested.

The case was accepted on following reasons.
1) With a brain malignancy it is usually impossible to remove the entire mass
2) Even for biopsy via burr hole the patient was not fit.
3) In the case of anamnesis: Characteristics feature, constitutional feature before the illness, original unmodified picture was available -both mental & physical.

TOTALITY

From the evolutional point of view her basic nature (Disposition) was:
1) Irritable[3], excitable, gets anger easily.
2) Consolation aggravates.
3) Contradiction aggravates.
4) Obstinate[3] nature
5) Interest in music, art. Average in studies.

On physical plane:
1) Lean, thin.
2) Hot patient.
3) Craving for salty things[3], sour[2]
4) Dislikes sweets and milk.

Disease Evolution: Sudden, fast leading to exhaustion; fulminating in character -indicates a dominant Tubercular miasm. Sensitivity is high, Susceptibility is poor with Structural irreversible changes.

Constitutional Remedy: *Nat-mur* was selected.
Potency: 30 HS
Intercurrent: *Tub-bov*
Acute remedy: *Glonoine* 30 or *Iris*-v 30.

Summary:
The treatment started on 18th Jan 03. The patient is still on treatment as of Jan 04
17/10/03, Better, medicine given for 2 months.
31-12-03: Wt 40. GC good. No weakness. No headache. Appetitie N. No nausea, no vomit or fever. Next Follow up will be in Feb 04

Follow up Criteria
Subjective:
1) Dullness
2) Weakness
3) Appetite poor
4) Headache
5) Nausea
6) Vomiting
7) Fever

Objective
1) Wt
2) CT - MRI after 6 months.

First prescription given on 18th Jan 03: *Nat-mur* 30 4P 1P HS.
The patient reported on 22nd Jan. 03: The patient is looking fresh, feeling hungry and asking for food. Took breakfast, bread and apples. Mother accompanied the patient.
Following history became available.
Patient → **born at home.**
Dentition → Diarrhoea.
Walking → 2 ½ years
Speech → 2 yrs.
P/H At the age of three year suffered from Typhoid, and was ailing for 3 months.
F/H Paternal grandfather's elder brother suffered from liver cancer and died four years back.
Maternal grandmother suffered from kidney stone.
Father is suffering from migraine since last 10 years.
Mother is suffering from Hypertension, Menorrhagia.
The patient's temperature was 100.8°F on 21 Jan → then touch normal.
Nat-mur 30 3P 1 P HS.
25th Jan 03: Mother gave further history that patient suffered from Boils and abscesses at the age of 5 years. More in monsoon.
Actively craves eggs[3]. *Nat-mur* 30 7P 1 P HS.
1st Feb 03: Active[3]. Wt- 33 kg
8th Feb 03: Overall patient is better[2]. Weakness >2. No Nausea. No vomiting. No fever
Tub-bov 1M 1P HS. Next day *Nat-mur* 30 6P 1P HS.
15th Feb 03: *Nat-mur* 30 1P daily HS.
22nd Feb 03: Suffering from urinary tract infection. Pus cells: 60-80. *Nat-mur* 30 7P 1P HS.
01/03/03: Appetite erratic. *Tub-bov* 1M 1P HS. *Nat-mur*. 30 6P 1P HS.
08/03/03: Appetite Better. *Nat-mur* 30 7P 1P HS.

Further management continued. *Nat-mur* 30 BD and *Tub-bov* 1M 1P once in month.
General: Weight 38 kgs. Appetite - normal. Patient has gone to village.
Follow up **MRI scan (26/03/2003) reveals**:
Resolution of the hematoma within the neoplastic process detected in the superior portion of the left thalamus and adjoining portions of the septum pellucidum, trigone and corpus callosum. Possibilities of Glioma / subependymoma need to be considered in differential diagnosis.
Patient is still on treatment.
17/10/03: Wt 38 kg. Patient had Menarche 4/9/03.

Motivation will almost always beat mere talent...
Norman R Augustine.