

BRIEF PEDIATRIC CASES.

Dr. D. E. Mistry.

M.S.

Solapur-413001. (India).

CASE NO-I-MULTIJOINT ARTHRALGIA.

(No4520) Master.S.A,6 years old brought on 14-6-90 with c/o mild pains in knees and elbows on off since one year.but since a month pains are continuously present.

Pain worse after sunset & early mornings.No fever. No swelling.

Clinical Diagnosis- Multijoint arthralgia.

Past history- Lt. ear discharge-4 month of life.Routine allopathic vaccinations.

Family history- Diabetes from mothers and fathers side.Cancer in paternal grand mother.

Other symptoms- poor appetite,oily food causes sore throat,normal thirst. Quiet nature. Sensitive: likes company but weeps on slightest injury.

Investigations.RA-negative.ESR-4 mms.Hb-10 gms %. WBC-9000.P-60.L-36.RBC-2.7 mill/cmm

Treatment:-Pulsatilla 1M-one dose only.

03/08/90 Was all right so far but pains have returned again. Rx.Thuja 30-3 doses 6 hourly.

18/08/90 Reported No pains. No medicine.

28/09/90 Very mild pains due to cold wet weather. Rx.Rhus tox 30-3 doses 6 hourly followed by Pulsatilla 1M next day. Has not reported any pains subsequently.

COMMENTS- Pulsatilla was the child's constitutional remedy needing Thuja as intercurrent before a second repeat of dose of Puls. Perhaps Carcinocin will have to be given if the child returns with same complaints.

CASE-II-POLIOMYELITIS

{No4811} Male 4 years child Master S. S. B first seen on 11/12/90 with a paralysis of both lower limbs since 14 months following an Injection of probably penicillin during a bout of fever.On examination-some movement only in great toe of Lt. side & minimum movements of some of the toes of both feet.Child can not stand, can only sit. No vaccines were given by the parents as they were staying in a remote village.No other relevant findings. Based on rubric -Paraplegia after fever in Phataks repertory there is only one remedy-Rhus tox.

So Rhus tox CM 3 doses given in one day. Patient was brought on 9/1/98 with return of movements in both thighs. Subsequently the parent reported- but they had not brought the child-that the child could stand and walk with support.

COMMENTS What surprised me in this case is the partial recovery that began 14 months after the paralysis with CM dose of Rhustox. That the proximal thigh muscles began to recover & show activity was a very good sign. Unfortunately as it often happens with very poor village patients they never bothered to bring the child for regular follow-up.

CASE III- RECURRENT TONSILLITIS

{No-4384} P.B, female child, 9 years old, first seen on 3/3/90 with-

H/o repeated bouts of tonsillitis since 3 years. by winter, ice cream and cold drinks.

Clinically both tonsils enlarged: rt. more than lt.

Likes-salt, eggs, sour, spicy and warm food also. Thirst-Medium.

Quiet, medium bold, likes company. Father- TB, Grand mother- Diabetes.

Treatment-Thuja 200-3 doses hourly. One more dose of same repeated on 9/4/90.

17/04/90 C/o pain in tonsils both sides after taking cold drinks.
Rx. Ars alb 30.2 doses only.

19/05/90 No further progress in size reduction of tonsils but not having any complaints like before. Rx. Baryta Carb 10M one dose only.

07/06/90 Sudden bout of Lt. ear pain & cough with painful submandibular gland. Does not complain of pain in tonsils. Mildly feverish. Rx Hepar sulf 30-4 doses 3 hourly.

14/06/90 Reported no ear problem after hepar doses but again fever, frontal headache with changing weather. Rx. Dulcamara 30-4 doses.

15/06/90 Sulphur 30 one dose.

16/06/90 Tardy Improvement. Rainy weather still. Rx. Rhustox-30. 4- doses 12 hourly.

28/07/90 Reported above complaints ceased quickly. Now tonsils size reduced but not still normal. Rx. Thuja 1M-one dose.

18/08/90 -Thuja 1M .One dose.

31/10/90 No complaints. Tonsils almost normal.

23/11/90 No complaints. Tonsils normal.

Since then patient has not had tonsillitis bout.

COMMENTS-Main remedies in this were Thuja with help of Baryta Carb high. Child may need tuberculinum later. Throat sensitivity to cold drinks much reduced.

CASE IV-RECURRENT TONSILLITIS.

Master S.K.S 5 & 1/2 years old, first reported on 26/07/90 with C/o repeated bouts of tonsillitis since 3 years. Each bout coming once in two to three months. Past h/o measles, diarrhea and repeated vaccinations. Vomiting & diarrhea during dentition. Father- Coryza & asthma.

Grand mother (F)- asthma. Much sweating. No other homoeopathic modalities.

Treatment was begun with Thuja 200 one dose. 24/08/90 Thuja 200 hourly 4 doses given.

27/09/90 Only mild cough. Thuja 200 -3 doses hourly given.
24/11/91 No complaints.No medicine.
02/03/91 No complaints.No medicine.

COMMENTS-This child with otherwise no clear constitutional picture needed just three doses of Thuja 200-given only on basis of repeated vaccinations. Has remained well since then and has had no further tonsillar trouble. Because of the family background it looks that Silica may be needed

CASE V-CALC CARB CASE

(No 5126)-Master K.A.D aged 5 years, presented with C/o on 27/5/92

- 1) blinking of eyes repeatedly especially seen on reading,
- 2) grinding of teeth with anal itching,
- 3) passage of threadworms.

All above mentioned complaints since 2 years & are worse in each May.

Personal History-Likes raw food vegetables & desires sweets.Likes food on colder side.

Sweating head chiefly.Mother has noticed a faintly brown 2" circular patch on Rt. rectus muscle near umbilicus since 2 years.No special mental characteristics.From Phataks repertory the following rubrics taken.

- 1) Teeth grinding during sleep.
- 2) Winking eyes while reading.
- 3) Shy. 4) Taciturn. 5) Worms.

Calcarea came prominently in all rubrics.

Rx.Calc carb 10M one dose only.

21/06/91 Much less blinking and anal itching.

01/07/91 No complaints.No blinking.No anal problems.

COMMENTS There has been no relapse since.

A single dose of child's constitutional remedy has cleared the child's wormy condition plus the concomitant eye problem.

CASE-VI.FREQUENT UPPER RESPIRATORY TRACT INFECTION

{No 4264} Master N.B.P 10 years old male child first seen on 24/11/89 with-

H/o repeated coryza then cough, then fever since 1.1/2 year. This is aggravated in winter and always at change of season. The complaints begin as mild cough the proceed to coryza and then goes on to fever.He had antibiotics, crocin & Adulsa syrup..

Family history of TB in Grand Mother.

Personal History-All mile stones normal. Usual Vaccinations. Likes sweets and sour.Sweats occiput & neck. Frightful dreams.

Is a mixer- affectionate-likes company yet can play alone & not get disturbed. Chest- Bony-prominence of costo chondral junctions. Long

narrow chest. Appearance- Fair skin. Long eyelashes.

Investigations:- X ray chest-nad. HB-12gms. WBC-9000/c.mm. P-68.L- 26.E-6.ESR-40.

Clinical Diagnosis-Allergic bronchitis.

Treatment:-The boy was given Calc phos 12x -one tablet BD till 20/3/90.

27/03/90 Reports mild fever, coryza & cough. Rx Gelsemium 30.6 doses 12 hourly. (because of the summer, thirstless condition & mild course of his acute ailment.

30/03/90 No fever or cough.

06/03/90 Sulphur 200 one dose.

28/04/90 Return of mild fever & coryza & cough. Rx. Tuberculin 200/1 dose.

03/07/90 Reports no trouble.No doses.

23/08/90 No trouble.No medicine.

15/12/90 No trouble.

Subsequently the patient was given glasses for myopia with a dose of Pulsatilla 10M followed by Calc flour 12x one tablet TDS for his myopic condition. When last reported on 7/4/91 his vision was not altered but had no allergic bronchitis problems.

His father recently in May 92 reported that patient has been free of chest problems.

COMMENTS:-Tuberculin was the main remedy to help this boy however favourable ground for this remedy was prepared by first giving the bio-salt-Calc phos. One wonders whether in view of the initial raised ESR, the boy would have landed himself later as TB lung but escaped from this.

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CASE VII-CORYZA, LYMPHADENOPATHY & JAUNDICE

No 4269 Male child T.P-first seen on 11/11/89 ,came with history of fever on & off since 6 month.

Past history:-3 years ago he had mild fever.loss of weight & some lymph nodes in neck & was probably given allopathic anti TB drugs for 2 months only.Diarrhea during dentition.Breath holding attacks in early childhood.H/o measles & dry itch and boils.

When he came for consultation there was no fever,but gives history of on off coryzas.He complained of ear aches during fever both recently and in past but no ear discharges.

Personal History:--Likes sweets,salt and spices.Sleeps mainly on abdomen. Sweats mainly head & neck.

Investigations:-ESR-22,Hb-8 gms, RBC-2.84 mill/c. mm, WBC-9000.N-40, L-52.X-ray chest slight increase in cardiac size. Rest-nad.

Observations:Child was well nourished. alert, intelligent ,obstinate

at home ,normal behaviour out side.Liked winter but was normal to summer.

Family history:-Grand mother-asthma.

Constitution-Bony, strongly Carbo calcic. Except for mild anaemia & repeated viral infections the child did not have any other pathological picture.

Treatment started with Calc carb 10 M one dose.

- 01/12/89** Ferrum phos 12x, QID.
- 11/12/89** Mild coryza; otherwise nad. ct Ferr. phos.
- 18/01/90** Coryza with cough- changeable weather. Rx. Dulcamara 30/3 doses only.
- 12/02/90** Repeated Dulc 30/3 doses for return of cough and coryza. No fever.
- 07/03/90** Blood report: Hb-8.4, RBC-3.28 mill/c. mm, WBC-10000, N-36 L-57, ESR-8
On basis of his lymphocytic increase he had Thuja 200 one dose & after 48 hours as he was still low on Hb; Ferrum phos 12x QID again.
- 29/03/90** Mild cough again. Thuja 1M & ct Ferrum phos 12x.
- 25/04/90** Return of mild cough but no fever. Rx. Thuja 1M/1 dose.
The patient then disappeared for 3 months but came again on.
- 6/07/90** Signs of jaundice of a weeks duration. Reports were
Serum bilirubin- - - -9.00 mgm
Serum bilirubin direct--6.00 mgm
Serum bilirubin indirect-3.00 mgm
Hb-8.0gms. RBC-2.86, WBC-11800, N-76, L-24, ESR-20 mm.
He was given Cardus Mar QT-before

meals and a Biochemic mixture of Ferrum phos, Natrum phos, Natrum sulf 12x after meals.

- 13/07/90** Appetite increased. No itching, urine almost clear. Rx. ct.
- 30/07/90** Reports were encouraging.
S. Bil—3.5 mgm
Direct—2.8 mgm
Indirect-0.7 mgm
Hb-8.4, RBC-3.32, WBC-9850, L-45, N-55. Only Cardus Q drops, No biochemics. Plus Sulphur 30/3 doses.
- 16/08/90** Billirubin Normal. 0.6 mgm. Rx. Lyco 30/3 doses, each dose on alternate night, cardus omitted.
- 12/09/90** Reports no problem at all.
Six months later father reports child is well-no fever & healthy appetite.

COMMENTS--The boy did not show any clear symptoms of his constitutional picture. He had come during an a febrile phase. Based on the strong bony constitution, his history of being given antikoeh's Calc carb 10M was given with support of Ferrum phos low for his obvious anaemia. I could have even started with Thuja because of his obvious lymphocytic picture when he first came but gave this remedy on 7.3.90 after his blood picture showed still a relative lymphocytosis though there was a marginal improvement in Hb and RBC count & ESR had obviously become normal. Thuja was repeated 3 times when he returned with cough. The last dose of Thuja 1M obviously did him

good for 3 months and then he returned with jaundice. I usually give cardus Q in preference to Chelidonium Q when there are no other features. I feel addition of biochemics helps faster recovery. Sulphur was given when Cardus

was stopped & Lyco followed as a final support to the liver. I was influenced to give this Lyco because he did give history of his earlier one month fever bouts as coming on & off at 4 pm each day almost till midnight

CASE VIII-A CASE OF CHRONIC OSTEOMYELITIS

No 3445 Matsr R.P male , 9 years from Gulburga first reported on 30/10/87 with a referral note from orthopaedic consultant there stating " case of chronic osteomyelitis Lt. tibia-all antibiotics used not responding to them"

Past history -Injury to Lt. foot & leg by a stone around June 87. In spite of antibiotics pus developed. The pus was drained & osteomyelitis tibia diagnosed. Second operation done in July 87 at Gulburga and third by another orthopedic specialist in Solapur in Aug 87. In spite of this the child continued to have pus discharges from 4 to 5 sinuses, a deformed enlarged leg in plaster cast & pyrexia irregular on & off.

Family history of asthma in grand father.

Observations-Hot patient. Aversion to sweets. Wants fan air always. Obstinate & sweats all over. Child is intelligent. Very fond of cricket and comes first in his class. Misses his school a lot

As there was nothing to go by for the first prescription being a hot patient. I gave Sulphur 1M one dose.

14/11/87 Report by orthopedic consultant that sequestrum is getting separated with good involucrum. Not much

improvement in pus.(parents too illiterate to opine on this.) Rx Sulphur 10M one dose.

16/12/87 Child reported saying he felt better. Rx No medicine.

31/12/87 Again reported. There were 4 sinuses discharging pus - serous - moderately bad smelling. Tibial surface much thickened. At times father reports child had fever but no medicines were given. I decided to try a biochemic combination. No 22 which has Calc phos, Kali mur & Ferrum phos in 3x & silicea 6x. It was given one tablet QID.

25/01/88 Patient reported less pus discharge from two sinuses and one bony sequestrum had come out on its own from one of the sinuses. Rx.No22 continued as before.

22/02/88 Discharges much less. Pains not there as before can bear weight on the limb. Rx.No 22.

26/03/88 Sinuses at two sites healed, rest still discharging.

14/04/88 Much better can walk more on the
Lt. leg Rx.ct No 22

05/05/88 Walking all over the house. Almost
no discharge. Here No 22 omitted
and only Calc phs 3x QID given.

10/06/88 All sinuses healed & dried up walks
in the house only.Rx ct Calc phos 3x.

18/07/88 Still on Calc phos.Can bear weight
well & walks everywhere.

His consultant orthopedic at
Gulbarga wrote back saying "X ray
shows new bone formation. There
are no sequestrae.No discharges
from the sinuses."

Rx.Calc phos 6x QID

03/01/89 Pt came in person except for slight
curvature of tibia all sinuses were
closed.However he came with the
complaints of pus discharge from rt
ear-a complaint which he had before
the osteomyelitis. Rx.Pulsatilla 1M/1
dose only.

03/02/89 Still reports mild pus discharge.Sent
a dose of Puls 1M again.

04/03/89 No pus discharge.Slight redness of
eyes.Walks well.Rx Sulphur 200/1
dose.

From 31/3/89 to 5/10/89 the patient reported
periodically with no complaints each time & no
medicines were given.He was advised to stop
coming & come only if necessary.

COMMENTS

With 3 operations and system full of antibiotics
I could have given Pulsatilla or Nux vomica to
start with but chose sulfur instead, mainly as he
was a hot patient and aversion to sweets. I could
have given Calcarea sulph after this but decided
on No 22 because I wanted to see for myself
what this combination would do. I think the silica
Kalimur and ferrum phos covered his fever,thin
discharges and pus formation allowing the
sequestrum to separate & get thrown out & the
Calc phos enabled the involucrum to form.This
was to me a gratifying result though today if such
a case comes I would opt now for only one
biochemic remedy. Finally stabilised after Calc
phos only and the child needed no further
operations. The subsequent purulent ear
discharge that responded marvelously to just
two doses of Pulsatilla makes me wonder
whether the ear was the original site of septic
focus that lodged itself at the site of tibial injury
to create an osteomyelitis.Who can say whether
this child's 3 operations could have been
avoided plus the obvious break in his school
career had he come to homoeopathy the
moment he got his injury ??
