Seizure Disorders in Children

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Summary:

The author discusses three cases of children with organic brain pathology, apparently cured of seizures with homeopathic treatment. Two had severe cerebral palsy (CP) caused by perinatal brain injury, and one had congenital microcephaly. Parents tried homeopathic treatment because of limited efficacy of conventional anticonvulsant therapy and because of adverse health and developmental effects. Homeopathic treatment removed the seizure disorders in all three cases.

Introduction:

Structural brain lesions, as may be encountered after trauma or asphyxia, are often accompanied by severe symptoms such as paralysis and chronic seizures. Spontaneous remission of chronic seizure disorders is rare. Thus, when homeopathic treatment brings about a lasting cessation of seizures, such that treatment can be discontinued where otherwise perpetual treatment with anticonvulsive medication would be the norm, this is noteworthy. I have selected three cases taken at random from twenty-five years of practice, which were reasonably well documented for more than six months after treatment was discontinued.

Seizures are the clinical manifestations of abnormal electrical activity in the brain as demonstrated by EEG, and may be asymptomatic. Symptomatic seizures can be characterized by temporary loss of consciousness, involuntary convulsive movements and/or general or localized rigidity of muscles; distortion of face, eyes, and mouth; drooling, grinding of teeth, and systemic symptoms of hypertension; tachycardia, arrhythmias, and hyperglycemia. Seizures often terminate after lactic acidosis develops.

During the postictal, or recovery stage, prolonged sleepiness, confusion, loss of appetite and dehydration may be noted. In cases where seizures last longer than five minutes or fail to self-terminate, or when there are recurrent seizures without return to consciousness between seizures, status epilepticus may be diagnosed.

Conventional treatment with anticonvulsive medications aimed at controlling the seizures is often unsatisfactory and fails to bring about a permanent recovery. Adverse effects of anti-convulsive medications include drowsiness, developmental delays, increase in the number and severity of seizures and other, more serious health effects such as liver damage and even cancer.

Seizures resulting from brain pathology constitute what Hahnemann referred to as “one-sided” cases, where only pathological symptoms can be elicited. This makes it necessary to take an especially detailed case to obtain every available element of the totality of the symptoms of the disorder and peculiarities to narrow down selection of an appropriate remedy. It is necessary to take note of subtle differences such as the areas affected during convulsions and the character and nature of the convulsive activity, as well as symptoms that appear when no seizures are noticeable, since convulsive disorders can affect the general well-being of the whole person.

In such cases, it is important to understand that emotional signs such as crying may be misleading in severe organic brain pathology. Crying and laughing are sometimes triggered by abnormal neurological reflexes. It is often best to rely on the parents’ intuition as to the meaning of their child’s emotional expression. For these reasons, these symptoms are relatively less reliable than they would be under other circumstances.

The cases below share the following characteristics: All had clinical petit mal seizures that were controlled — not always successfully — by anticonvulsive medication. In all cases, concern about adverse effects of the medication was the reason given by the parents to seek homeopathic treatment. In all cases, clinical seizures receded and remained absent over an observation period of at least six months after all treatment had been discontinued.

In these three cases, language ability was completely absent. Only objective signs of their disorder could be obtained. In all cases there were no reliable signs of a “mental state,” “sensations as if,” even of the details and location of pain and discomfort, or the reasons for their emotions. Fortunately, the success of the homeopathic method never rests on any one group of symptoms, such as mental state or sensations, but on the totality of all overt signs of the disorder.

Case 1. Petit mal and focal seizures with severe cerebral palsy (CP)

Adam was born to healthy parents following an uneventful pregnancy. During normal labor, complications developed: Fetal distress was noted, including late deceleration of the heart-beat and meconium in the amniotic fluid. Use of suction was attempted, but because of faulty equipment, forceps delivery followed. Upon delivery, the infant had asphyxia (low APGAR
After immediate transfer to the neonatal ICU, asphyxia was diagnosed, and chemical buffering restored vital functions.

After two weeks, the boy was released as “fully recovered” with diagnosis of seizures and unfavorable prognosis. Phenobarbital was prescribed. During the first several months Adam cried almost incessantly and failed to thrive. At seven months CT scans and MRI showed global brain injury with lesions throughout the cortex and most of the brain. EEG showed frequent abnormal electrical discharges in the brain, signifying seizure activity. Phenobarbital was continued, and at first seemed to successfully preempt clinical seizures.

In spite of general good health, the child showed significant developmental delays within six months of birth: profound motor impairment and severe athetosis. His neck and back were floppy, and by 18 months, when he was first seen for homeopathic treatment, he had shown no signs of walking or talking and had profound lack of anti-gravity control, combined with muscle spasticity. He was unable to keep his body upright. He had contractures of fingers, hands, arms and legs. There were severe swallowing difficulties, and because the parents refused tube feeding, the child had to be fed with liquid food through a syringe by the parents or an attendant. These problems, as well as all other signs of CP, persisted throughout his later life, and he remained confined to a wheelchair.

At nearly eighteen months, Adam had a seizure with clonic convulsions of the right arm, upward fixed gaze, nystagmus, salivation, and muscle rigidity, followed by profound sleepiness. Diagnosis in the ER was “status epilepticus.” Treatment with a “loading dose” of Phenobarbital caused a severe drop in heart rate and blood pressure, prompting emergency transfer to the ICU at another hospital, where a pediatric neurologist diagnosed “overdose of Phenobarbital.” The ER physician had given an adult dose of Phenobarbital in addition to misdiagnosing “status epilepticus” for what really was a prolonged postictal state of the seizure. After release, the daily dose of Phenobarbital was increased, yet focal seizures continued to recur.

Following the increased dose of Phenobarbital, Adam’s parents observed further developmental delays. For example, he had just begun to make first attempts at vocal expressions, which stopped after the daily dose of Phenobarbital was increased. He was continuously drowsy and listless. However, on doctor’s advice, the parents continued administering the medication. After a few months, the parents had become concerned about the declining health of the child, noting such symptoms as pallor, lack of appetite, reflux, projectile vomiting, general malaise and constipation—all of which they suspected were adverse effects of the medication.

After moving to a metropolitan area with more available medical services, the parents approached a new pediatric neurologist, who incidentally, did not agree with their conclusion that Adam’s symptoms were due to the medication. Reluctantly, he ordered a change of prescription to Tegretol, which he felt would be more appropriate for focal seizures, and which, to the parents’ dismay, required regular liver function testing. They observed a further decline in Adam’s health, but not in the focal seizures after the change in medication. During one of these seizures they decided to seek homeopathic care.

During the initial acute assessment, the child presented with distorted facial features, sunken-eyed, pale, with the eyes turned upward, staring towards the right with oscillatory sideway movements. He had a bluish discoloration around the eyes and a sad, worried expression. His teeth were clenched, with foamy saliva near the corners of the mouth; and he exhibited horrible breath. His right arm had a mild but regular twitch; trunk, arms, and legs extended backwards rigidly; the head and whole upper body were pulled backwards and kept pushing backwards, toward whatever support was provided. His back was rigid, hollow, and curved backwards so that it was impossible to lie flat on the back. His fingers curved inwards, with clenched thumbs.

**The object in cases suffering from profound CNS impairment is not to cure the patient, but to restore back to order what is curable**

Plan: *Cuprum metallicum* 30C, single dose, liquid on forehead.

The result was that the seizure terminated within a few minutes. Encouraged by the results, the parents decided to use the remedy in other, similar seizures. They had such good results that they approached their pediatric neurologists and expressed a wish to wean Adam off anticonvulsants, while trying homeopathic treatment. They were dissatisfied with the marginal efficacy of the medication and concerned about potential adverse health effects. The neurologist was willing to give the homeopathic treatment a try; with the caution that in case the seizures should get worse and not improve from homeopathic treatment, the medication should be resumed.

Under the neurologist’s guidance, they reduced the dose of Tegretol over the next two weeks. During this time, an increase in intensity and duration of the seizures was noted. While most seizures still resembled the symptoms as presented during the
No more noticeable seizures. Opium was given for one more month, and then discontinued. During a follow-up three months after Opium was discontinued, no more seizures had been noted. Based on several routine neurological check-ups over months, his pediatric neurologists recorded that no seizures were recorded during a series of EEGs. The boy remained seizure-free, and while he remained severely compromised by CP, his talent for writing poetry was later noted; with the help of facilitated communication, he learned to express his thoughts with a rare poignancy. During approximately ten years of observation following homeopathic treatment, no seizures were documented.

Case 2. Petit mal seizures and eczema with microcephaly

Thomas was seen for his first initial consultation at 4 weeks old. He was born with the frontal lobes of his brain missing. Almost no information is available on the family history since the child was adopted within days after birth. The adoptive parents are both well educated; the father is a professional in the medical field. The parents adopted the child fully aware of his condition. Whatever rudimentary part of the child’s cortex could be detected was severely deformed.

Seizures were noted soon after birth. The parents had not seen any signs of seizures when they first brought him home. Neurological exam found microcephaly and unilateral cleft on the right side of the brain. The seizures were found during a routine EEG within two weeks of his birth. There were, on the average, three seizures that lasted about three minutes over one-hour periods of observation. Phenobarbital was recommended and found to successfully control the seizures during four follow-up tests.

There were no visible signs of adverse reactions to the medication. Even though the medication controlled the seizures, as determined by EEG; parents noted episodes of “staring,” during which Thomas suddenly seemed to have a fixed stare lasting a few minutes. Concerned about the potential long-term effects of the medication, the parents sought homeopathic treatment.

The child was in good overall health, except for moderate to severe eczema on his neck. Rough skin was covering his neck, which at times seemed to cause discomfort. The child was quiet and appeared overall to be happy. He was in part, nursed by the adoptive mother, who was able to produce a small amount of breast milk. She also fed the baby with breast milk obtained from a friend.

Plan: Sulphur 1Q, once daily, in a liquid dose, to be followed after ten days with the 2Q. Follow up in three weeks.

After the initial consultation, the parents decided to gradually wean Thomas off of his prescription medication. Within a few days after it was reduced, the seizures became more pronounced. When the medication was discontinued completely,
he had regular seizures several times per hour, but they remained mild. Parents also noted some bouts of diarrhea; stools were liquid, dark, two per day, with more thirst than usual.

Thomas’ seizures began with a jerk or startling motion, as if surprised. He exhibited nystagmus: the left eye rolled up and down; both eyeballs rotated, or rolled up and down. Sometimes they would roll or twitch sideways. Face would have a grimace, worse on the left, and tightness of face. Arms would jerk. Left arm and both legs twitched, but that was hardly noticeable. He looked weak, wrinkled, pale, drawn.

Plan: Antidote secondary effects of Phenobarbital with *Phenobarbitalum* 30C, liquid, three doses daily, for three days. Change *Sulphur* to olfactory dose. Alternate once daily with *Belladonna* 1Q. This is to be followed after ten days with *Opium* 1Q. Follow up in three weeks.

After about six to seven days of *Bell*. 1Q, no seizures were noted for three days. Then *Opium* was started. Seizures returned, more intense than before. More violent, twitching more pronounced, rigidity, arching backwards, right eye twitched, not as rapidly as the left eye. Arms went up and right arm reached out, head turned to left side, staring, with twitches in eyes. Fearful or painful cry. If in mother’s arms, grabbed her hair or shoulder, while eyeballs started twitching - all of this lasting at the most 30 seconds.

However, the mother noticed that she could “catch” him, by distracting him, to the effect that he wouldn’t convulse. He appeared to be aware during the seizure. Seizures still commenced with a big twitch, as if startled. He started easily in general. The frequency was about one seizure per hour.

A skin rash developed on the face, moving to the back of the upper arms, elbows and then the back of the calves. It was gone by the time they came to the follow-up consultation. The mother had started to put lotion containing lanolin, oatmeal flower, and petroleum on it.

Plan: Discontinue lotion. Continue *Sulphur* 4Q, followed by 5Q, olfactory dose, once daily. Alternate with *Bell*. 2Q, followed by 3Q once daily. Follow up in three weeks.

Possibly initial aggravation of seizures and skin rash, lasting a few days, after first few doses of *Bell*. 2Q. Then seizures became less frequent, baby more aware during seizure. By the follow-up consultation, no further seizures. There had been no more twitches, no staring for the past several days. There was no return of rigidity since returning to *Bell*. Starting still seemed a problem for a while, but that also subsided. The painful cry stopped completely after several days. His mother had not put any lotion on skin. Rash was still present mildly, but is slowly clearing up. The baby had been thriving. Because the mother did not have enough milk, she started the baby on goat’s milk. He spit it up several times, which had not happened with breast milk.

Plan: Continue next four higher potencies of same remedies, changing potency every ten days, olfactory dose. Follow up in six weeks.

Doing well; no seizures. Skin had improved. Growing and looking well. No complaints. No neurological symptoms left. Leathery skin in neck had persisted. Good appetite, no more spitting up from goat milk. Still had patches of the “rash” on cheeks and elbows. Rattling in chest, without cough.

Plan: Discontinue *Bell*. After three days, try *Puls. 30C*, as needed for rattling in chest. Continue on *Sulphur*, daily, next four higher potencies, ten days each, olfactory dose. Follow up in 6 weeks.

Things were going well. Looked good, thriving. Had not had any sign of seizure or any other neurological symptoms. Dryness of skin, eczema in neck much better but not completely gone.

Plan: *Sulphur* next 4 levels in Q, same instructions. Follow-up in six weeks.

Parents called to cancel follow-up consultation, stating there were no more symptoms left. They said the rash on the neck and elsewhere had completely receded.

During a conversation about a month later, the mother stated that none of the seizure symptoms or eczema had returned. Her son had not had a single problem. This was confirmed again later by the friend who had referred them. The mother noted that, while the majority of other children Thomas was in contact with had been sick with cold and flu-like symptoms all winter long, Thomas had been spared.

A call to the parents six months after this last communication to ask for the most recent medical records revealed continued good news. There had been one check-up with the pediatric neurologist since the last homeopathic consultation. It showed that the child was thriving and had not had any return of clinical symptoms of seizures, and EEG showed no seizure activity. The child does not currently receive any kind of treatment.

**Case 3. Complex seizure disorder, causing multiple focal seizures, in child with profound CP**

Corinne was born with a difficult birth after a very easy pregnancy (mother took vitamins, exercised, meditated). The labor was long and protracted, failed to progress, and was induced after ten days of false labor. The cord was wrapped twice around the neck, with multiple additional complications, and Apgar score at birth was low. Corinne was subsequently treated in the NICU for brain swelling, where she developed seizures on the first day of life, and continued to have seizures as swelling
receded. She failed to achieve normal developmental milestones during her first year while under the supervision of pediatric neurologists. Anticonvulsant medications were begun immediately to control the seizures.

The mother consulted with two teams of neurologists from leading neurological centers in the country. Because there were hundreds of seizures daily, multiple anti-seizure medications were given simultaneously. In 1995 both neurological teams were excited about new anti-seizure drugs just on the market. “They tried each one, one at a time, and each drug became its own nightmare. Each seizure got worse; all the side effects were too numerous to sit here and tell you about.” Tegetol caused only two to three hours of sleep daily, anorexia and constant crying. In the mother’s words, “It should say in the PDR, ‘Warning: after six months on this medicine, it will darn near kill an entire family!’”

The mother finally tried homeopathy with another practi-
tioner; *Viscum album* tincture worked initially, reducing the frequency of seizures significantly, but gradually the seizures returned and she ended up back on five anti-seizure medications. So far, she had been given the following drugs: Felbatol, Ativan, Phenobarbital, Clonazepam, Klonopin, Depakote, Lamictal, Tegetrol, Neurontin and Dilantin.

At the time Corinne was first seen for homeopathic treat-
ment at age twelve, she had profound motor impairment, limited antigravity skills, and was non-ambulatory. She had a variety of equipment at home, as well as a Mulholland wheelchair, and received physical therapy and speech therapy. She was still at pre-
puberty, somewhat tall for her age and of overall healthy appearance. She had multiple muscle clonic motions and contractures of her extremities, which appeared to complicate a significant scoliosis. She had been suffering from severe constipation and was being treated with Senokot. She was treated with various proton pump inhibitors for esophageal reflux, and had been given numerous antibiotics, such as Cefzil, Erythromycin, Biaxin, Nystatin, etc. for recurrent infections.

She was on several anticonvulsive drugs for seizure clusters. In spite of several daily doses of these drugs, she had multiple breakthrough seizures per day, which was presented as a “good pattern” compared to other times when seizures were not con-
trolled as “successfully.” According to the neurologist’s notes, the seizure control had “waxed and waned” over the past several years. Her EEG was abnormal, with intermittent spikes and waves with a general distribution that indicated involvement of the left occipital region. The diagnosis was “multifocal seizure disorder.” In addition, Corinne was treated for sleep apnea, which appeared to be unrelated to the seizure activity. MRI showed periventricular leukomalacia with slight ventricular dilatation, but no evidence of increased intracranial pressure. These findings date back to the neonatal history of encephalopathy.

Between seizures, her extremities had a primarily spastic tone with a relatively hypotonic trunk. She had paroxysms of extensor hypertonus throughout the trunk; extending her head backwards and arching the back, lasting for ten to fifteen minutes. Protective reflexes were not integrated. She responded to auditory and visual stimuli. She was able to focus and track motion, and at times seemed to be able to control her gaze. She was completely non-verbal at the time first seen. She was vocal but had no ability to articulate. She expressed displeasure, joy, and sadness through sounds and facial expression. She smiled and interacted socially with her mother. She was mostly calm during the consultation, though at times exhibited a sudden burst of laughter, apparently a reflex impulse.

The seizures came in paroxysms, about two to twelve per hour. She would turn flushed in her face; the trunk and extremi-
ties would extend, become rigid, and exhibit small clonic con-
tractions. There was nystagmus, with eyeballs moving to the side, and she would utter a moaning sound, followed by drowsiness after the paroxysm. There were minor variations of these symp-
toms; and various factors could trigger the seizures. Fever, during one of her frequent flu-like colds, would increase seizure activity. The more numerous the seizures, the less distinct they were.

**Plan:** *Nux vomica.* 1Q, daily, ten days, then 2Q, five-drop dose. Mother was eager to discontinue proton pump inhibitors, Senokot, antibiotics, and gradually all anti-seizure medications, which she did with doctor’s supervision. Begin tautopathic an-
tidotes, in 30C potency, one at a time, for each medication as soon as it has been discontinued for at least 24 hours. Follow up in three weeks.

Seizures significantly reduced in frequency, and overall be-
came milder. She still seemed to have serious digestive and ab-
dominal complaints, including severe constipation. She was off all prescription medications except Depakote, which she began to gradually withdraw. Still had stomach pain, but reflux was improved. Overall health improved.

**Plan:** *Nux-v 3Q, 4Q, alternating with Opium 1Q,* then 2Q, standard dose. Antidote antibiotics with respective pharmaco-
des. Discontinue Depakote. Follow up in three weeks.

Seizures were completely gone. No more seizures were ob-
served except some minor symptoms of uncertain origin, such as fluttering of eyelids or waking at night and making moan-
ing sound with stiffness, with stomach complaint. Major over-
all health improvement, had not had any colds. Indigestion was mild, reflux almost gone. Difficulty falling asleep. Still had sleep apnea. Still had terrible constipation, but was able to do without suppositories. Stamina was also increased; she was able to ride horse for one hour without tiring, whereas before she would ex-
haust after 30 minutes. Teachers and therapists commented on Corinne’s overall improvement.
Plan: Nux-v. 3, 4Q, and Opium 2, 3Q., standard dose. Antidote proton pump inhibitors. Follow up in three weeks.

Continued problems with constipation. Doing well overall. Sleep apnea gone. Occasional stomach pain, probably related to indigestion; possibly also to diarrhea. Had not had any reflux. Seizures had not returned and patient was off all anti-seizure medication.

Plan: Nux-v. 5, 6Q. Opium 4, 5Q., standard dose. Continue to antidote past drugs, in reverse chronological order.

Doing well overall. Abdominal pain clearly related to constipation. Required glycerin suppositories to have a bowel movement. Continued constipation but improvement in stool. Doing well, showing improvements in learning skills and social interaction. Mother noted she seemed to make attempts to communicate. Sleep improved.

Over the next few months, the constipation continued to improve, but did not yield. It was obvious that the treatment had improved symptoms only, but was unable to resolve the disorder. Eventually it was demonstrated that the scoliosis caused impaction of the bowel and caused the constipation. Body manipulation by chiropractic, massage, and finally, Rolfing seemed to bring significant improvement, while the homeopathic treatment continued for several more months and was finally discontinued.

Homeopathic treatment continued for more than a year because of improvements in development and overall health, which continued throughout the 18-month period during which the case was monitored. None of the other symptoms returned during the time she was treated. Corinne’s overall health was improved. The seizures never returned after they disappeared during the first two months of treatment. (According to a written neurologist’s report requested eight years later, there had not been any relapse.) Homeopathic treatment ended in two months a twelve-year nightmare of suffering for a whole family, as a result of seizures inadequately controlled by the latest designer drugs.

Discussion:

One-sided cases constitute the crème de la crème of homeopathic prescribing. If successful, they illustrate that homeopathy can succeed in resolving serious and even desperate chronic disorders even when only the symptoms of the pathology are present or expressed. The object in cases suffering from profound CNS impairment is not to cure the patient, but to restore back to order what is curable—in this case, the seizures. Injury to the CNS cannot be reversed, but some of the functional disorders it induces can be. The difficulty for the homeopathic method is the paucity of symptoms that are exhibited or can be elicited in these cases, given the absence of speech. Even “facilitative communication,” while sometimes apparently able to elicit profound expressions on the part of nonverbal individuals, has largely failed when it comes to yielding the valuable, but trivial, details of human feeling and sensation that often provide the key to the optimal match in homeopathic prescribing.

Cases almost entirely lacking any subjective symptoms have one advantage over the rest: Objective symptoms are, as a rule, more reliable and less ambiguous than subjective symptoms. The guidelines left by Hahnemann, supplemented by additional evidence confirming his principles which has been discovered since, when systematically applied, lead to lasting curative results where nothing is known about a patient’s spiritual or psychological state. Indicators such as “core essence,” “vital sensations,” “central delusions,” “signature,” or purported greater symbolic or astrological significance or synchronicities are subject to interpretation and introduce an element of uncertainty. Rather than using barely proven and obscure remedies, the most common of polycrests more often than not prove most successful in resolving the case where the full extent of symptoms cannot be known.

These cases responded predictably to a remedy or several remedies that covered the totality of the symptoms of the disorder or disorders, especially those that were peculiar. There was virtually no possibility of communicating with the patients themselves. However, the message conveyed by their observable pathological symptoms and history proved sufficient to find the medicines that cured their seizure disorders gently, rapidly and permanently.

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