



Homoeopathic Approach Towards Cerebral Palsy

Dr. Unmesh L. Patil M.D. (Hom.)

Professor & HOD, Department of Homoeopathic Materia Medica
Foster Development's Homoeopathic Medical College, Aurangabad. (M.S.)
E-mail: unmeshpatil68@gmail.com

ABSTRACT

Cerebral palsy (CP) is a group of permanent movement disorders that appear in early childhood. Cerebral palsy is caused by abnormal development or damage to the parts of the brain that control movement, balance and posture. Risk factors include, but are not limited to, preterm birth, twins, certain infections during pregnancy such as toxoplasmosis or rubella, exposure to methylmercury during pregnancy, difficult childbirth, and head trauma during the first few years of life. About 2% of cases are thought to be due to an inherited genetic cause. A number of subtypes are classified based on the specific problems present. Treatment must be goal-directed, such as assisting with mobility, reducing or preventing contractures, improving posture and hygiene, and providing comfort. Every member of the child's multidisciplinary team, including the child and both parents, should participate in serial evaluations and treatment planning.

Keywords : Doctrine of Signature, Homoeopathic Medicines, Homoeopathy and Materia Medica

Introduction

Definition

Cerebral palsy is defined as a chronic impairment of the CNS involving posture and tone, occurring at an early age, not as a result of a progressive neurological disease associated with vision, hearing, teeth, behavior with or without seizures. Cerebral palsy is the most common motor disability of childhood. The incidence of cerebral palsy in multiple births is 7.5/1000 live births and in singletons it is 2.1/1000 live births and over 1500 grams or less is 80/1000. 10% of the world's population has some form of disability from various causes, in India it is 3.8% of the population. Almost 15-20% of the total number of physically disabled children suffer from cerebral palsy. In India, the estimated incidence is around 3/1000 live births. In an analysis of 1000 cases of CP, it was found that spastic quadriplegia accounted for 61% of cases, followed by diplegia in 22% [1]. The prevalence of CP has increased somewhat due to the increased survival of very premature babies weighing less than 1000 grams, who develop CP at a rate of 15 per 100. Risk factors include preterm birth, twins, certain infections during pregnancy such as toxoplasmosis or rubella, exposure methylmercury during pregnancy, difficult childbirth and head injuries during the first few years of life, among others. About 2% of cases are thought to be due to an inherited genetic cause.

Classification

The topographic classification of CP is monoplegia, hemiplegia, diplegia, and quadriplegia; monoplegia and triplegia are relatively rare. The affected areas overlap considerably. In most studies, diplegia is the most common form (30%-40%), hemiplegia is 20%-30% and quadriplegia represents 10%-15%. CP can also be classified based on the type of neuromuscular deficit to

- A. Spastic.
- b. dyskinetic (including choreoathetoid and dystonic)
- c. Ataxic
- d. Hypotonic.
- E. Mixed.

Spastic CP is the most common, accounting for 70% to 75% of all cases, dyskinetic 10% to 15%, and ataxic less than 5% of cases. Spastic types show pyramidal involvement with upper motor neuron signs, weakness, hypertonia, hyperreflexia, clonus, and a positive Babinski. Dyskinesia is characterized by extrapyramidal involvement, in which rigidity, chorea, choreoathetosis, athetoid and dystonic movements are seen. This type of CP is also associated with birth asphyxia. The severity of dystonic postures can vary depending on body position, emotional state, and sleep. Clonus and Babinski are missing. Primitive reflexes are more pronounced and last longer in dyskinetic CP. These movement patterns are eliminated during sleep with a reduction in the tone of the affected limbs

There are also abnormalities of postural control and coordination. Children who start with hypotonia may develop into this type between the ages of 1

and 3. The majority of this group does not have a cognitive impairment. Dysarthria, oromotor problems with salivation and difficulty swallowing appear. Hypotonic CP is characterized by generalized muscle hypotonia that persists beyond 2 to 3 years of age and is not the result of a primary muscle or peripheral nerve disorder. Deep tendon reflexes are normal or hyperactive, and muscle and nerve electrical responses are normal. More than half of the children develop overt cerebellar deficits in coordination, ataxia, and impaired rapid successional movements. Dysequilibrium syndrome can be seen as manifesting difficulties in maintaining an upright position and experiencing the position of the body in space.

Gross Motor Function Classification System (GMFCS) – This is a recently developed system that has been found to be a reliable and valid system for classifying children with cerebral palsy according to their age-specific gross motor activity. The GMFCS describes functional characteristics in five levels, from I to V, with level I being the mildest in the following age groups: under 2 years, 2-4 years, 4-6 years, and between 6 and 12 years. Separate descriptions are provided for each level. Level III children usually require orthotics and mobility aids, while Level II children do not require mobility aids after age 4. In IV. disabled children function in supported sitting, but independent mobility is very limited. Children in grade V lack independence even in basic anti-gravity postural control and need strength mobility.

Homeopathic Approach

CP is a syphilitic disease leading to muscle paralysis and later atrophy. Whatever pathology happens in the disease, it ultimately leads to a loss of muscle mobility. In doing so, the motor cortex is affected, so fewer nerve impulses are transmitted to the corresponding muscle, causing the muscle to lose function. The purpose of paralysis is to show fake death, like when animals play dead when faced with a predator or danger. Here again it is important that paralysis is the result of disease; not the disease itself. As this representation of the dead is a reaction/defense adopted by the constitution of the child, but not the disease itself. The real disease is why he wants to show up dead, why he doesn't want to move, what started the disease process in the womb or at birth or after birth, why his brain was targeted and that also some specific area of the brain and not any other area or authority. The conflict related to muscle movement is the motor conflict "not being able to move" or "feeling stuck". The fetus may experience an "inability to relocate" conflict when the mother is in danger or due to threatening sounds in the immediate environment, such as jackhammers, chainsaws, lawnmowers, lawnmowers; loud kitchen equipment such as blenders held close to the uterus scream and shout. (quarrels between parents, mothers shouting at their children). In this case, if the conflict is not resolved, the child may be born with partial paralysis of the legs with motor disabilities. The conflict of "feeling stuck" can be activated during a difficult birth as the child coped immediately after birth. The motor disability seen in CP is the result of motor conflicts experienced by the fetus in utero or during the birth process.

MIASMUS: Syphilis destruction and autoimmune.

Pathological and specific rubrics:

1. Head; Softening of the brain
2. Head; Atrophy, brain, of
 3. Head; Brain, complaints of
 4. Head; Fontanelles, open
 5. Limbs; Contraction of muscles and tendons
 6. Limbs; Contraction of muscles and tendons, lower limbs
 7. Head falling forward, backward or sideways
8. Limbs; Emaciation, lower limbs

Mental rubrics can be:

1. Feeling helpless
2. Delusion, cannot be helped
3. Illnesses from rage, affliction
4. A/F anger, indignation, dismay, shock s
5. Offenses A/F insult
6. Delusion of unhappiness inconsolable over
7. Delusion, abandoned abandoned
8. Delirium, terrifying
9. Desire for death
10. Resignation in disgust
11. Delusion, error of personality identity

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