EPILEPSY CASE STUDY - by Kay Sainsbury

By Deb Goulden Kendall on Wednesday, 13 July 2011 at 14:03

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Summary: Primary Generalized Epilepsy in a young girl, diagnosed at 3 years 1 month, comprising an aggressive 4-seizure type condition (tonic-clonic, myoclonic, atonic and Salam seizures). Some seizures were experienced at night (diagnosed as "nocturnal epilepsy") and carried a higher mortality risk. A regular reflexology treatment pattern along with low dose anti-epileptic medication achieved full seizure control within six months!

History: M was born with eczema all over her body, but with the help of, soya milk instead of cows' milk, and chamomile cream applied after baths, the dry skin and flakiness gradually diminished by about nine months, leaving it just behind her knees. After being weaned on to solids into toddlerhood she could be heard to "yelp" about an hour to two hours after being put to bed. On investigation it was found that she was "out cold" (presumed asleep) but lying in a pool of undigested food which she had vomited up. These could have been early signs of a seizure and instead of being asleep, she was unconscious. She was very active in the uterus during pregnancy and the mother had nine months of morning sickness. It is possible that seizures were occurring in utero.

Growth was normal between 18 months and just under 3 years. The sickness and stomach noises in her sleep continued on occasion. She had an unusually large uvula and suffered quite a few skin complaints, but no determined signs to give reasons to suspect epilepsy at that time.

Onset of seizures: The first visible waking seizure was in March 2002 with rolling eyes in the head, tongue hanging out of her mouth and her arms flopped to the side. She was taken to hospital for observation but nothing abnormal was found.

Intestinal link: Two days after this first seizure she began to show signs of a bout of enteritis. Reflexology was performed to help with the gastroenteritis and association discomfort and the reflex areas of her feet showed inflammation over the small intestine area, the ileocecal valve, the transverse colon on the right side of her body and on the left at the sigmoid colon. She often gave out gasps in her sleep, especially between the hours of 4.30 and 6.30 a.m., which coincided with loud "tummy noises" and jerks of her body (later diagnosed as myoclonic seizures).

Research was conducted on the internet about a link between the stomach and brain - abdominal reflexology - via the vagus nerve (or pneumogastric nerve) which has a direct effect on the digestive system. This could have been a reason why "stomach noises" were heard preceded a seizure and became a warning sign.

According to her epileptic consultant, in childhood epilepsy if a child is not born with the condition, seizures typically occur during the years between 1 and 3. Any parent will realize this is at a time when a child's immature digestive system is struggling to cope with an array of newly introduced foods. In M's case it was highly likely that some compromise of the digestive system was triggering a reaction in the brain, possibly through the vagus nerve.

Most of M's seizures were within two hours of going to sleep or within the two hours of waking, within which time of course she will also have eaten. Also if constipated, seizure activity would increase and adequate fluid intake became a focus of attention.

Diagnosis: Within two weeks of the gastroenteritis M had her first tonic-clonic seizure, which was followed later in the day by two more. Two weeks later she had three more. This time she was admitted to hospital where they did an EEG, an MRI scan, an ECG and a Woods light examination, and of course blood tests. During this stay in hospital she was jerking (myoclonus) and dropping to the ground (atonic seizures) when playing within the same two hour period on waking, and then a fourth seizure type (Salam seizures) began. By the end of April 2002 she was diagnosed with Primary Generalised Epilepsy with four seizure types. By June 2002 she was having upwards of 10 seizures a day. Her parents were advised she should wear a helmet to protect herself and that this pattern was likely to increase with growth and into puberty. This was a typical pattern of epilepsy diagnosed from age 3 and the consultant informed the parents he was monitoring at least three other children with exactly the same pattern and age. Medication was prescribed with a warning of a multi-dose (i.e. more than one drug) being needed as time progressed.

Initial alternatives to anti-epileptic medication: A cranial osteopath brought initial relief. The daytime myoclonic seizures appeared to cease immediately following the treatment. On the second visit a twist in the sacral bones of the lower spine was identified, which appeared to be rectified. Though a calming treatment for the child (resulting in sleep) only partial relief was obtained for a brief period.

There followed a 10 day monitoring of her eating, sleeping and bowel habits. Reflexology was done more frequently during this period increasing it to three times a week. During this 10 day period there were no tonic-clonic seizures, but other seizures continued. However, a further distressing tonic-clonic seizure forced the parents into accepting anti-epileptic medication. She was started on Epilim (Sodium Valproate), which was followed six weeks later by Lamictal (Lamotrigine).

Meridian link: In Meridian Therapy (as in TCM) it is believed that if the energy of a particular organ or meridian is insufficient or excessive for prolonged periods, the body will be thrown out of balance and, if severe enough and prolonged enough, dis-ease will result. Each meridian has a peak flow of energy during which time each organ performs its designated functions and a quiet time when it is at rest to allow the flow of energy to enter another meridian.

Large Intestine Meridian energy giving way to the Stomach Meridian: Combined peak times for these meridians is between 05:00-09:00 a.m. Excess energy (chi) appeared to be manifesting in the peak period of these meridians as this was the period of time when M had her worse seizures, several of which included unconsciousness. Using linking and holding techniques on the meridian points for the large intestine in the foot during this time helped to sedate the excess energy. If she had managed to empty her bowel in good time, then she wouldn't have a seizure; however this was very erratic at the time.

Reflexology treatment: In the initial stages treatment was four to five times a week, going down to two or three further into the treatment. A deeper pressure than would normally be envisaged on a child's foot was needed around the large intestine area, except (as explained above) during seizure activity. Areas treated included the whole of the digestive system, head/brain, adrenals, bladder

and kidney. The stomach meridian pathway was followed on the foot (mimicking the area of the lymph drainage on the top of the foot, running from the second (stomach) toe to the ankle.

During the first two weeks there was an increase in seizure activity but a reduction in the duration of the tonic-clonic seizures, reducing from two minutes to one minute. This was seen as a classic healing crisis. *The longer the seizure activity the more likelihood of damage to the brain so a reduction in duration was to be welcomed.* Other seizure types were also reducing in frequency.

Within five months of regular twice weekly treatment there was only one seizure type showing up (tonic-clonic seizures) reduced to two or three a month - finally going altogether by six months after diagnosis with sustained treatments. All seizures were monitored daily and because of the obvious reduction in seizures, the epilepsy consultant suggested that one of the anti-epileptic medication was reduced with a view to withdrawal. The other was maintained but not increased, so effectively reducing its potency in the growing body.

Reflexology and side effects to medication: The frequency of reflexology was an important factor in minimizing the expected side effects of anti-epileptics. M was regularly given blood tests to assess liver function as these drugs can cause liver damage. There was also advice that there may be developmental retardation due to the Epilim, and drowsiness. All tests came back perfectly normal. Reflexology hastened the toxic element of these drugs from the body, allowing the organs to function normally and healthily, avoiding long term damage and expected side effects. Although suffering some injuries during seizure activity, there was no evidence to support the initial fears surrounding the side effects of medication.

Seizure recurrence: It was initially advised that seizures were likely to recur after seizure control was established due to the growth of the brain stimulating further seizures and the ineffectiveness of the medication due to increased weight. During the normal growth period between ages 3 to 5 M had no "breakthrough" seizures at all. She had a very slight tremor for a while which was worse when she was tired, and it is believed that this could be a side-effect of the medication, or a residual nerve response.

Progress to date: After becoming seizure free after six months, there were no signs of seizures after that. The medication M was administered when she was 3 was not increased. The level of the medication in the blood needed for seizure control is determined by the weight of the individual. It is normal for the dosages for children to be increased with age (and obviously weight). At M's regular consultant reviews an increase was not felt necessary because of early seizure control. Her natural increase in weight had the effect of slowly weaning herself off the drug - its effect in the body being diluted. All seizures ended at the age of 4 and there have been none recurring. She was fully weaned off all medication by the age of 5.

Case Study Conclusion: A comment which M's Consultant made at her six monthly review was that with an aggressive seizure pattern of this nature he would not be surprised to be introducing a third or fourth medication and still be trying to get seizure control a year to 18 months after diagnosis. I believe it is thanks to reflexology that she is not in that unhappy position.

UPDATE: M is now 14 years of age. She has had no recurrent seizures. She has had normal childhood illnesses, some with high fever, including influenza and viruses, and no seizure pattern

observed. She is fit, active, sporty and arty. She attends a local grammar school and is an A student. She appears regularly in dramatic plays, with long days at school and rehearsing and doing sports. She is a keen swimmer and tennis player. She has flown a plane (!) done horse-riding and bungee jumping. She is currently embarking on canoeing and water sports with great enthusiasm. She is also a dancer and choreographer. There have been no signs of a flare-up of this condition and it is thought that regular reflexology has kept this at bay. She is fortunate enough to have a mother who is a reflexologist so treatment can be as and when needed.

CASE STUDY CONCLUSION AND NOTES FOR COLLEAGUES

Epilepsy as a contra-indication: When trained in reflexology many of us are taught that epilepsy is a contraindication as it could possibly bring on a seizure. Whilst this may be true (and is certainly something both client and therapist should be aware of) the benefits of ongoing treatment far outweigh the initial adverse reaction to treatment of this kind. There is also the very real effect that reflexology has on the side effect to the anti-epileptic medication, which can be quite severe and debilitating for some people. Therefore reflexology in epilepsy should be treated as a caution rather than a contra-indication. An initial and temporary "healing crisis" where things appear worse as the body clears is expected with other conditions when using reflexology so why not epilepsy? Possibly the fear of witnessing a seizure could put many reflexologists off, but if seizure control is affected and improved by reflexology then that has to be of benefit to the individual. However, it must be a matter of choice for the reflexologist. If you are prepared to treat but do not want the responsibility of dealing with a client's possible seizure, ask that they bring a friend or relative with experiences of seizures into the therapy with you. ***NB: Never suggest to a client or attempt to influence a reduction in anti-epileptic medication. This is a decision only the client's consultant can make.*** However it would be acceptable professional practice to write to the consultant with any findings or results from a treatment pattern only at the request of and with the consent of your client.

General conclusion: (1) Reflexology is only contraindicated in epilepsy if the therapist does not feel comfortable doing it and/or the epilepsy consultant, through the client, does not agree with the treatment. (2) If considering working with children it is necessary to get a "consent" or "agreement to treat form" signed by the parent and have the parent present at treatment. (3) As with any other condition symptoms can "appear" to get worse before they get better; epilepsy is no different. The client (or parent) is best informed of this and the reasons why. (4) Frequency of treatments is key to a successful outcome. The more frequent the better, but always bearing in mind any other factors which would affect this such as age and overall health. (5) Timings of seizures may be crucial to identifying when to treat. Ask your client to have their seizure times monitored if possible to see if there is any link with sleep habits, bowel habits or eating habits. (6) Be prepared for an initial increase in the amount of seizures and advise client accordingly (duration should show as reduced). (6) Do not under any circumstances suggest a change in the taking of anti-epileptic medication, even if your treatments result in a reduction of seizures.

Other advice: (1) This is one of those conditions where asking as many questions as possible will help. Being as informed as possible will help you help your client. If in doubt as to anything you could consult colleagues, your Association or one of the many forums available on the internet now. I would strongly advise that you give water before any treatment for reflexology and continue the

suggestion that the client drink water more regularly. I think there is a general misunderstanding of the vast need for water for brain activity, especially during growth periods, but this remains true of some adults, especially the elderly. (3) Read up as much as you can on this condition if you wish to treat. There are quite a few Facebook pages with a plethora of experienced reflexologists from around the world. There is a lot of information available on epilepsy (and also abdominal epilepsy) and the connection between the brain and the stomach. Go to https://www.epilepsy.org.uk/ for more information and http://www.ncbi.nlm.nih.gov/pubmed and put in key words. Your client (or the parent) may well ask questions about what you know about this condition. It is a vast subject and we are not doctors, but a global knowledge may help you to approach working with clients with epilepsy more professionally. It can be very rewarding, but challenging at the same time.

If you would like any further information Kay can be contacted on: Email: kasss6@hotmail.com

NB: Due to health reasons Kay is no longer practising reflexology and is not, therefore, a member of the Association of Reflexologists in the UK and is not covered by therapists insurance. Any advice given in this article is from her own experience from when treating this condition in her practice.

Legislation and best practice varies from country to country. If in any doubt about treating and the extent to which to treat, please consult the relevant Reflexology Associations/authorities in your own country.

This case study is presented to colleagues for information only and no liability is to be assumed from information and advice given in this article.