

A NATUROPATHIC APPROACH TO HEAD INJURY

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ABSTRACT

Trauma to the head, and potentially to the brain, can be a complicated health issue, responsible for a variety of symptoms. This article reviews five cases of head injury treated with homeopathic medicine, and suggests that a homeopathic remedy be prescribed for head injury based solely on the specific symptoms of the lesion or injury.

Traumatic brain injuries accounted for 34% of all injury related deaths in the United States in 1992. The primary cause of traumatic brain injury (TBI) is transportation (motor vehicles, bicycles, pedestrians, and recreational vehicles). The highest rates of these accidents are among people 15-24 years of age. The second leading cause of TBI is falls, with the highest rates occurring among people 75 years and older. In the United States, the incidence of head injury resulting in hospitalization or death is approximately 1 per 100 people having fallen from 2 per 100 people in the 1970s. This decline indicates a decrease in TBI-related deaths associated with motor-vehicle accidents and in the number of nonfatal TBIs resulting in hospitalization. This decrease may reflect the success of injury prevention devices like seatbelts, and motorcycle helmets and may be associated with changes in criteria for hospital admittance since patients with mild injuries are frequently not admitted (1). (Barbara Gabella, MSPH, from the Colorado Department of Public Health and Environment, who reported these statistics to the Center for Disease Control, said to this author that the number of people with TBI is probably much higher since these statistics reflect only those reported by hospital discharge and death certificates.)

There is a continuum in classifying the severity of head injury. The symptoms related to head injury vary greatly depending on the location and intensity of the trauma. A severe head injury from massive trauma may result in permanent coma or death due to skull fracture, hemorrhage, or extensive brain damage. Whereas, in a mild head injury from minor trauma the skull is not fractured, and the cranium remains intact (2). A person may maintain consciousness with a minor head trauma and consider it "just a bump" but its importance should not be dismissed, given that brain injury may result from both major and minor trauma (3).

When the head hits an immovable object such as the floor or a dashboard, the brain, still in motion, collides with the inside of the skull causing localized trauma. This localized, or "focal" trauma, also occurs with coup, injury to the brain at the site of primary impact, and contre-coup, brain trauma opposite the site of impact (4). Accelerative force that rotates or torques the brain within the skull causes diffuse axonal injuries resulting from a stretching and tearing of the microscopic nerve cell filaments (5). Focal injury and diffuse axonal injury are both forms of brain injury that are not always detected by standard medical procedures such as neurological examination, CT scans, MRI or EEG (6).

Effective methods for evaluating brain injury are found in the field of neuropsychology. Early approaches that included the Glasgow Coma Scale, Jennett/Teasdale Scale and the Russel Index often offer vague

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CASE STUDY

evaluations (7). The General Neuropsychological Deficit Scale, however, is a highly useful measure providing a comprehensive evaluation of brain-behavior relationships (8). A neuropsychologist may take up to twelve hours to do a thorough evaluation on a patient with brain injury. Ideally the testing will be divided into several short sessions over a number of days since, generally, an individual's stamina decreases after brain injury. Controversy exists over when a patient should be given a neuropsychological evaluation. Some doctors suggest that the patient wait three to six months after the injury to allow the brain to heal spontaneously. Others feel that patients should be tested as soon as they are physically able. Results from these tests are used not only to evaluate the person for diagnosis and treatment plans, but also in litigation (9). It may be prudent to evaluate the patient as early as possible to show the level of damage incurred. Patients with a high intelligence may test as "normal" after three months, but they were far above "normal" prior to the injury (10).

The symptoms of mild traumatic brain injury (MTBI) include fatigue, depression, anxiety, vertigo, headaches, impaired memory, loss of behavioral control, problems with cognition, problems with attention and concentration, visual disturbances, sleep disturbances, emotional instability, and seizures (11,12). The DSM-IV definition of MTBI lists "cognitive deficits" as well, which are defined as those "involving attention, concentration, perception, memory, speech/language, or executive functions that cannot be completely accounted for by emotional state or other causes" (13). Severity of the symptoms ranges from minor manageable complaints to extreme, sometimes disabling, problems. The patient may have difficulties returning to employment and functioning in the home (14). The patient may never fully recover from the injury.

In the treatment of brain injury, beneficial modalities include: cognitive training, occupational therapy, speech and language therapy, Tomatis (auditory brain retraining), sensory integration, neuro-feedback, physical therapy, exercise, recreational therapy, psychotherapy, cranio-sacral technique, acupuncture, and homeopathy (15).

Homeopathic medicine addresses the initial trauma to the head and helps restore normal body function (16). This author suggests that the homeopathic case be taken based solely on the symptoms associated with the head injury. In taking a homeopathic case for head injury, the symptoms specifically related to the injury are the focus of the interview. These are the symptoms that occurred acutely and as sequelae to the injury. These symptoms, and only these symptoms are utilized for assessment of the homeopathic remedy. After the lesion has been cleared, the doctor can address the miasmatic or constitutional case.

In cases in which the initial injury is not severe, or has even been forgotten, the subsequent symptoms are frequently not diagnosed as head injury related. A thorough history is essential in determining if symptoms are related to previous head injury. Patients may initially reply that they have never had a head injury. Further investigation often reveals accounts of whiplash, childhood falls, sports injuries, and other contusions that the patient may not associate with concussion or brain trauma. The doctor's meticulous inquiry in obtaining an accurate trauma history is crucial in formulating the correct diagnosis for brain-related head injury.

Clinical experience shows that the time elapsed between the accident, whether recent or occurring a number of years ago, and the present, has little effect on the curative power of the remedy. Exacerbation of symptoms is common in homeopathic medicine, and the author's experience has shown it to be especially dramatic in head injury cases. It is recommended that head injury patients take the homeopathic remedy at night in bed. Taking the remedy at night in bed will help the patient to avoid misfortune arising from an aggravation. From clinical experience the patients should be advised that they may vividly remember the events of the accident, may dream about it, and may re-experience the acute symptoms of the injury. They should have a day of rest scheduled after taking the remedy in case these symptoms persist. Clinical experience has shown that after taking the homeopathic remedy the patient's overall sense of well-being is increased, and specifically the symptoms addressed by the homeopathic

remedy are improved if not eliminated.

CASE #1

MB, an 18 year-old male, presented with headaches that occurred when he was in sunlight. He had no other symptoms and was basically healthy and physically strong. He lived and worked on his family's ranch. He had experienced headaches since the age of 11 and could not relate them to anything other than exposure to the sun. He was in sunlight on a regular basis and could find no relief from these headaches. His history revealed a head injury at age 10. He was running behind some large haying equipment, turning his head to look over his shoulder and he smashed his head into the machinery. The impact was so hard that he lost his vision for about 3 minutes. He did not lose consciousness, and when his vision returned, thinking he was OK, he resumed his work. He had never associated his headaches with this accident. Since the headaches started soon after the head injury the author assumed a relationship between the two. The rubrics consulted in Kent's Repertory were: Head, Concussion of brain; Head, Pain, sun, exposure to; Vision, Loss of Vision, sudden. Natrum Muriaticum was the only remedy found in all of these rubrics. MB was prescribed a homeopathic dose of Natrum Muriaticum 200 C potency. He took the remedy in the office and he promptly lost his vision. (This illustrates the importance of the patient taking the remedy at home and in bed; experiencing this aggravation while driving could have resulted in disaster.) His vision returned after several minutes and he was monitored at the office for an hour before being released to drive home. MB later reported he no longer had headaches from exposure to sunlight after taking the remedy. This author monitored MB for four years during which time he reported no recurrence of symptoms.

CASE #2

KM, a 42 year-old male, presented with mid-back pain, flatulence, and a fear of public speaking. His primary complaint was his fear of speaking in public. He was an entrepreneur, and had to present at meetings, speaking to small and large groups of people. He was usually outgoing, athletic and robust. Upon first approaching this case,

Lycopodium seemed appropriate but a previous prescription of Lycopodium was not effective in treating his symptoms. His fear of public speaking was the result of a memory problem. He said, "When I stand up to speak it is like a wave passes over me and I cannot remember what I am about to say." During a lengthy review of his life history, he referred to a surfing accident when he was 18 years old. He was swept off his surfboard, and struck his head underwater on a rock. KM reported, "That wave passed over me and I didn't think I was going to live." The two "wave" stories were told with similar intensity and the relationship between his fear of speaking and his head injury from the surfing accident were apparent to this author. At the time of his concussion KM had vertigo and a band-like headache for several days. He soon recovered, and never had these particular headache symptoms again. The rubrics consulted in Kent's Repertory were: Head, concussion of brain; Mind, Memory, weakness of, mind, say, what is about to; Head, Pain, pressing, band, as if by. Mercurius was the only remedy that was found in all of these rubrics. This author gave KM a homeopathic dose of Mercurius 200 C potency. Three weeks later KM reported that his memory was intact and his fear of public speaking was gone. KM has been monitored for five years with no recurrence of these symptoms.

CASE #3

DB, a 37 year-old female, presented 2 days after a racquet-ball game during which she slipped and fell backward. Her occipital bone took the full brunt of the fall. As a result of the fall she had ecchymoses around her eyes and DB reported difficulty tracking visually due to a wandering eye, occipital headaches from thinking, inability to concentrate, extreme fatigue, and a feeling of being completely overwhelmed. This author recommended that she see an MD who could monitor her case and provide her with a diagnosis that would be covered by her insurance company. (In states where naturopathic physicians are not licensed it can be crucial that patients receive a diagnosis that will be covered by insurance, especially given that they may require long-term treatment by various health care practitioners.) In DB's case her MD diagnosed her with MTBI and referred her for

cranio-sacral therapy, counseling with a trauma specialist, and acupuncture, all of which were covered by her insurance.

It was obvious to the author that her symptoms were related to head injury, as the fall had recently occurred. The rubrics consulted in Murphy's Repertory were: Head, Injuries, headache, blows, from injury, after; Head, Pain, occiput, mental labor; Eye, Movement, involuntary; Calcarea Carbonica was in these rubrics and, in addition, is a classic homeopathic remedy for feelings of being overwhelmed. Calcarea Carbonica 200 C potency was prescribed and within four days her vision was normal and her headaches were gone. The other modalities she utilized were also advantageous in her recovery and after six months the majority of her symptoms were gone. This six month period might represent the time she needed for spontaneous recovery. However, DB continues to take a dose of Calcarea Carbonica as needed when any of the symptoms of the head injury (fatigue, inability to concentrate or sense of being overwhelmed) return. It has now been one year since her injury.

CASE #4

TM, a 16 year-old male, presented with a burning, bright red face, disorientation, and difficulty performing small motor skills such as tying his shoes, or holding objects. His symptoms had started the day before after riding on a human gyroscope set up in a local parking lot. He had a previous history of sports-related head injuries from football and skiing. The author speculated that the motions of his body spinning around on the gyroscope, where his head was not supported, jarred his brain and restimulated his previous head injuries. This type of trauma is similar to the indirect injuries caused by shearing forces seen in axonal lesions (17). The rubrics consulted in Kent's Repertory were: Head, Concussion of brain; Face, Discoloration, red, glowing red; Extremities, Awkwardness, hands, drops things. Belladonna was in all of these rubrics. TM was prescribed Belladonna 200 C potency. One dose promptly ameliorated all of his symptoms. TM was advised not to ride on the gyroscope again. (The gyroscope attendant was advised that this device could possibly be associated with head injury.)

TM has been monitored for six years with no similar symptoms.

CASE #5

KK, a 26 year-old female, presented after recently having a car accident. She was driving seventy-five miles an hour at night when she hit a backhoe parked on the highway. KK was taken to a hospital by a truck driver who came upon the accident. The truck driver reported to KK that he was astonished that she was alive, given that her car was flattened from the front bumper to the back window. At the time of the accident KK lost her vision for five minutes and received a large gash in her right thigh, but had no other apparent injuries. KK was hospitalized for treatment of the laceration and released after five days. On the sixth day KK presented in the author's office in an ecstatic state of mind, laughing and saying that she had been in a car accident. Based on the concussion, the physical trauma, and her apparent state of shock, Arnica Montana 1M was prescribed. The following day, seven days after the accident, the entire right side of KK's head displayed a huge colorful ecchymosis. KK also reported muscular aching over most of her body. This was a surprising event considering the seven day time interval between the accident and ecchymosis. After taking the remedy KK realized that she had been in a potentially life-threatening accident and her mental attitude became more somber. In the author's opinion, KK's shock prevented her from physically and emotionally responding in what is considered a normal course of reaction. Arnica Montana 30 C was prescribed on a daily basis until her symptoms abated. KK was monitored for the three years and had no further symptoms from the accident.

CASE MANAGEMENT

Brain injuries and the various problems resulting from these injuries need to be addressed with understanding and compassion. It is not always obvious when a person has experienced a head injury and the diagnosis is frequently overlooked, especially in acute situations where the person has sustained other more obvious injuries such as broken bones or lacerations. Once a person has a head injury, both cognitive and emotional abilities may be impaired, leaving them unable to

cope with many situations, particularly those that overstimulate their senses. Noise, bright lights, confusion, crowds and mental exertion are often too much to handle. Fatigue, depression and mental impairment are common symptoms of head injury. Information and treatment plans need to be written out in simple terms and repeated frequently for the cognitively impaired patient. Family and friends may not understand why the patient is acting so differently since they don't "look" hurt. The doctor's patience, compassion and understanding of the entire situation are important aspects in the treatment necessary for patients to regain their normal brain function.

SUMMARY

Head injury is relatively common and patients can present with a variety of symptoms. Thorough evaluation of patients for recent and previous head injury is necessary for an accurate diagnosis. Referral to other health care practitioners for diagnosis and treatment may be indicated. A variety of treatment modalities may be utilized in the patient's recovery. Homeopathic medicine is an inexpensive and profoundly acting form of treatment for patients with head and brain injuries. Lesional prescribing is recommended in the homeopathic treatment of head injuries. The symptoms that are repertorized are only those specifically relating to the injury or lesion, or as a sequelae to the injury or lesion. From clinical experience, the author suggests that the specific homeopathic remedy be taken at night and in bed to ensure the safety of the patient during any aggravation that may occur. With homeopathic medicine, head injuries can be addressed acutely or treated decades later and the appropriate remedy may help to bring about restoration of healthy brain function. Physicians need to manage their head-injured patients who are cognitively and emotionally impaired with extra patience and understanding.

BIOGRAPHY

JoHannah Reilly ND is a graduate of National College of Naturopathic Medicine and is a Diplomate of Acupuncture (NCCA). She holds a BS in Human Biology from Kansas Neuman College, and a BA in Religious Studies from the University of Colorado.

REFERENCES

1. Traumatic brain injury- Colorado, Missouri, Oklahoma, and Utah, 1990-1993. Morbidity and Mortality Weekly Report, Jan 10, 1997 v46 n1 p8.
2. Rizzo M, Tranel, D. Head Injury and Postconcussive Syndrome. Churchill Livingstone Inc. NY 1996, p2.
3. IBID.
4. Bennett, T. Individual Psychotherapy and Minor Head Injury, Cognitive Rehabilitation. Sept/Oct 1989, p20.
5. Rizzo, M; Tranel, D. Overview of Head Injury and Postconcussive Syndrome. Churchill Livingstone Inc. NY 1996, p3.
6. Bennett, T. Individual Psychotherapy and Minor Head Injury. Cognitive Rehabilitation, Sept/Oct 1989, p 20.
7. Teasdale, G; Jennett B, Assessment of Coma and Impaired Consciousness A Practical Scale. The Lancet, July 13, 1974, p81.
8. Reitan, R; Wolfson, D. Normative Guidelines and the Neuropsychological Deficit Scale. The Halstead-Reitan Neuropsychological Test Battery. Neuropsychology Press, Tucson, Arizona 1993. p347-364.
9. Rizzo, M; Tranel, D. Overview of Head Injury and Postconcussive Syndrome. Churchill Livingstone Inc., 1996, p15.
10. Czuba, C.A. Traumatic brain injury—An intellectual's need for cognitive rehabilitation. Education, Fall 1996 v117 n1 p51.
11. Haglin, C. Insight into mild brain injury from the Adlerian perspective. The Journal of Rehabilitation, Oct/Dec 1996 v62 n4 p37(6).
12. Clements, A.D. Mild traumatic brain injury in persons with multiple trauma: the problem of delayed diagnosis. The Journal of Rehabilitation, Jan/March 1997 v63 n1 p3(4).
13. Schutte, JW. Howell, M.F. Refuting common defenses in traumatic brain injury cases. Trail, Jan 1997 v33 n1 p32(7).
14. Haglin, C. Insight into mild brain injury from the Adlerian perspective. The Journal of Rehabilitation, Oct/Dec 1996 v62 n4 p37(6).
15. Denton, G.L. Brainlash Maximize Your Recovery From Mild Brain Injury. Attention Span Books, Colo. 1996 chapter 27.
16. IBID. p259.
17. Rizzo, M. Tranel, D. Head Injury and Postconcussive Syndrome. Churchill Livingstone Inc. NY 1996, p6.

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