Dynamic Chiropractic

PEDIATRICS

The Case of Little Sarah: Stimulating the Brain With Chiropractic Care

Edgar Romero, DC, DACNB

Little Sarah, 5 years old and with the biggest blue eyes you have ever seen, presented to the office with a history of seizures that had started at the age of 3. According to her parents, Sarah, without any other previous predisposing signs or symptoms, had her first seizure while falling asleep one otherwise normal day. Since that event, she had suffered, on average, five such episodes per week, and at one point as many as five per day. These seizures always began just as she was about to fall asleep, and took the form of muscle contractions that began on the left side of her body and sometimes affected the right side of her body as well. They would sometimes start in the left leg, sometimes in the left arm, but always on the left side of the body first.

At the time of her evaluation, she was on two medications that her parents felt were helping somewhat, although the seizures continued. She had been through a plethora of tests, as you can imagine; I was touched by her nonchalance at meeting another "scary" doctor when she was first introduced to me. She had been through so many tests at that point that she had essentially been desensitized to anything even remotely resembling a doctor's office.

Anatomy of a Seizure

We can define a seizure as a spontaneous firing of cortical cells, such that activity is produced where otherwise there should be none. Depending on the area of the brain that fires, the seizures can present as visual, emotional, auditory or motor. It can focus in one area or it can spread to other areas. It can present without loss of consciousness or present as a tonic-clonic (grand mal) seizure characterized by a generalized motor response and loss of consciousness.

We could have discussions of tumors and a plethora of various other pathologies and disorders that all could have and should have been part of her differential. And it would be right to discuss these scenarios because we are, after all, primary care physicians and we have to know about these other conditions. You can look up all this information in any good textbook (e.g., Beck's *Functional Neurology*). However, as I have stated emphatically before, who cares what you call something if you cannot fix it?

Searching for Clues

As most of you have experienced in your own practices, this little angel had been brought to my office by somewhat scared and skeptical parents. I was the doctor of "last resort." Neither parent had ever been adjusted, so you can understand their trepidation at what this chiropractor would do or say. Sarah had undergone every test in the book (and probably some more), and everything was negative. The medical perspective on her condition was simple: seizures of unknown origin, medication to control them and the hope they would not worsen as she aged. Knowing that all her tests were negative actually opened the door to what all other physicians had not assessed, of course, which was the central integrative state of Sarah's nervous system.

Due to certain signs and symptoms that are commonly seen with a transneurally degenerated

brain, her evaluation was rather straightforward. Her right pupil was somewhat constricted initially, but started to present with hippus with repeated pupillary challenges. The right pupil then dilated dramatically after about four light flashes, revealing a brain that was craving oxygen. Her signs and symptoms almost always started on the left side of her body, and then sometimes proceeded to the right side. (The right cortex has a somatic presentation on both sides of the body and thus, can present with motor disorders that can in some cases become bilateral.)

Most importantly, Sarah's seizures primarily only occurred when she was about to fall asleep. This is significant because a brain that is not firing well will reflexogenically fire more when faced with the possibility of not waking up later. In other words, if the brain were so deficient that it doubted its own viability to continue to function, it would fire to a greater extent than it should to maintain function.

We can extrapolate this to many conditions. Some, like dystonia, can sometimes be treated, not by trying our hardest to turn off the movement disorder, but in fact by supplying the body with some alternate stimulus to promote natural inhibition of an overly stimulated system. This can translate into a whole other form of treatment for our offices. Instead of trying to turn off a painful spasm, for example, perhaps we can learn why it was there to begin with and stimulate some other system to prevent the continued reaction. In fact, this is what we do with a really good adjustment.

Stimulate the Brain

The brain is in and of itself primarily inhibitory in nature. Thus, when the brain is not firing properly, an increased level of tone is the greater probability of symptoms that would present. This could include spastic paralysis after a stroke, aura from migraines, tics from Tourette's syndrome, or stimming from an autistic patient. The treatment should not be to overmedicate these patients to slow down the brain more, since that would only be more likely to perpetuate the deficiency leading to the imbalances. The best treatment is to stimulate that deficient brain, and thus stabilize central neurons such that spontaneous firing from a sick cortex ceases. There are many, many ways to do this, and the approaches are way beyond the scope of this article.

Sarah was stimulated for her diseased right cortex, which showed transneurally degenerative signs. She stopped having her "normal" seizures from the very first adjustment. The first period lasted three days, then eight days, then two weeks. As of this writing, she is no longer on medication and is seizure-free following approximately six visits. Her parents, as you may guess, are no longer afraid of chiropractors.

SEPTEMBER 2009