

Barral Institute Case Study

Visceral Manipulation – Epilepsy

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Patient: 10 year old male

Symptoms

CC: epilepsy

Patient came in with his mother for assessment and treatment of epilepsy; his mother reports that he was adopted when he was 1 and 1/2 month old from Japan; he was healthy but when he was 2 years old, he had first episode of febrile seizure and had subsequent 3 other episodes next 3 month; when he was 5 years old in preschool he had seizure and diagnosed with epilepsy; since then medication was administered until last year; because last 2 years he was without episodes, they discontinued medication since Jan 2023; he had an episode of seizure Oct 2023; since then, he restarted medication, Divalproex Sodium Tab delayed release, 1000mg once a day.

Evaluation/treatment

At first visit, GL: left neck, LL: left cervical plexus. Visually, his head is tilted towards right by 10-15 degree and torticollis suspected. Right SCM rigid, left posterior cervical muscles tight. It is suspected that seizure is due to abnormal tension in the meninges in the cranium caused by torticollis. Treated left cervical plexus, neural buds on C1, C2, greater occipital nerve, perforating nerve of levator scapular muscle, and jugular foramen. At second visit one month later, GL: left cranium, LL: left tentorium. Treated left tentorium. Then, LL changes to right tentorium. Treated right tentorium. At third visit, GL: right cranium, LL: right greater occipital nerve. Treated greater occipital nerve on occiput and on C2. Then, LL changes to right tentorium. Treated right tentorium and performed dura stretch between sacrum and occiput. At 4th visit, GL: right anterior, LL: liver, EL: spleen. Treated with double induction of liver and spleen. LL changes to left lung. Treated left lung oblique fissure. At 5th visit, GL: right posterior, LL: right posteromedial pleura. Treated right mediastinal recess, posteromedial pleura. At 6th visit, GL: left posterior, LL: left dura at occipito-cervical junction, VL: right falx cerebelli. Treated cranial dura via sagittal suture, right dura at RCPM, right pleural dome vertebro-pleural ligament.

Outcome/discussion

Since the beginning of treatment, he has not had any sign of seizure but also he is on medication. This is ongoing case and the patient comes every 3-4 weeks. The goal is to treat torticollis and release neuro-meningeal tension within and around craniao-cervical region. His neck became less tight and rigid, his neck posture is not yet straight but looks slightly less of tilting than before. Because of adoption, his birth history is not known to the parents. It is suspected that torticollis condition might have started during pregnancy or around birth. Intrauterine fetal constraint and malposition are cited in researches as the cause of congenital muscular torticollis.¹ Then, seizure might be secondary to neuro-vascular meningeal tension.

¹ Yee YT, et al, Risk factors for intrauterine constraint are associated with ultrasonographically detected severe fibrosis in early congenital muscular torticollis. J. Pediatr. Surg. 2011, 46: 514-519.

Zollar JA, et al, Neural and visceral manipulation in infants with congenital muscular torticollis: a feasibility study. J. Phys. Ther. Sci 2019, 32: 7-15.