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Original title: Aus der Praxis der anthroposophischen Medizin. Kaustistik: Chronisch-progressive Encepahlomyelitis disseminata. Der Merkurstab 1997; 50:105-7. English by A. R. Meuss, FIL, MTA.

Medical history

In 1990, Mrs. M., then 22 years of age, developed numbness in the right side of the face. Investigations, including MRI and lumbar puncture, suggested disseminate encephalomyelitis. Repeated acute episodes over the next few years were always followed by incomplete remission.

Clinically, the symptoms were mainly due to lesions in the area of the brain stem/cerebellum; from 1994 onward, transition to the chronic, progressive form. Acute episodes were always treated with cortisone. In March 1996, the patient was admitted to a municipal neurological hospital department, being completely immobile and needing assistance.

On admission: massive cerebellar ataxia, unable to drink or eat on her own. Spontaneous, image-directed nystagmus in all directions. Scanning speech, severest degree of dysarthrophonia. Spastic tetraparesis, severest degree of ataxia in extremities; unable to sit unsupported, walk or stand. MRI showed marked, florid episode of disseminate encephalomyelitis with multiple CM-receptive foci in the CNS.

With fresh lesions present that took up contrast medium, the patient was given cortisone impulse treatment in high doses. An acute psychosis developed on the third day of this so that treatment had to be discontinued. Treatment with neuroleptics led to complete remission, Inmunosuppression with mitoxantrone followed. A highly febrile bronchopneumonia developed two weeks after exhibition of the first 20 mg dose, the infiltrates slowly regressing with antibiotic treatment. High-dose anticholinergic treatment with trihexyphenidyl was initiated to relieve the massive cerebellar ataxia. When there had been no improvement after 2 1/2 months of inpatient treatment, the patient requested transfer to our neurological unit at the Havelhohe Community Hospital.

Treatment and evolution
Neuroleptic treatment with 200 mg of perazine and the 40 mg doses of the anticholinergic trihexyphenidyl were gradually reduced and discontinued.

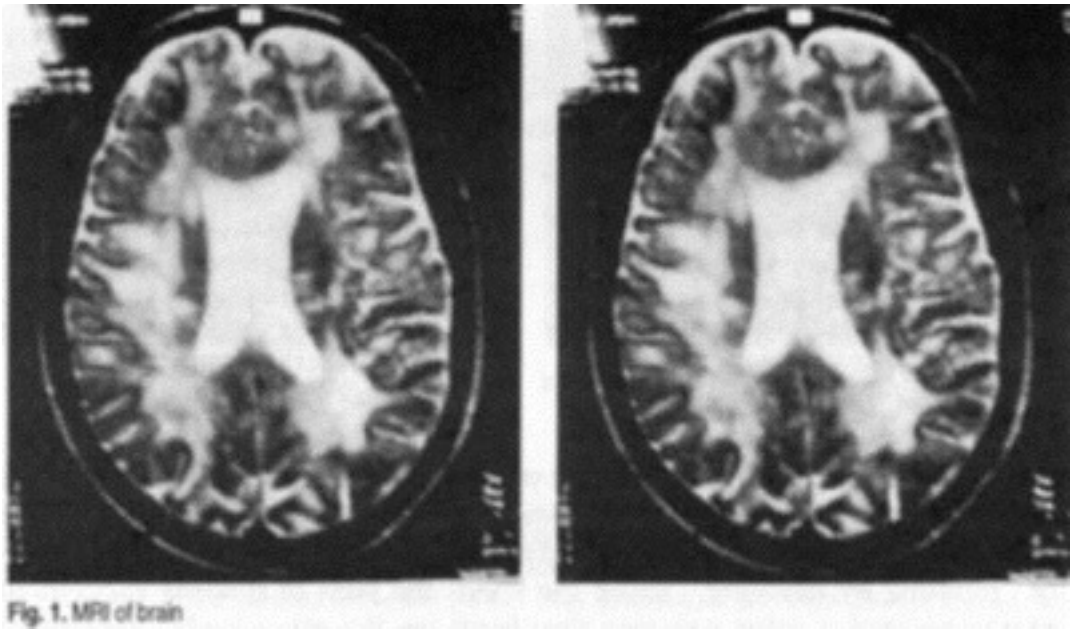
Fig. 1. MRI of brain

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The patient was given one ampoule of *Arnica Rh Radix* 20x and of *Argentum metallicum* prep. 20x, alternating daily. An ampoule of Cerebellum was given by *s.c.* injection 3 times a week. The combination of *Arnica* and *Argentum* was used to influence the inflammatory process in the neurosensory system. Rudolf Steiner spoke of *Arnica* as a plant that imitate I-organization and astral organization. Both are released from their connection with the pathological nerve process so that the principle of action is one of taking over. *Cerebellum* was injected to guide the *Arnica* injections to the site where the majority of symptoms had their origin.(1) Silver is the metal representing the anabolic, form-giving principle. Its

constructive actions thus counter the astral body-mediated, excessively destructive aspects of the inflammatory process.

Report on painting therapy

When the patient was first brought for painting therapy, one noted above all a strong will quality with the patient growing impatient with herself when something could not be accomplished, e.g. taking off her gloves. The eruptive power of her uncontrolled movements limited the potential for art therapy.

Mrs. M. first used a sketch pad and pastel crayons. A better solution was found in the use of ground-up crayon pigments scattered over large areas on the paper. Circling movements would then leave their mark, initially aided by supporting the arm and adding pressure to the hand. Pastel crayons rubbed in directly have a binding quality due to their tangibly granular consistency; the densifying process makes them adhere to the paper, creating a soft veil.

Radial movement starting from the center of the individual was con-

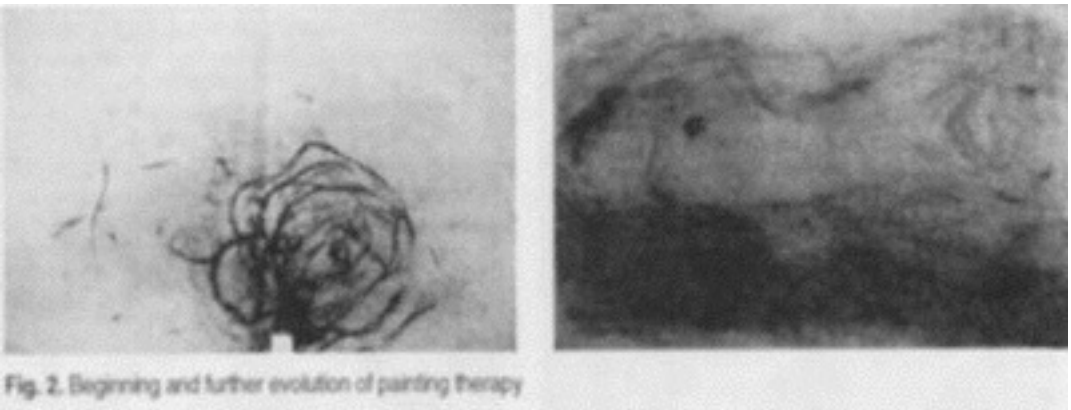

Fig. 2. Beginning and further evolution of painting therapy

trasted with the circle, the archetype of all that lives and develops. From the circle it was possible to evolve rhythmically flowing spirals, lemniscates and large forms that gradually gained in differentiation. In

the rhythmical process of "painting by drawing," using the hand, the sum of flowing movement marks created a color painting that built up the ether body. Treatment addressed not the neurosensory system where the pathology lay, but the middle human being.

It was gradually possible to reduce the physical support and guidance, and toward the end of her painting therapy, the patient only needed gentle support at the elbow.

Evolution

After 2 weeks in the unit, the urinary catheter could be removed. Residual urine volume gradually reached an acceptable level of about 50 ml. The patient was gradually able to sit unsupported in a wheelchair, and later her cerebellar ataxia was markedly reduced so that she was able to get herself from bed to wheelchair without help.

Mrs. M. was an in-patient with us for just under 3 months. Progress was such that we were able to prescribe rehabilitation. She did not have to go into a care home and throughout her stay with us had always expressed the wish to return to her own home. At the time of discharge, medication was changed to *Scorodite comp*., 1 ampoule *s.c.* three times a week. The medicament was chosen under the impression of a weakened vital forces organization dominated by the neurosensory process. This was consistently continued from August 1996 to February 1997. The patient's condition has been stable since she left the hospital. Mobility improved further, albeit slowly. Mrs. M. is now able to walk about 10 meters with the help of her remedial gymnast. The last time she came to the outpatient department in February 1997, she seemed definitely stronger, with rosy cheeks. She had gained some weight, and it seems the weakness in the sphere of constructive, anabolic forces has been overcome.

In view of the extreme immobility that led to the patient's admission just under a year ago, with massive inflammatory changes in form of CM-receptive foci in the CNS, the evolution so far may be said to have been extremely good.

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