

CLINICAL PROFILE OF EPILEPSY IN NEPAL

BY:

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ABSTRACT:

EPILEPSY is one of the most unwelcome socially stigmatized neuro-psychiatric syndromes with serious public health problem in NEPAL. Study of three Hundred Epileptics confirmed with DSM IV criteria & ILAE, revealed that was more common among young 24 years age (29%), male (68.66%), low socio-economical status (75.33%), unemployed (54.66%), non vegetarian (90.66%) groups. Neurocysticercosis (46.66%) was increasing, preventable & treatable main cause of epilepsy in comparison to neuro-toxoplasmosis (33.33%), brain tumor (9.00 %), vascular conditions (4.33%), nutritional & metabolic (2.66%) & other surgical & idiopathic conditions. This study revealed the preponderance of Generalized Seizure 71.66 % over Partial Seizure with or without generalization 33 %, Unilateral Seizure with or without Generalization 5 %. This study showed Epilepsy is associated with significance Neuropsychiatric complication like Depression 50 % outnumbering the other conditions anxiety 16.66 %, Dementia 8.33 %, Epileptic psychosis 6.66%, Personality disorder 6.66 %, Todd's paralysis 6.66%, Parasuicide 3.33 % & manic condition 1.66 % were the least in number. Despite of relation between neuropsychiatric symptoms & underlying cerebral lesions, various types of epilepsy & prognosis this study showed that cultural beliefs & epilepsy myths delayed the diagnosis, traditional treatment approach sustained the epilepsy syndrome, associated neuro-psychiatric symptoms, material, physical, relation problems & psychosocial stress complicated the Epilepsy in NEPAL. Chhetry ethnic groups (46.48%) were more pronounced adopting various modes of traditional treatment & cultural beliefs than other ethnic groups. Mono therapy of anticonvulsant drug jointly with multidimensional psychiatry & psychosocial approach involving community orientated mental health program were more effective, urgent need felt than traditional approach. "Mental tranquility is one of the most strongest anticonvulsant".

Key Note: Epilepsy, Neurocysticercosis, ELISA.

INTRODUCTION:

In the 19th century Emil Kraepelin was the first to view Epilepsy as one of the major division of insanity (Blumer 1985). Since then there have been significance revolutionisation about the concept of Epilepsy & many research reports from various parts of the world. The prevalence of Epilepsy in general population is estimated 4-7/1000, which means that there are 84,000 to 147,000 epileptics in NEPAL. The prevalence & incidence rate of Epilepsy should be more than estimated as they conceal the disorder because of social stigma, misconception attached to it. At the same time Epilepsy in Tropical Country as a whole is at least twice the prevalence in the western countries (ILAE 1994). Higher prevalence of psychosocial & neuro-psychiatric problems among the epileptics has become the greatest burden to the undeveloped country. There is no racial & geographical variation about the occurrence of Epilepsy even though it is a most common disease of undeveloped country like NEPAL. No culture or society, urban or rural is free from crippling effects of Epilepsy. Nepalese Community is not free from such psychosocial & neuro-psychiatric problems of Epilepsy. Epilepsy is a complex organic mental disorder comprising various combination of symptoms mimicking acute or chronic Organic Brain Syndromes like dementia, anxiety, depression, psychosis, mania, personality & behavioral disorders & Todd's paralytic condition. Most of the epileptics prefer seeking help from traditional faith healers like Mantravadi, exorcist (Dhami, Jhankri) magician & fail to use modern available neuro-psychiatric service because of lack of mental health awareness, misconception, social stigma, cultural beliefs & myths of Epilepsy. They still believe that Epilepsy is due to the work of demons, witches & black magic & can not be preventable & treatable. Cultural

beliefs, misconception, social stigma, psychosocial, socio-economical stress & environmental factors got a greater bearing upon the outcome, psychosocial & neuro-psychiatric complication of Epilepsy. Clinical profile of epilepsy depend varies according to geographical location, cultural belief, psychosocial & socio-economical status. Cerebral parasitosis of neuro-cysticercosis & neuro-toxoplasmosis were most common, increasing prevalence, preventable & treatable, main causes of Epilepsy among the young groups in Tropical Country like NEPAL Three Hundred epileptics were studied for clinical profile of epilepsy & etiological, cultural, psychosocial & socio-economical stress & geographical location.

Aims: -

Main objective is to undertake the following study: Demography & Epilepsy (Mirgi Rog).

- (2) Characteristics & Epilepsy (Mirgi Rog).
- (3) Neuro-Psychiatric Manifestation & Epilepsy (Mirgi Rog).
- (4) Etiology & Epilepsy (Mirgi Rog).
- (5) Traditional Approach & Epilepsy (Mirgi Rog).
- (6) Therapeutic Implication & Epilepsy (Mirgi Rog).

Materials & Methods:

Samples: - Three Hundred confirmed new Epileptics.

Methods:

Initially, especially self-designed socio-demographic proforma was administered to all the new patients for detail demographic study. Through neuro-psychiatric check up being done with symptom check list and evaluation protocol were used before & after treatment for the patients to evaluate Neuro-psychiatric symptoms. At the same time cognitive function evaluation being done with Folstein Mini Mental State Examination tools, during traditional therapy & following after anti epileptic drug with psycho & behavioral therapy. Subsequently Multi-Phasic & Questionnaire inventory was administered twice to all patients to study psychiatric problems before & after treatment. Max Hamilton's Anxiety & Depression rating scale were being used to assess the anxiety & depression profile initially & followed after treatment, Mental Health Attitude Proforma was administered to all the patients to know the attitude towards Epilepsy. Investigatory tools like MRI Brain, Elisa-serological test & EEG etc. done to confirm the diagnosis before and after treatment. Therapeutic efficacy of traditional approach & anti - convulsant drugs, psycho & Behavioral therapy were being compared & evaluated. Neuro- psychiatric, psycho-social, cultural traditional & modern treatment practice were correlated with the outcome, courses, prognosis & seizure situation then the factors were analyzed in details. Patients were given cysticidal, anti - oedema, anti-inflammatory drugs & macrolide, pshychotropic medication specifically for those indicated but Poly drugs therapy & surgical approach were strictly avoided for the prevention of drugs effect interference.

Results:

DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE

Table No 1:

AGE DISTRIBUTION

AGE GROUP YEARS	NO	%
> - 14	58	19.33
5 - 24	87	29
25 - 34	85	28.33
35 - More Then 44	70	23.33
Total	300	100

Demography profile of the epileptics with diverse cultural beliefs, religious & traditional practice reveals that it is more commonly seen among young age groups ranging from 15- 25 years. Most of them have immense faiths on misconception, cultural beliefs, religious & traditional practices despite of the underlying cerebral organic pathology of epilepsy.

Table No 2:

SEX DISTRIBUTION

SEX	NO	%
Male	206	68.66
Female	94	31.33
Total	300	100.00

As per sex distribution male groups 206 (68.66%) were with strong cultural beliefs and traditional practices, suggesting from Epilepsy in contrast to female groups 94(31.33%).

Table No 3:

SOCIO-ECONOMICAL STATUS

S.E.S.	NO	%
Upper	21	7
Middle	53	17.66
Lower	226	75.33
Total	300	100

It is a poor man disease from undeveloped country. Patients from low social economical status 226 (75.33%) were more sufferers in comparison to middle 53 (17.66%) & upper socio-economical status 21(7%).

Table No 4:

JOB STATUS

NATURE OF JOB	NO	%
Employed	136	45.33
Unemployed	164	54.66
Total	300	100

The job status professional protocol showed the unemployed group's 164 (54.66%) were more sufferers, they follow misconception & traditional practice than employed groups 136 (45.33%).

Table No 5:

FOOD HABIT

TYPES	NO	%
Vegetarian	28	9.33
Non Vegetarian	272	90.66
Total	300	100

Regarding the food habit of the patients, this study revealed those 272 (90.66%) patients, were non-vegetarian & 28 (9.33) were taking vegetarian food. Habit of taking contaminated non-vegetarian food by non-vegetarian groups were more exposed to epilepsy problems, compounded the problem with associated strong misconceptions excessive religious practices & vigorous social exercises in contrast to vegetarian groups. Vegetarian groups were also no exception to have epilepsy & associated cultural & social practices because of taking contaminated food & water.

Table No 6:

CASTE & EPILEPSY (MIRGI ROG)

TYPES	NO	%
Non Brahmin	230	76.66
Brahmin	70	23.33
Total	300	100

Study of frequency of epilepsy, adherence to cultural & traditional practices among the Brahmin & Non-Brahmin groups the analysis revealed that the Non-Brahmin groups 230 (76.66%) were more vulnerable to epilepsy showing more adherence to cultural & traditional practices than Brahmin groups 70(23.33%) even though Brahmin strictly following the excessive cultural, religious & traditional practices. There were no exception to epilepsy & related neuro-psychiatric & psychosocial problems.

Table No 7:

DURATION OF ILLNESS

DURATION	No	%
0 — 6 Months	63	21
7—12 Months	53	17.66
2—5 Years	104	34.66
5 — 6 Years	80	26.66
Total	300	100

Duration of illness profile analysis showed that onset of symptoms & identification of cases were delayed & variable ranging from 6 months to more than 6 years. Maximum cases were detected 104 (34.66%) after 2 years of duration of illness. It is because of social stigma misconception, cultural beliefs, excessive religious practices lack of investigatory tools, costlier modern medical service, financial constrain absence of mental health awareness & unpredictable Neuro-psychiatric symptoms they do not take the help of physician. Most of them were sufferer to psychosocial & neuropsychiatric complication because of late identification & delay use of modern medical service.

Table No 8:

ETIOLOGY & EPILEPSY (MIRGI ROG)

Cause	No	%
Neurocysticercosis	140	46.66
Toxoplasmosis	100	33.33
Brain Tumors	26	9
Vascular Diseases	13	4.33
Nutrition & Metabolic	8	2.66
Head Injury	5	1.66
Idiopathic	3	1
Degenerative	4	1.33
Congenital	1	0.33
Total	300	100

Despite of misconception, social practices for the treatment of epilepsy the most common causative factors of epilepsy were neuro-cysticercosis 140 (46.66%), neuro-toxoplasmosis 100(33.33%) & it follows brain tumors 26 (9%), vascular disease 13 (4.33%), nutritional & metabolic 8(2.66%), head injury 5(1.66%), idiopathic 3 (1.00%), degenerative 4(1.33%), congenital 1(0.33%), respectively. Cerebral parasitosis causative factor for epilepsy is seen more alarming in underdeveloped country Nepal.

Table No 9:

CAUSATIVE FACTORS & AGE DISTRIBUTION OF EPILEPSY (MIRGI ROG)

Age Distribution in Years					
Cause	0.14 yrs.	15.24 yrs.	25.34 yrs.	35 More Than yrs.	%
Neurocysticercosis	38	43	33	26	46.66
Toxoplasmosis	14	29	33	24	33.33
Brain Tumors	5	9	6	6	9
Vascular Diseases	1	3	4	5	4.33
Nutritional and Metabolic	Nil	2	4	2	2.66
Head Injury	Nil	Nil	3	2	1.66
Idiopathic	Nil	Nil	Nil	3	1
Degenerative	Nil	Nil	2	2	1.33
Congenital	Nil	1	Nil	Nil	0.33
Total No.	58	87	85	70	Nil
Total %	19.33	29	28.33	23.33	Nil

This analysis showed that the frequency of causative factors of epilepsy in different age groups neuro-cysticercosis, neuro-toxoplasmosis, vascular disease, nutritional & metabolic & head injury were common respectively at the age groups ranging 25 to 34 Yr. The epilepsy due to brain tumors were noted more at the age 15 to 24 Yr. where as vascular, idiopathic & degenerative factors of epilepsy were seen more at the age of 35 Yr. & congenital epilepsy seen at the age 15 to 24 Yr. This result showed that epilepsy due to cerebral parasitosis is one most common young man disease. Which is the marker of in sanitation, strong cultural belief, and psychosocial & socioeconomic stress.

Table No 10:

CHARACTERISTICS OF EPILEPSY (MIRGI ROG)

TYPES	NO	%
Generalized Seizure	215	71.66
Partial Seizure with / without Generalization	70	33
Unilater Seizure with/without Gneralization	15	5
Total	300	100

Characteristics of epilepsy profile most of the epileptics had 215(71.66%) generalized seizure, 70(23%) partial seizure & 15(5%) unilateral seizure. Short lasting, unpredictable neuro-psychiatric symptoms created strong influence to adhere cultural belief, and religious & social practices. They believed that super natural power, evil spirit, and ghost-revenge of God, which could not be counteracted, afflicts this. They sustained & prolonged the syndromes by seeking the help of traditional healers & religious practices. They did not have any faith on modern medicine.

Table No 11:

NEURO - PSYCHIATRIC COMPLICATION IN EPILEPSY (MIRGI ROG)

Neuro - Psychiatric Complication	No	%
Depression	150	50
Anxiety	50	16.66
Dementia	25	8.33
Epileptic Psychosis	20	6.66
Personality Disorder	20	6.66
Todd's Paralysis	20	6.66
Parasuicide	10	3.33
Mania	5	1.66
Total	300	100

Neuro-psychiatric complication analysis revealed that out of 300 epileptics 150 (50%) had depression, 50 (16.66%) anxiety, 25 (8.33%) Dementia, 20 (6.66%) Epileptic psychosis, 20 (6.66%) personality disorder, 20 (6.66%) Todd's paralysis, 10 (3.33%) Parasuicide & 5 (1.66%) manic condition. Strong adherence to cultural belief, religious practices misconception, social stigma & vigorous traditional treatment approach, lack of faith on modern treatment approach delayed the identification of the disease lead to significant neuropsychiatric & psychosocial handicapped influenced the reduction of the quality of life, coping life style with problems, resulting social & mental dysfunction multiplying the burden to the society.

Table No 12:

STRESS & EPILEPSY (MIRGI ROG)

Types	No	%
Psychological	200	66.66
Material Problems	80	26.66
Physical Problem	15	5
Relationship Problem	5	1.66
Total	300	100

Correlation between Psycho-social stress and Epilepsy showed that 200.0 (66.66%) Epileptics had Psychological stress, Anxiety, Depression, Neuro-Psychiatric problems, 80 (26.66%) material problems like loss of job, retrenchment, inability to cope with the job situation and illness, poor earning, accommodation problems, 15 (5%) physical problems - physical disability and 5 (1.60%) patient had relationship problems like strained relation with spouse or husband, family members, neighbors, friends and society. They were socially stigmatized, isolated, deserted and unwelcome in the society and family. Some of them had legal problem in society.

Table No 13:

CULTURAL BELIEFS & EPILEPSY (MIRGI ROG)

Caste	No	Various Cultural Beliefs
Newar	27	122
Brahmin	70	342
Chhetriya	137	688
Vyashya	48	226
Shudra	10	79
Buddhist	8	23
Total	300	1480

Study of cultural belief, religious, social & traditional practices by the various Hindu & Buddhist Nepalese ethnic groups the analysis revealed that out of 300 patients 137 (45.66%) Chhetriya ethnic groups with strong cultural beliefs, traditional practices out number 70 (23.33%) Brahmin, 48 (16%) Vyashya, 27 (9%) Newar, 10 (3.33%) Shudra & 8 (2.66%) Buddhist

Table No 14:

MYTHS, TRADITIONAL THERAPY & EPILEPSY (MIRGI ROG)

Caste	No	Types of Traditional Therapy					
		Dhami Jhankri	Jharphuk	Possessed Azima God	Sacrifice Animal	Worship Family God	Pitri Puja
Newar	27	4	26	27	15	6	11
Brahmin	70	30	50	4	Nil	60	65
Chhetriya	137	40	60	40	120	110	75
Vyashya	48	30	Nil	20	30	20	15
Shudra	10	8	10	5	10	7	8
Buddhist	8	Nil	8	2	Nil	4	3
Total	300	112	152	98	175	207	172

Table No 15:

MYTHS, TRADITIONAL THERAPY & EPILEPSY (MIRGI ROG)

Caste	No	Types of Traditional Therapy					
		Worshiping Ghost & Evil Spirit	Wearing Mantra but Vanter	Smelling Dirty Clothes Shoes	Holding Sharp Metallic Object	Worshiping Buddha Ghyang	Beating with broom stick & hot Iron
Newar	27	10	12	Nil	5	Nil	6
Brahmin	70	30	55	8	40	Nil	Nil
Chhetriya	137	40	80	45	70	Nil	8
Vyashya	48	35	40	10	10	12	4
Shudra	10	3	10	7	6	Nil	5
Buddhist	8	Nil	Nil	Nil	Nil	8	Nil
Total	300	118	197	70	131	20	23

Chhetriya ethnic groups 48.31% showed maximum various cultural beliefs, social practices Dhami, Jhankri, Jharphuk, possessed Azima Goddess, sacrifice animals, worshipping family God, Pitri Puja (Ritual offerings to departed soul) more than Brahmin's (22.69%) Vyashya (12.48%), Newar (9.66%), Shudra (5.21%) & Buddhist (1.62%) respectively. Mostly Buddhist & Brahmin ethnic groups do not believe animal sacrifice to treat the epileptics. Higher number of Chhetriya groups showed maximum various cultural beliefs (81%) worshipping Ghost, evil spirit, wearing Mantra Buti, vanter, smelling dirty clothes & shoes, holding sharp metallic objects, worshipping Buddha Ghyang (Monastery), beating with broom stick & hot iron etc either to please God or to protect or to torture to expel out the evil spirit from the victim in comparison to Brahmin (23.45%) Vyashya (19.57), Newar (5.82%), Shudra (5.46%) & Buddhist (2.82%) respectively. Strong cultural beliefs about epilepsy as a result of evil spirit, God's punishment or God's will, fate of

past deeds, anger of departed soul, bewitched delayed the early diagnosis; continued religious traditional treatment practices welcomed the neuro-psychiatric & psychosocial complication. Failure the modern mental health services approach encouraged the multiplication of burden of society. Those ethnic groups strictly following cultural beliefs, misconception, religious practices, traditional approach, lack of faith on modern medical service had shown poor outcome, prognosis & prolong the course and welcome neuro-psychiatric & psychosocial dysfunction.

Table No 16:

ANTICONVULSANT DRUGS & EPILEPSY (MIRGI ROG)

Drugs Used	No	%
Carbamazepine	275	91.66
Carbamazepine & Phenobarbitone	15	5
Phenobarbitone & Phenytoin	5	1.66
Phenobarbitone & Sodium Valporate	5	1.66
Total	300	100

Study of virgin, treated by traditional healers with complicated epilepsy cases revealed that out of 30 cases 275 (91.66%) was on Monotherapy Carbamazepine, 15 (5.00%) on combination of Carbamazepine and Phenobarbitone, 5 (1.66%) was on Phenobarbitone and Phenytoin, 5 (1.66%) was with Phenobarbitone and Sodium Valporate. They showed remarkable improvement.

Table No 17:

THERAPEUTIC RESPONSES OF ANTIEPILEPTIC DRUGS & PSYCHO THERAPY IN EPILEPSY (MIRGI ROG)

Types of Epilepsy	No	A.E.D. & Psychotherapy	
		Improved	%
Generalized Seizure	215	210	97.67
Partial Seizure with / without Generalization	7	65	92.85
Unilateral Seizure with / without Generalization	15	13	86.66
Total	300	288	96

Correlation between therapeutic efficacy of anti epileptic drugs, psychotherapy & behavioral therapy with traditionally treated complicated uncontrolled epileptic cases revealed that 210(97.67%) Generalized seizure, 65(92.85%) Partial seizure, 13(86.66%) unilateral seizure were improved in term of course prognosis & outcome. They were clinically & psycho-socially improved. Their attitudes & faith toward the illness were significantly changed. They reached to premorbid level of normal quality of life in society. Monotherapy combined with psycho & behavioral therapy & tranquility of mind was preferred more effective than traditional treatment approach.

Discussion:

Cursed contaminated geographical area of undeveloped country showed significance higher prevalence of cerebral parasitosis N.C.C. 46.66 % of main cause of epilepsy which support the report of ILA WHO, EPICADEC 1996. It contradicts the result of the West that trauma, head injury are more common cause of epilepsy than cerebral parasitosis in South East Asian undeveloped country. This study revealed that this is common young man disease the maximum case of epilepsy seen at the age ranged from 15 to 24 Yr., 87 (29 %) affected by the epilepsy because of their migratory habit & exposure to the endemic area. The children below 14 Yr. of also no exception they had epilepsy 58 (19.33 %). Mostly male patients 206(68.66 %) were affected by epilepsy in contrast to female 94 (31.33 %) because of more exposure

endemic area. Low socio-economical status 226 (75.33%), unemployed 164 (54.66%) & non vegetarian group 272 (90.60%) had greater bearing upon the vulnerability of epilepsy because of costlier modern treatment approach, poor purchasing capacity of the patients, unavailability of medicine, poor personal hygiene & strong misconception in undeveloped country. Non Brahmin had strong misconception about the illness & seeks faith healer more than Brahmin belonging to higher caste that practices excessive religious activities but less exposed to misconception & traditional treatment approach. Out of 300 epileptics, 137 (45.66%) Chhetriya groups showed significance highest believer of culture & traditional practitioner (46.48%) in contrast to other various ethnic groups. The Buddhist ethnic groups (2.66%) were the least to follow cultural belief & traditional healer (1.55). Chhetriya ethnic groups showed more brutal practices of animal sacrifice & worshipping family God to treat the victim. Possessing Azima Goddess & Jar phuk technique were more common traditional technique for epilepsy problem among Newar community. Brahmin 70 (23.33%) supposed to be higher caste showed excessive religious practices of family rituals 65 (37.79%), Jharphuk 50 (32.89%) wearing treated beads (27.91%) for the treatment of epilepsy attack. Vyashya groups (16%) preferred more towards wearing treated beads, vanter 40 (20.30%) worshipping Ghost 35 (29.66%), animal sacrifice & Dhams, Jhankri to treat the epilepsy, Shudra group 10 (3.33%) equally believe treating Epilepsy by using vanter 10 (5.91%), animal sacrifice 1.0 (5.7%) but Buddhist seems attending Buddha Monastery 8 (40%) more common than other various mode. Most of the Nepalese ethnic groups do not visit to physician first, because of social stigma, lack of faith on modern treatment approach they believe Epilepsy is due to supernatural power or God's punishment of God's will which can be treated or prevented only by traditional healer. Misconception, strong faith on traditional treatment approach for epilepsy is common disease of undeveloped country like Nepal. Most of the epileptics were identified very lately after 2 years of duration of illness with neuro-psychiatric & psychosocial complication. It is because of social stigma they will be locked up inside the room. They prefer seeking help from traditional healer because, their mind seems to be fully ingrained that the epilepsy is due to affliction of super natural power which can not be counteracted by modern medicine. So they won't consult physician. Lack of proper investigatory tools, costlier modern medical services, absence of mental health awareness, unpredictable neuro-psychiatric symptoms may be the probable cause of delay identification of Epilepsy. Poor victims from far off rural area find difficult to visit the physician in urban area due to financial constraint & distance problems. Victims compel to consult the physician very lately when various traditional approaches fail to have effect for the treatment of Epilepsy. The short lasting, unpredictable, neuro-psychiatric symptoms made the victims to adhere the cultural beliefs, religious & traditional practices & made to sustain & prolong the syndrome. Despite of underlying preventable & treatable cerebral parasitosis in Neuro-cysticercosis, Neuro-toxoplasmosis, causative factors of Epilepsy, victims consult traditional healer due to lack of mental health awareness. These preventable & treatable conditions are ironically neglected in tropical country. Most common presentation of epilepsy were Generalized Seizure associated with neuro psychiatric complication like depression, anxiety, dementia, epileptic psychosis other paralytic, suicidal & manic problems. They become jobless deserted from family, society & exclusively isolated becoming the burden to society of undeveloped country. Those neurological, & psycho-social handicapped influenced to reduce the quality life, coping life style, resulting mental & Psychosocial dysfunction. Epilepsy associated with psychological problems more than material, physical & relation problems. Reduction of associated stress showed decrease frequency of epileptic attacks & its complication. Monotherapy with Carbamazepine was more effective & preferred by victims than other combination treatment. Psychotherapy, behavioral therapy combined with anti-epileptic drugs & multidimensional approach were more effective & accepted by the victims. Out of 300 epileptics 288 (96%) consulted the physician & taken anti epileptic drugs, used psychotherapy & behavioral therapy showed significance improvement resulting good outcome, course & prognosis of the epileptics. They could reach to better quality life.

CONCLUSION: -

Cultural beliefs & EPILEPSY MYTHS delayed the diagnosis, traditional treatment approach sustained the EPILEPSY Syndromes, associated neuropsychiatric, material, physical, relation problem & psychosocial & socio economical stress complicated the EPILEPSY in undeveloped country. EPILEPSY

is one of the most unwelcome, socially stigmatized, Neuropsychiatric syndrome with serious public health problem & burden of undeveloped country like NEPAL. Cerebral parasitosis of Neuro-cysticercosis & Neuro-toxoplasmosis were increasing, preventable & a treatable main cause of EPILEPSY among young groups being ironically & awfully neglected in undeveloped country. Lack of early identification of EPILEPSY due to absence of proper suitable investigatory tools, costlier modern medicine, financial constrain, lack of faith on modern medicine, poor health awareness, misconception & cultural beliefs, social stigma attached to it, transient & unpredictable symptoms, unavailability of neuro-psychiatric service resulted failure to prevent neuro-psychiatric & psychosocial complication of EPILEPSY in undeveloped country. In Nepal, Chhetry ethnic groups showed more pronounced various modes of traditional treatment & misconception, cultural beliefs than any other ethnic groups. Efficient well organized Epilepsy Care Unit is essential to manage the problem of the most preferable ethnic groups. Monotherapy of anticonvulsant drugs jointly with psychosocial, multidimensional community orientated neuro & mental health program were more effective & urgent need than traditional treatment approach for EPILEPSY problem in undeveloped country. Clear evidence of misconception, cultural beliefs, psychosocial & socioeconomic stress neuro-biological & environmental factors got a great bearing upon the development of the psychosocial & neuro-psychiatric complication of EPILEPSY. Breaking down misconception, cultural beliefs, prevention of psychosocial stress, proper management of the disturbed neuro-biological environment prevented the further mortality, morbidity, and psychosocial & neuro-psychiatric complication of EPILEPSY.

SUGGESTION:

MENTAL TRANQUILITY IS ONE OF THE BEST ANTICONVULSANT DRUG FOR MIRGI ROG

1. Preventive: - Urgent need of multidisciplinary community orientated Neuro & Mental Health program for preventive, promotive & curative aspect of EPILEPSY.
2. Needs of efficient, well organized EPILEPSY Care Unit for education, training, breaking down misconception & social stigma attached to MIRGI ROG.
 - (1) Epileptics counseling training program. (ECTP)
 - (2) Parent counseling training program. (PCTP)
 - (3) Teacher counseling training program. (TCTP)
 - (4) Student counseling training program. (SCTP)
 - (5) Community counseling program. (CCTP)
 - (6) Professional health course training program. (PHCTP)
 - (7) Faith Healers counseling training program. (FHCTP)
3. **Psychosocial Management: -**
Care for Epilepsy Complicating Factors:
 - (1) Material.
 - (2) Physical.
 - (3) Relation.
 - (4) Economical.
 - (5) Psychosocial stress.
4. **Epilepsy Treatment Program: -**
Anti-convulsant "MONOTHERAPY" Preferable over "POLYOTHERAPY"
 - (1) Specialized Services.
 - (2) Clinical Psychological Services.
 - (3) Clinical Sociologist Services.
 - (4) Occupational Therapy.
 - (5) Rehabilitation Program.
 - (6) Self-help Group. Referral Epilepsy Clinic: -

5. Referral Epilepsy

- (1) Free distribution of medicine.
- (2) To monitor treatment.
- (3) To monitor compliance.
- (4) To Assess Seizure Control.
- (5) To Seize Further Epileptic Complication.

Research Study: -

1. To explore better Medical & Psychosocial Management Approach.
2. To find out new Technology for early identification of preventable & Treatable Epileptic condition.
3. Search for least Toxic, more effective Anticonvulsant Drug.
4. Study on Trans-cultural & Psychosocial Aspect of Epilepsy.
5. Neuro-Biological & Immunological study of Epilepsy.
6. To find out effective Epilepsy Neuro-Mental Health Service Delivery System.
7. Systematic Epidemiological Study on Epileptic Mortality & Morbidity.

Acknowledgements: -

I am very much thankful to Mrs. Usha Rajbhandari and Mr. Nivesh Rajbhandari for making this useful manuscript.

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