A Child With Recurrent Laryngeal Papillomatosis
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History: Sarah was born 31 March 1993, her first visit with me was 30 June 1997, at age 4. Chief complaint was hoarseness, established to be as a result of recurrent laryngeal papillomatosis (RLP). Her father is a pilot in the Air Force and her mother is a nurse and currently a homemaker. Since Sarah first learned to talk her voice had been a bit deep, but with good volume and clarity until her onset of hoarseness. At her 3 year old check-up with her pediatrician, in April of 1996, the parents reported that she had had progressive worsening of a deep and raspy voice. She was referred to an ENT consultant in Rapid City, SD, who made the tentative diagnosis by laryngoscopy and referred her to the Denver Children's Hospital. Between April and July of 1996, her voice had become more raspy, her respiration became stridulous and wheezy, she had a persistent dry cough and was short of breath at night, when lying. After each surgery her voice would be raspy for a week or so, then improved partially, then was reduced to a hoarse whisper within 6 weeks, along with noisy respiration, first when lying and later even when upright. She would become more tired and listless when her hoarseness recurred. After surgery her larynx was painful with talking.

Since her first surgery, in July of 1996, she had required repeat excisions approximately every 3 to 4 months. By the time of her first visit with me, she had just had her fifth laryngeal surgery to remove as many of the papillomas as possible, at Denver Children's Hospital. The surgeon had recommended shortening the interval to every 2 months, as her symptoms were recurring more quickly after each successive surgery. He had told the parents that there was no other effective treatment for her disease and that she would be likely to require repeated surgical procedures indefinitely.

In August of 1996, she became suddenly more listless, developed a 104 degree fever and crying with urination, a urinary tract infection was diagnosed and a voiding cystourethrogram (VCUG) was performed, which demonstrated bilateral uretero-vesical reflux, for which she was treated with prophylactic Septra. Thereafter, her quarterly urine cultures remained negative. The parents were also using Indole 3 carbinol, at the suggestion of the ENT surgeon, who had heard of anecdotal reports of modest improvements in other RLP patients in conjunction with its administration.

Sarah is very easygoing (2), outgoing (2) and social (2). She loves to cater to people, to get things for them. She has many imaginary friends, including "princess", she can occupy herself well. She seems to have a high pain threshold. She has a big heart, is very sympathetic (2), tends to take care of other children a lot. She doesn't have nightmares after movies which scare her. She likes to make up shows, to perform, to dance. She is adventurous, likes to try new things, likes to climb, likes physical challenges. She will watch the Surgery Channel on TV for long periods. She likes to go on high slides at the playground. At home she is happy and contented just to be outside, doesn't always ask to go other places.

Her mother's pregnancy with Sarah was easy, her father was working 2 hours away, and home only on weekends, for the first 7 months of the pregnancy. They then they moved to South Dakota at the 7th month; neither of these was reportedly a big stress for Mom. Sarah's mother's membranes were ruptured for 30 hours before her birth, and she tested positive vaginally for group B streptococcus, with antibiotics administered during the later part of labor. Delivery was uneventful, and Sarah was fine and vigorous at birth. Mother has never shown evidence of infection with Human Papilloma Virus. She had cervical dysplasia on one Pap smear, in 1997, biopsy was negative, and subsequent Pap smears have also been negative.

Her mother is very neat, but Sarah rarely cleans up or puts things in order spontaneously. She likes trips and traveling, but not to go to the store or run errands with Mom. She has a marked fear of spiders (3), i fearful if seeing one on TV. She likes bugs, fears monsters (2), snakes, bees (2), dark (2) and uses a night light. She is affectionate (2), loves to be comforted (1), touched (2) and rubbed (2). Loves music (1) and dancing (2). She seems happier in the

summer, generally a bit subdued and "blue" during the winter. She likes being in the sun, and to be in water (bath, pool, boating). When they're approaching home in the car, she asks to get out and run the rest of the way home. Excited when watching lightning (1). Thunder scares her some, if it wakes her from sleep. Doesn't take naps, seems very energetic in the evening, but she is pretty steady all through the day in her energy. She prefers to be outdoors (2), likes to be cool in winter, goes barefoot in summer and winter (in the house). When she sleeps, she puts the cool part of the blanket against her face. Her feet sweat, with an odor (2), her face sweats some. Her head sweats at night if she is covered, she kicks off her covers at night or will lie sideways in the bed with only her feet uncovered. Dad had to cut the feet out of her winter pajamas for her, at her request. Sleeps on her back (2), rarely slept in knee-chest position when younger. She's had no warts or skin rashes, back was not hairy at birth. Digestion and bowel movements are normal. She has a moderate appetite, craves bacon (2) as her father does, she asks for it frequently, also craves butter (2), eats it straight, they have to hide it from her. Also likes salt (1), eggs (1), milk (1), raw dough (2), chicken (2)—especially the "crunchy part". Likes fat (2) ice cream (1), picks onions out of salad. Likes warm things, asks Dad to warm her chocolate milk.

She had been completely immunized, apparently without ill effects. Her only injury had been a lacerated finger from being accidentally slammed in a door, December of 1995. In the family history, all 6 of mother's uncles had diabetes, and there were at least 2-3 more cases in mother's more distant relatives. Three of four of mother's grandparents died of various cancers, as did one of her father's uncles. Sarah's mother had had polio at age 4 (despite having been immunized), and has an atrophic calf as a result. Parents and grandparents otherwise healthy, with both paternal grandparents being smokers. Sarah has no siblings.

Examination: On observation, Sarah was a very sweet and magnetic child. Her weight was 34_ pounds, her height was 40_ inches, both near the 50th percentile for her age. She has big eyes and relates very warmly. Her sclerae are bluish, and she has one small café au lait spot on her right flank. Exam of her pharynx was unremarkable, her voice was hoarse, currently without stridor. There were no enlarged lymph nodes in her neck, no hair on her back. Her abdomen was soft without masses or tenderness, nor enlargement of liver or spleen. My assessment, then, was that she suffered from recurrent laryngeal papillomas and uretero-vesical reflux, and her prognosis was for repeated laryngeal surgeries unless our work together could change the course.

Recurrent Laryngeal Papillomatosis (RLP): This is a disease entity which is a subgroup of the larger category of recurrent respiratory papillomatosis (RRP). The latter can affect not only the larynx, but trachea and bronchi distal to the larynx, often with more severe respiratory compromise and mortality. It has been linked with the presence of human papilloma virus (HPV) in surgical specimens, the same virus group involved in genital and peri-rectal condylomata. Statistics indicate that first-born children delivered vaginally to young mothers under age 20,with active condylomata during pregnancy, are at greatest risk. In pre-pubertal children the disease is most aggressive, with many such children having continued symptoms until puberty. Some children experience continued recurrences after puberty, and others who have remissions will experience relapses later in life [1]. HPV types 6 and 11 are almost exclusively the subtypes recovered [2]. It is estimated that approximately 5% of the population harbors HPV in their respiratory tract, but less than 1 in 1000 of those "colonized" ever develop infection. (This is consistent with our understanding of miasmatic differences in individuals, resulting in different vulnerabilities, [3]) Surgical excision under general anesthesia is the accepted mainstream mode of treatment, with the recognition that the natural history of the disease is for the lesions to continue to recur. Adjunctive therapies which have been tried are Indole-3-carbinol/Diindolylmethane, a phytochemical found in cruciferous vegetables, interferon and cidofovir (an anti-viral) as well as other anit-virals, photodynamic therapy and even mumps vaccine. All of these have yielded inconsistent and disappointing results. According to statistics from the RRP Foundation, the majority of patients with juvenile onset RRP can expect from 60-100 surgical procedures during their lifetime [4].

Analysis: My differential of therapeutic choices included Carcinosinum, which seemed like a very strong contender despite her lack of tidiness, and Tuberculinum, which was strong but not so consistent with formation of papillomas. Sanicula seemed not to fit her mentally. Thuja was also a consideration, though her most peculiar symptoms directed me elsewhere initially. Nitric acid and Medorrhinum were also candidates, but I persuaded myself in favor of others more than against these.

I was seeing Sarah at a time when I strongly considered synthetic prescribing in each case that I saw. I would frequently consider a mineral salt composed of two other remedies, both of which came up strongly in my differential analysis, especially if there were one or more keynotes of the combination strongly represented in the case. Sarah—with her exuberant, compassionate, magnetic and extroverted nature—made me think first of Phosphorus, and there was some support for it in her physical symptoms, except for her desire for warm drinks and her apparent lack of impressionability by frightening images. Calcarea carbonica came up very strongly in her symptoms, especially the more striking ones such as head sweat in sleep, inclination to uncover her feet, laryngeal polyps, fear of spiders, etc. Her craving for bacon and her more adventurous nature headed me more toward the combination of Calcarea and Phosphorus. My first prescription was therefore Calcarea Phosphorica 200c, one dose, on 30 June 1997.

Clinical Course: On telephone follow-up 14 August 1997 (all follow-ups were via telephone), her voice had been more loud after the remedy, but her hoarseness relapsed. She had no apparent aggravation after the remedy. Her nocturnal head sweat was now nightly, whether or not she was covered, she had more craving for salt, eating it from her hand. The father had been re-assigned and they were moving to Abilene, Texas. I concluded that the change was hopeful but brief and prescribed Carcinosin 200c, one dose, and we planned to talk again in October.

27 October 1997, she had had surgery in late August and earlier in October, representing an 8 and 7 week interval, respectively. Before the last 2 surgeries, Sarah didn't have the deep wheezy cough, but had the same raspy voice and degree of laryngeal occlusion at operation. The papillomas had been more on the left, now were more on the right part of the larynx. She sleeps on her left side now, feet are out of the covers nightly, feet are hot and sweaty, with offensive odor (2). She was having nightly head sweat, craving butter (3), bacon(3), fat (2) and salt (2). She was still desiring to be outdoors. I did not change the remedy at this point.

22 January 1998, still with 8 weeks' interval between surgeries, but papillomas were growing in fewer spots in larynx. Her voice had been barely above a whisper for 6 months. No desire for warm drinks, no change in original cravings, hot feet, fears, sleep position, very warm still. Also desires eggs, asks for eggs and bacon, asks for and eats frozen waffles. Dislikes potatoes, even french fries. I sent Calcarea Carbonica 1M, one dose.

26 February 1998, she had to have surgery 2 weeks earlier than expected, with 90% occlusion of the larynx. No other changes observed. At that time I prescribed Calcarea Phosphorica 10M and planned to speak again in one month.

7 April 1998, surgery again last week (5 week interval), though respiratory and vocal symptoms weren't quite as bad. I interpreted this as potentially encouraging, I elected to not prescribe yet, and asked parents to call me after the next surgery.

11 June 1998, surgery again May 10th, 6 week interval, no worsening of laryngeal symptoms at this time. I interpreted this as also encouraging, no prescription was sent and we planned to talk in one month.

30 June 1998, most recent surgery at 6 week interval, only 50% occlusion this time, her voice had been less raspy before the surgery and she had had no dyspnea for the first time.

10 August 1998, recent surgery, again with only 50% occlusion, but VCUG showed an increase in bilateral reflux, and a dose of Calcarea Phosphorica 1M was sent.

From that time until March of 1999, she had had surgery every 5-7 weeks, with progressively less vocal changes before each and with progressively less papillomas found at operation. At the March, 1999 surgery, the parents reported that there were slightly more lesions found and a dose of Calcarea Phosphorica 1M was again prescribed. Laryngoscopy was then performed in June and December of 1999 and in June of 2000, and no further papillomas were found.

Since 1998 her VCUG improved, with no reflux on the right and with only grade 2 reflux on the left. Her urologist recommended discontinuation of her antibiotic prophylaxis.

Comments: The accompanying graph summarizes Sarah's course, starting with the beginning of her homeopathic treatment. As described earlier, symptomatic improvement was apparent in early Spring of 1998, and objective improvement became apparent soon after.

Sarah and her parents currently live in Virginia. Sarah loves to run, ride bikes, ride her scooter, is a star soccer player and is now playing little league baseball. She has no symptoms of illness. Her mother perceived the turning point in Sarah's illness to be in December, 1998, soon after a healing prayer group which was conducted for her. The Indolplex supplement was started in October, 1998, as a result of the parents' research and because the Indole 3 Carbinol was not seeming to help.

References:

[1] **Nelson's Textbook of Pediatrics**, R. Behrman, R. Kliegman and H. Jenson editors. 16th Edition, W.B. Saunders, London, 2000, p. 1283.

[2] **Otorhinolaryngology: Head and Neck Surgery**, Ballenger, J., and Snow, J.B., Jr.. 15th Edition, Williams and Wilkins, Philadelphia, 1996, p. 1206.

[3] **Organon of the Medical Art**, Sixth Edition, Hahnemann, S., translated by J. Kunzli, A. Naude and P. Pendelton, J.P. Tarcher, Los Angeles, 1982, *Aphorism 206*, p. 148.

[4] *Recurrent Respiratory Papillomatosis Newsletter*, Vol. 10, Number 1, Summer 2001.