The Child and Orthomolecular Medicine

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Many issues in pediatrics call for an Orthomolecular approach in order to forestall or replace more traditional measures of medical management. This paper will address the issues of recurrent upper respiratory disorders (RURD) and the hy-perkinetic/attention deficit disorder (HK/ADD).

The child with recurrent upper respiratory disorder (RURD) manifests in a variety of ways. One has repeated sore throats, another is plagued by middle ear infections, yet another has one cold after another, and then there is the child who sustains all of the preceding at various times. Although it is, indeed, possible to encounter the child who has a fixed defect in immunity, the vast bulk of the time some Orthomolecular approach will be responsible for amelioration or eradication of the health departure.

What criteria of definition can we use to establish RURD? The matter is somewhat like defining an automobile, a thunderstorm or a dog. We know one when we see one. Although there are gray areas in which a child's illness may be gauged to be within "normal limits", most of the time parents will be anxious to reduce or elimi-nate a child's colds, sore throats, and middle ear infections, no matter how frequent or infrequent they are. In fact, a case can be made for the position that a child should grow to maturity without ever having an infectious disease. It is true that when a child's environment, feeding, and nutritional supplements are optimal the number and severity of respiratory illnesses can be brought to a minimum. Rarely, however, can perfection be achieved either by parents or the physician.

Let us conclude the matter of definition this way: any child with more than three upper respiratory infections per year or whose illnesses last more than a week or two may be considered to have RURD.

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The environment of the child is often a major factor in precipitating illness. Untoward reactions to cigarette smoke, insecticide sprays, perfumes, paints and the like must be considered. The child sensitive to gas may show his sensitivity by having another respiratory illness. Thus one must ask the question whether the home uses a gas furnace or a gas cooking range.

A major irritant to some children is the accumulative load of particles that abound in their environment. Dust and lint particles appear to be conducive to respiratory illness in the susceptible child whether or not the child has an allergic reaction thereto. Accordingly, the use of air cleaners (filters) that effectively remove room air particles can be most helpful in lessening RURD. Better yet, remove the source of those particles by eliminating stuffed toys, fuzzy clothing, chenille bedspreads, papers and journals, from the child's immediate area. Particles from intimate pets may, of course, also be implicated in the problem.

In most cases of RURD a dietary factor can be implicated in causation. Often the child's resistance may be lowered because of a diet that is excessive in unwanted food items and undersupplied in foods of high nutrient density. Such a child eats a narrow food dietary that consists primarily of peanut butter and jelly sandwiches; chips, cookies and cakes; sodas; French fries; hot dogs and luncheon meats; and a variety of sweets. Sometimes sugared cereals figure prominently in the diet. It is difficult for the immune system to effectively counter the sea of infectious organisms that colonize the individual who regularly eats in such a manner. An adequate supply of nutrient factors must be available for the immune manufacture of antibodies that constitute infectious resistance. Moreover, foreign or toxic elements in such a diet may directly injure cells thus inviting infectious attack.

Part of the environment, too, is the child's psychological ambience.

The child who is unhappy because he is not loved may manifest that state by means of repeated infectious disorders. Ordinarily, however, the child with RURD is well cared for by loving and attentive parents who often are "at their wits end" to assist their child.

A convenient method of interrupting repeated respiratory infections is the use of judicious nutrient supplements. Because, as a a rule, it is easier for parents to administer supplements than to change dietary patterns, one may wish to establish initial effectiveness by supplement use. Then, later, appropriate dietary manipulations can be made. In some cases, however, it is best to tackle the dietary problem(s) directly and to institute needed changes as soon as possible. In still other cases, the therapist may wisely elect to make a slight dietary change while invoking the tool of nutrient supplementation. The choice of a particular therapeutic move is crucial because parents may possess only limited capacities for problem solving. If faced with excessive demands in too short a time, parents may "turn off" in regard to needed changes and elect to use symptomatic measures that do not eradicate underlying causes.

When an RURD child is treated by the daily administration of vitamin C, bioflavonoids, vitamin B complex and/or individual B vitamins, calcium, vitamin E, amino acids, magnesium, zinc and other minerals (in appropriate doses), the RURD often melts away. The need for iron must also be assessed. Homeopathic preparations and herbs are often useful to treat or prevent the respiratory disorders.

The presence of an allergic disorder must always be considered in RURD. Allergy to inhalants, chemicals or foods constitute precipitating factors for secondary infectious invaders. The allergic child usually has a characteristic appearance. He is pale and often blonde haired or lighter in hair colour than the rest of the family. Dark circles under the eyes are prominent. The tissues under the eyes are often hyperwrinkled. The eyelids are puffy. "Bags" under the eyes may be present. Infraorbital edema is characteristic. The child often exhibits "bunny nose" and/or the "allergic salute" in which the child uses the palm of his hand to rub his nose. Sniffing, sneezing, hawking, throat cleaning and drippy nose are common.

Appropriate testing for inhalant, chemical and food allergies must be carried out. If the child is found to be definitely sensitive to house dust, dust mites, molds or pollens appropriate densensitization may need to be carried out. Food sensitivities need to be seriously addressed. The options for treatment of food allergies include food eliminations, spacing of foods and food desensitization. At all times whenever dietary manipulations are undertaken, the therapist must be intently alert not to produce nutritional deficiencies. Some individuals who are treated by means of well-meaning allergy diets actually worsen due to the nutritional factor.

By the time that the usual child with RURD reaches the Orthomolecular physician the child has been treated over and over again with antibiotics. Some may even be taking antibacterial preparations on a continuing basis. As a result, Candida/yeast overgrowth has become established and may be a principal cause of presenting symptoms. Especially significant is the child with recurrent sore throat or tonsillitis. Often yeast overgrowth is the actual unrecognized cause of the disorder and the repeated antibiotics merely feed the condition. Appropriate management of the primary or secondary yeast infection will usually obviate the "need" for further antibiotics.

Care must be taken, however, not to exclude the use of antibiotics entirely. Some children have become so compromised in immune function and nutritional status that they are unable to mount effective resistance vs. bacterial invaders. Until all health factors are improved, the child may require the use of dwindling numbers of antibiotics in order to remain well. One "walks the tight rope" attempting to use nutrients, herbs or homeopathic preparations rather than antibiotics but not failing to invoke the latter, if necessary, to clear a respiratory illness that does not respond to Orthomolecular measures.

Many of the same factors of investigation and management are employed in the child with HK/ADD. However, what parents need more than anything is some

relief from the incessant barrage of confrontation with their child. Even in the best families parents may be prone to "lose their cool" in the face of constant testing of limits by the child.

Many factors can drive the child into undesirable patterns of behaviour. Although it is vital that a careful sorting out of these factors be accomplished, immediate relief should be sought for the beleaguered parents and child. Most often such can be supplied by nutrient supplements. However, parents must be able to be secure about reliably getting these into their child on a regular basis. The therapeutic situation is variable — some children will pose no problem in regard to supplements whereas in others their administration provokes more crises for already strained relations between adult authority figures and the child. In those "tough" cases one must choose a single nutrient that will have the greatest likelihood of modifying behaviour. Then, as improvement occurs, other nutrients can be added, and other treatment measures invoked. In some cases the use of "stimulant" medications such as methylphenidate (Ritalin, Ciba Pharmaceutical Co., Summit, NJ 07901) or pemoline (Cylert, Abbot Laboratories, N. Chicago, IL 60064) can be considered on a temporary basis in order to assist the parents in establishing the Orthomolecular mode of treatment. Almost never, however, is it necessary to continue such medications on a chronic basis.

Whenever nutrient supplements are used, the physician must utilize those products that have little or no likelihood of evoking untoward reactions. Thus the preparations must be absolutely free of corn, wheat, yeast, milk, sugar, dyes, flavours and preservatives.

Invariably a dietary factor exists in the child with HK/ADD. Sometimes the problem is an inordinate load of sugar, dyes, flavours or preservatives; sometimes the problem is a narrow, repetitive diet with food allergies; sometimes the problem is insufficient supply of nutrient-dense foods. Often, all three of those factors coexist. Nutritional changes can not be counted on to produce immediate results tomorrow, although such can occur. Needed is a constant, steady guidance of family members toward improved eating. Either the father or the mother may take the lead in initiating and continuing dietary changes. Sometimes it is an informed aunt or grandparent who will lead the way. In order to provide "ammunition" for the interested party or parties I provide copies of various publications (see references).

Most helpful has been the use of the laboratory to analyze the child's amino acid "finger print". In a single fasting-blood amino acid analysis one can uncover clues for therapy that assist in turning down unwanted behaviours. Provision of amino acid supplements with special attention to those that are low can greatly assist in producing a more cooperative, attentive child. Whenever possible, the Orthomolecular physician will wisely seek to also investigate the needs of the parents of the child. Nearly always, buffeted by years of interaction with a challenging child, parents are in great need of Orthomolecular care.

As soon as possible the child should be placed on vitamin C, B Complex, B_6 and supplemental niacinamide. An appropriate multivitamin may also be used. Vitamin E can be used. Calcium and magnesium will usually be helpful. Choline and inositol are often helpful. Zinc is usually needed. Chromium, manganese, molybdenum and selenium are commonly supplied. Measurements of mineral status in the body can be made to guide the therapy. Children, their parents and their disorders come in all varieties. Some are diagnostic and therapeutic challenges that call for the best of traditional medicine and the best of Orthomolecular medicine. Most of the time, however, carefully ordered Orthomolecular medicine will provide answers that make unnecessary the use of drugs for the treatment of children. In this paper I have discussed the use of the Orthomolecular approach in regard to recurrent upper respiratory disorder and the hyperkinetic/attention deficit disorder. The physician will find that the same general approach can be utilized to investigate and manage most other health departures encountered in children.

References

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