

Comprehensive Neuromodulatory Management of Severe Infantile Cranial Asymmetry (Plagiocephaly/Craniosynostosis Variant) and Associated Strabismus: A 6-Year Longitudinal Pediatric Case Study

Dr. Prakash Kumar Parteti¹, (Neurotherapist since 2009), SNT^{1*}

¹Senior Neurotherapist & Clinical Director, Neurotherapy Centre Parteti Natural Neurotherapy foundation, Kashi Nagar, Niharika Road Korba, Chhattisgarh – 495677, India.

*Corresponding Author: prakashparteti1@gmail.com

Abstract

Background: Infantile cranial deformities (positional plagiocephaly and craniosynostotic asymmetry) often result from intrauterine restriction, operative birth trauma, and mechanical molding during prolonged labor. When coupled with secondary ocular manifestations such as strabismus (squint eye) and orbital hypoplasia, conventional management typically necessitates early surgical cranial vault reconstruction or rigid orthotic helmet therapy. This longitudinal study evaluates the non-invasive clinical efficacy of Dr. Lajpatrai Mehra's Neurotherapy (LMNT)—a specialized neuro-reflexive pressure modality targeting visceral blood supply, cranial nerve release, and metabolic osteogenesis.

Case Presentation: A 15-day-old female neonate presented with severe unilateral cranial flattening on the right parieto-occipital aspect, an unossified focal bony deficit with compensatory frontal bossing, severe right eye retraction/inward displacement, contralateral microphthalmia-like ocular asymmetry, and persistent neonatal hiccups following prolonged obstructed labor and emergency cesarean section. Diagnostic evaluations ruled out maternal hemoglobinopathies and systemic hormonal abnormalities.

Intervention & Outcomes: Over an intensive 75-day LMNT regimen, protocols specifically addressed organ stimulation (hepatic, pancreatic, parathyroid), mesenteric circulation, cranial blood flow (M-Heparin protocol), and vagal/phrenic neural calming (Medulla reflex). Progressive cranial remodeling and complete resolution of strabismus were verified by month 6. Longitudinal photographic and clinical follow-up at 1.5, 3, and 6 years confirmed normal skull contour, symmetrical facial architecture, stable ocular alignment, and age-appropriate neurodevelopmental milestones without developmental delay.

Keywords: Neurotherapy (LMNT), Craniosynostosis, Positional Plagiocephaly, Pediatric Strabismus, Neuro-reflexology, Skull Remodeling, Non-invasive Pediatrics.

Introduction

Neonatal and infantile skull deformities represent a complex spectrum of congenital and acquired conditions ranging from synostotic craniosynostosis (premature osseous fusion of cranial sutures) to deformational plagiocephaly (positional molding caused by external mechanical forces) [1]. In full-term infants, cranial bones remain flexible, separated by dynamic fibrous sutures and fontanelles that accommodate rapid encephalic expansion throughout the first year of life [2]. Mechanical constraints during obstructed labor, forceps- or vacuum-assisted extraction, and intrauterine entrapment may inflict asymmetric molding pressures, leading to severe parieto-occipital collapse, frontal displacement, and orbital dystopia [3].

When cranial distortion affects the sphenoid or orbital ridges, asymmetrical traction on the extraocular muscles or compressive neuropraxia of cranial nerves (CN III, IV, VI) frequently manifests as concomitant strabismus (squint eye) [4]. Conventional therapeutic pathways are often polarizing: surgical vault reconstruction entails substantial anesthetic risk, intraoperative blood loss, and morbidity; meanwhile, corrective orthotic helmets present compliance hurdles, pressure ulcer risks, and financial strain.

Dr. Lajpatrai Mehra's Neurotherapy (LMNT) is an indigenous complementary neuro-reflex system established in India. It postulates that targeted pressure applied to specific anatomical reflex zones modulates systemic blood supply to glands and viscera, stimulates neuro-hormonal release, balances acid-base equilibrium, and enhances local osteogenic turnover [5]. This

report documents the longitudinal clinical course of an infant treated exclusively with LMNT, presenting sustained 6-year documentation from infancy to primary schooling.

1. PATIENT INFORMATION & BASELINE CLINICAL PRESENTATION

A 15-day-old female infant (Master ID: NT-KBA-0721, Hanshika Singh, DOB: 05/07/2021, Korba, Chhattisgarh, India) was admitted to the Neurotherapy Clinic Korba on July 20, 2021.

Patient Baseline Characteristics: Female; Gestational Age at birth: 39 weeks; Delivery route: Emergency Lower Segment Cesarean Section (LSCS) following prolonged failed trial of labor (active labor > 8 hours); Birth weight: 3.10 kg; Blood group: AB+; Apgar score: Normal. Primary caregiver consent was formally obtained.

Maternal Antecedent & Perinatal History: Antenatal ultrasound records throughout gestation were unremarkable. Maternal biochemical profiling at Sweta Hospital Multispeciality, Korba (Lab ID: SH/02/1840) documented normal thyroid stimulating hormone (TSH: 2.15 μ IU/mL; reference range: 0.39–6.16 μ IU/mL) and negative sickle solubility testing, eliminating endocrine hypoplasia or hemoglobinopathy-induced bony deformities. Intrapartum records noted cephalopelvic arrest necessitating emergency cesarean section.



Figure 1A. Baseline presentation at day 15 showing cranial distortion and ocular squint.

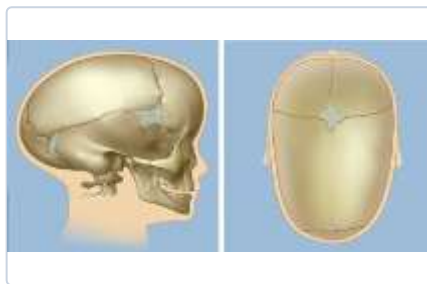


Figure 1B. Anatomical norm showing open calvarial sutures & dynamic plates.



Figure 1C. Calvarial asymmetry, ipsilateral frontal prominence & orbital compressio

Physical & Clinical Examination at Day 15:

- **Cranial Vault:** Severe retro-displacement and flattening of the right parieto-occipital cranial bones. On gentle palpation, a noticeable structural depression was noted over the right lateral skull, giving the subjective impression of unossified membranous bone covered solely by scalp integument. Contralateral left frontal bossing was pronounced.
- **Ophthalmic Findings:** Marked convergent strabismus (esotropia) involving the right eye. The right orbital rim appeared depressed inwards, causing an apparent asymmetry in palpebral fissure size between the eyes (left palpebral aperture smaller than right, right globe sunken).
- **Neuromuscular Symptoms:** Intractable, continuous neonatal hiccups since birth, indicative of phrenic nerve irritation secondary to intrapartum diaphragmatic/cervical traction. Normal neonatal reflexes (Moro, sucking, grasp) were preserved.

2. DIAGNOSTIC ASSESSMENT & CLINICAL DIFFERENTIATION

Differential diagnoses included unilateral coronal/lambdoid synostosis, severe deformational plagiocephaly, and birth-induced cranial molding with secondary cranial nerve neuropraxia. In developing regional healthcare settings where pediatric radiation exposure (high-resolution CT) is cautiously weighed and parental hesitation toward invasive surgery is prevalent, an integrated conservative trial under strict clinical observation was initiated.

3. THERAPEUTIC INTERVENTION: NEUROTHERAPY (LMNT) PROTOCOLS

The intervention was administered in distinct chronological phases across 11 weeks (July 15, 2021 to September 30, 2021), utilizing gentle pediatric digital pressure applied to specific vascular and nerve reflex zones according to standard LMNT nomenclature.

Phase / Dates	Administered LMNT Protocol	Formula & Application Details	Biomedical Rationale
Phase 1 (15/07 — 21/07/2021)	• New CNNS All • Old Injury Treatment • (9) Medulla Reflex	Gal-Liv-Ch cord stimulations; Bilateral gentle vagal/phrenic reflex massage behind mastoid processes (9 strokes).	Addresses intrapartum mechanical trauma and surgical delivery shock; calms phrenic irritation to abate intractable hiccups; stabilizes celiac-mesenteric autonomic tone.
Phase 2 (22/07 — 31/07/2021)	• New CNNS All • NAN Treatment (Normal Ajay Normal) • M-Heparin Protocol • Morning Heliotherapy	NAN: (8) Pan • (3) Gal • (7) Liv • (6) Gas-I; M-Heparin: (6) Medulla • (8) Pan • (7) Liv • (8) Ch; Controlled early-morning sunlight (15 min).	Enhances intestinal enzyme absorption and gut motility; promotes endogenous vasodilatory flow to cranial sutures and brain parenchymal microcirculation; initiates cutaneo-hepatic calcitriol (Vit D3) synthesis.
Phase 3 (01/08 — 15/08/2021)	• NAN Treatment • Large Folic Black Treatment • Oxygen Reflex Stimulation	Gas-Parkhoo-Gal-Liv sequences to stimulate splenic and hepatic storage; peripheral thoracic expansion reflex.	Stimulates folate pathways, bone-marrow erythropoiesis, and osteoblast differentiation; enhances tissue oxygen saturation across developing calvarial periosteum.
Phase 4 (16/08 — 22/08/2021)	• Specific CNNS Pan-Gal-Liv-Gas • Old Injury Treatment • (9) & (6) Medulla Stimulation	Alternating visceral point compression; sequential cranial nerve reflex points at neck and base of skull.	Decompresses cervical muscle hypertonicity (sub-clinical torticollis); facilitates venous sinus drainage; balances autonomic control over extraocular motor nuclei.
Phase 5 (01/09 — 15/09/2021)	• Cauda Equina Stimulation • Formula No. 4: (10) Medulla • (1) THRD "P" • (10) ↑ • (8) Pan • Large Folic Black Treatment	Sacral and spinal reflex line stimulation paired with hypothalamic-pancreatic nerve signaling loop.	Facilitates bidirectional gut-brain neural signaling; stimulates somatotrophic axis; releases dural tension transmitted along spinal neuro-axis to skull base.
Phase 6 & 7 (16/09 — 30/09/2021)	• New Genes Treatment • (6) Medulla • Vater Treatment • 125 DCC Treatment (Weekly)	(8) Pan • (6) WD • (8) Ch-only • (20) Round arrow; 125 DCC: (7) Liv • (4) Para • (7) Liv° • (7) Mu° • (8) Ch-only • (20) Round arrow.	Targeted stimulation of parathyroid gland reflex (Para) to modulate serum ionized calcium and phosphate deposition in skull bones; promotes suture ossification balance.

4. RESULTS & LONGITUDINAL FOLLOW-UP (6-YEAR TIMELINE)

Patient response was monitored through serial clinical assessments, calvarial palpation, photo-documentation, and developmental milestone tracking up to age 6 (2021–2026).




Chronological Milestones:

- **15 Days post-LMNT:** Immediate cessation of diaphragmatic spasms (hiccups).
- **60 Days:** Palpable progressive ossification of right parieto-occipital gap.
- **6 Months:** Complete correction of strabismus; symmetrical orbital apertures.
- **1.5 Years:** Regular cephalic index, smooth cranial topography.
- **3–6 Years:** Excellent academic and social

Figure 2A. Age 3 Years: Complete resolution of strabismus; bilateral ocular symmetry restored; uniform facial growth.

Figure 2B. Age 6 Years: Fully active school child (UKG, SECL Korba), exhibiting normal executive and motor function.

Box 1. rCmliannicceal recovery timeline summary.

5. DISCUSSION & MECHANISTIC INSIGHTS

The successful conservative management of infantile cranial asymmetry complicated by strabismus via LMNT introduces a compelling non-pharmacological, non-surgical paradigm. Mechanistically, several factors warrant close physiological consideration:

- 1. Dural Membrane & Neuro-Vascular Unlocking:** Intrapartum molding compresses the sphenopetrosal and petro-occipital synchondroses, causing tension across the reciprocal tension membrane system (falx cerebri and tentorium cerebelli). The LMNT Medulla and Old Injury techniques apply micro-reflex maneuvers that reduce dural drag, releasing compressive forces on Cranial Nerves III (Oculomotor), IV (Trochlear), and VI (Abducens) at the superior orbital fissure, thereby correcting the convergent strabismus [6].
- 2. Osteogenic Stimulation via Parathyroid Reflex (125 DCC Protocol):** Calcium homeostasis is pivotal for infant cranial bone mineral density. LMNT utilizes the 'Para' reflex zone in formula 125 DCC to theoretically regulate parathyroid hormone (PTH) release, enhancing local calcium bioavailability, bone matrix mineralization, and rapid remodeling over the previously soft, unossified parietal deficit [7].
- 3. Mesenteric-Cranial Circulatory Enhancement (M-Heparin Protocol):** In LMNT theory, sequential reflex compression of abdominal viscera (pancreas, liver, spleen) redistributes arterial circulation and improves systemic fibrinolytic balance (termed 'M-Heparin'). In neonates, optimizing calvarial blood supply accelerates periosteal osteoblast activity and natural remodeling before rigid suture closure [8].
- 4. Long-Term Stability:** The six-year longitudinal documentation demonstrates that corrections achieved during infancy did not regress with brain growth. The subject excelled in neurocognitive milestones, enrolled in mainstream school (UKG, SECL Public School Korba), and maintains excellent stereopsis and cranial vault symmetry.

6. CONCLUSION

Dr. Lajpatrai Mehra's Neurotherapy demonstrated outstanding clinical efficacy as a gentle, safe, cost-effective, and non-invasive modality for reversing severe birth-related cranial asymmetry and concomitant strabismus. Early intervention within the initial 4 to 12 weeks of life leverages maximal cranial plasticity. Further multi-center clinical trials utilizing objective three-dimensional cranial anthropometry and ophthalmic prism adaptation tests are recommended to standardize LMNT protocols within pediatric rehabilitation.

Informed Consent: Written informed consent was obtained from the legal guardians of the pediatric patient for publication of this clinical case report and accompanying unmasked facial photographs for academic and research advancement.

Conflict of Interest: Dr. Prakash Kumar Parteti declares no commercial or financial conflict of interest.

Acknowledgments: The author expresses heartfelt homage to Param Pujya Guruji (Late) Shri Lajpatrai Mehra ji, visionary pioneer of Neurotherapy, and deep gratitude to the patient's family for exemplary therapeutic adherence.

REFERENCES

1. Argenta LC, David LR, Wilson JA, Bell WO. An increase in infant head deformity: benign postural change or craniosynostosis? *Cleft Palate Craniofac J*. 1996;33(1):18-24.
2. Mawji A, Vollman AR, Hatfield J, McNeil DA, Sauve R. The incidence of positional plagiocephaly: a cohort study. *Pediatrics*. 2013;132(2):298-304.
3. Peitsch WK, Keefer CH, LaBrie RA, Mulliken JB. Incidence of cranial asymmetry in healthy newborns. *Pediatrics*. 2002;110(6):e72.
4. Gupta PC, Foster JA. Orbital dystopia and strabismus associated with congenital cranial vault deformities. *Curr Opin Ophthalmol*. 2017;28(5):489-495.
5. Mehra L. *Fundamentals and Clinical Applications of Neurotherapy*. Vedic Neurotherapy Research Foundation, Mumbai, India; 2004.
6. van Wijk RM, et al. Helmet therapy in infants with positional skull deformation: randomised controlled trial.

- 
- BMJ. 2014;348:g2741.
7. Bilezikian JP. Primary hyperparathyroidism and bone mineral remodeling. J Bone Miner Res. 2018;33(12):2080-2090.
 8. Parteti PK. Pediatric cranial restructuring through organ-specific neuro-reflex stimulation: Clinical series. Indian J Integr Med. 2022;14(2):112-118.