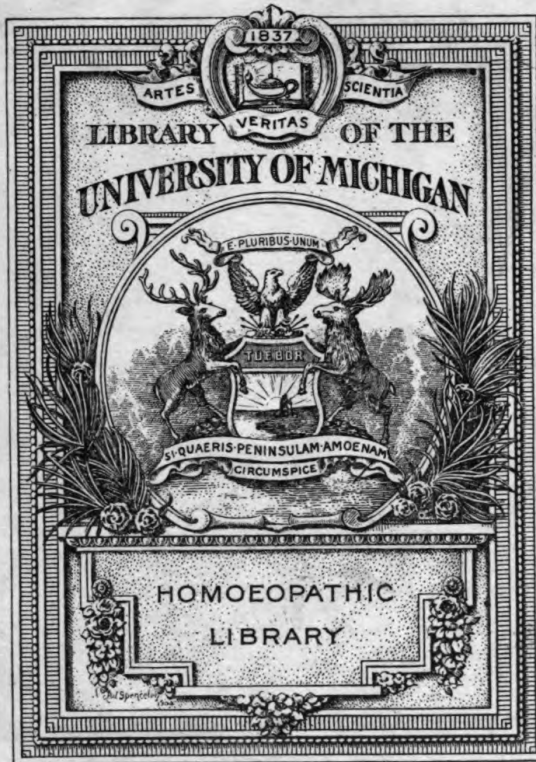




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The Journal
OF THE
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VOL. XVIII.

SESSION 1909-1910

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GILES F. GOLDSBROUGH, M.D.

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1913

EXCHANGES.

L'Art Médical.
The Calcutta Journal of Medicine.
The Chironian.
The Cleveland Medical and Surgical Reporter.
The Clinical Reporter.
The Hahnemannian Monthly.
Homöopathische Monatsblätter.
The Homœopathic Recorder.
The Homœopathic World.
Indian Homœopathic Reporter.
Journal Belge d'Homœopathie.
Journal of the American Institute of Homœopathy.
Medical Century.
Medical Counselor.
New England Medical Gazette.
North American Journal of Homœopathy.
L'Omiopatia in Italia.
Pacific Coast Journal of Homœopathy.
Revista Homœopathica Brazileira.
Revue Homœopathique Française.
University Homœopathic Observer.
Zeitschrift des Berliner vereins Homöopathischer Aerzte.

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- 1893 †CORBETT, HERBERT HENRY, M.R.C.S.Eng.; 9, Priors Place, Doncaster.
- 1890 COX, WILLIAM SPENCER, M.D.Brux., M.R.C.S.Eng., L.S.A.; Physician to the London Homœopathic Hospital; Physician to the Kensington, Notting Hill and Bayswater Homœopathic Dispensary; 90, Church Street, Kensington, W.
- 1892 †CRAIG, JOHN, L.R.C.P.Edin., L.F.P.S.Glas.; Shelton House, Stoke-upon-Trent.
- 1862 CRONIN, EUGENE FRANCIS, M.D.St. And., M.R.C.S.Eng., L.S.A.; Old Manor House, Clapham Common, S.W.
- 1892 CROUCHER, ALEXANDER HENRY, M.D., C.M.Edin., F.R.C.S. Edin.; Physician and Surgeon to the Leaf Homœopathic Cottage Hospital; to the Eastbourne Homœopathic Dispensary; and to the Eastbourne Homœopathic Convalescent Home; Onslow House, 6, Burlington Place, Eastbourne.

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- 1892 *DEANE, HERBERT EDWARD, M.D.Dur., M.R.C.S.Eng., L.S.A.; Lt.-Colonel Royal Army Medical Corps (*Retired*); Assistant Physician to the London Homœopathic Hospital; 33, Weymouth Street, W. (C. 1907.)
- 1907 †DECK, HORACE LEIGH, M.R.C.S.Eng., L.R.C.P.Lond., D.P.M. and H.Cantab. 1908; Withycombe, Ashfield, Sydney, New South Wales.
- 1875 †DECK, JOHN FIELD, M.D.St. And., M.R.C.S.Eng., L.R.C.P. Lond.; Ashfield, Sydney, New South Wales.
- 1906 EADIE, JAMES, M.B., Ch.B.Glas.; Assistant Surgeon to the London Homœopathic Hospital and Medical Officer to the Stratford Homœopathic Dispensary; 16, Weymouth Street, W.
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- 1887 ELLIS, JOHN WILLIAM, M.B., Ch.B.Vict. and Liv., L.R.C.P., L.R.C.S.Edin.; Honorary Physician to the Hahnemann Hospital, Liverpool; 18, Rodney Street, Liverpool.
- 1900 ELLWOOD, THOMAS ASHCROFT, M.R.C.S.Eng., L.R.C.P.Lond., D.P.H.Camb.; 99, Tollington Park, N., and 12a, Finsbury Square, E.C.
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- 1892 FINLAY, JOHN THOMAS, L.R.C.P., L.R.C.S., L.M.Edin. L.A.H., L.M.Dub.; Greystone House, Rawtenstall, Lancashire.
- 1881 GILBERT, SYDNEY, L.R.C.P., L.R.C.S.Edin., L.A.H., L.M. Edin. and Dub.; Somersfield Cottage, Reigate.
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- 1881 *GOLDSBROUGH, GILES FORWARD (*Editor*), M.D., C.M. Aberd.; Physician, and Physician for Diseases of the Nervous System to the London Homœopathic Hospital; 82, Wimpole Street, W., and Churchside, Herne Hill, S.E. (P. 1895. V.-P. 1893, 1894. C. 1897-98, 1901.)
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- 1901 GRANTHAM-HILL, WILFRED, M.D.Bru., M.R.C.S.Eng. L.R.C.P.Lond., L.S.A.; Anæsthetist and late Assistant Physician to the London Homœopathic Hospital; 49, High Road, Chiswick, W.
- 1892 *GREEN, CONRAD THEODORE, M.R.C.S.Eng., L.R.C.P.Lond., F.L.S.; Fell. Roy. Instit. Public Health; Honorary Medical Officer to the Wirral Homœopathic Dispensary; Major R.A.M.C.T.; Certifying Factory Surgeon; Admiralty Surgeon and Agent; 31, Shrewsbury Road, Birkenhead: (P. *Liverpool Branch*, 1896, 1908. V.-P. 1899.)

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- 1892 *GREEN, VINCENT, M.D.Edin. ; Assistant Surgeon for Diseases of the Throat and Ear to the London Homœopathic Hospital; Physician to the Wimbledon and Merton Homœopathic Dispensary; Greyroofs, Wimbledon Hill, and 155, Fenchurch Street, E.C. (C. 1902.)
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- 1909 GREGSON, ARTHUR H., M.B., Ch.B. ; 86, Lower Audley Street, Blackburn.
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- 1876 HALL, EDGAR ATHELING, M.B., C.M.Edin. ; Physician to the Surbiton, Kingston, and Norbiton Homœopathic Dispensary; Seacombe, Adelaide Road, Surbiton.
- 1892 HALL, FREDERICK, L.R.C.P., L.R.C.S.I., L.M. ; 18, Shakespeare Street, Nottingham.
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- 1902 HARRIS, HENRY ARTHUR CLIFTON, M.R.C.S.Eng., L.R.C.P. Lond. ; Lieut. R.A.M.C.(T.); Hon. Physician to Factory Girls' Country Holiday Society; 20, Dyke Road, Hove, Brighton.
- 1900 HARRIS, LILLIAN MAUDE CUNARD, L.R.C.P.I. and L.R.C.S.I., L.M. ; 20, Dyke Road, Hove, Brighton.
- 1878 *HAWKES, ALFRED EDWARD (*Liverpool Branch Representative*), M.D.Brux., L.R.C.P., L.M., L.R.C.S.Edin. ; Fell. Roy. Soc. Med., Medical Officer for Diseases of Women to the Hahnemann Hospital, Liverpool; 24, Rodney Street, Liverpool. (P. 1905. V.-P. 1903, 1904. C. 1898-1909. P. *Liverpool Branch*, 1892, 1901. V.-P. 1893, 1903-4.)
- 1908 HAWKES, ALFRED ERNEST UNDERWOOD, M.R.C.S.Eng., L.R.C.P.Lond., L.S.A. ; Bardsea, Penkett Road, Liscard, Cheshire.

Elected

- 1904 †HAWKES, JAMES L., M.D.Liv. (1906), M.B., Ch.B.Vict. and Liv.; "The Nook," Lyndhurst Road, Wallasey, Cheshire:
- 1905 HAYES, FREDERICK WILLIAM, M.B., Ch.B. Vict. and Leeds; Honorary Physician to Leeds Homœopathic Dispensary; 3, Reginald Terrace, Leeds.
- 1892 HAYWARD, CHARLES WILLIAMS (Barrister-at-Law), M.D., C.M.Edin., D.P.H.Camb., M.R.C.S.Eng., L.R.C.P.Lond.; Surgeon, and Surgeon to the Throat, Nose, and Ear Department, Hahnemann Hospital, Liverpool; 117, Grove Street, Liverpool. (P. *Liverpool Branch*, 1903. V.-P. 1902.)
- 1892 HAYWARD, JOHN DAVEY (*President, Liverpool Branch*), M.D. Lond., M.R.C.S.Eng., L.S.A.; Consulting Surgeon to the Hahnemann Hospital, Liverpool; Leyfield Priory, West Derby, Liverpool. (P. *Liverpool Branch*, 1897, 1909. V.-P. 1899.)
- 1868 *HAYWARD, JOHN WILLIAMS, M.D.St. And., M.R.C.S.Eng., L.S.A., M.D. (Hon.) New York; Consulting Physician to the Hahnemann Hospital, Liverpool; 61, Shrewsbury Road, Birkenhead. (P. *Liverpool Branch*, 1895. V.-P. 1897. C. 1892-97.)
- 1904 HEY, CLARENCE GRANVILLE, M.B., C.M.Ed.; Assistant Surgeon, Assistant in the Ophthalmic Department, London Homœopathic Hospital; 138, Earl's Court Road, Kensington, W.
- 1885 HILBERS, HERMANN GERHARD, B.A.Camb., L.R.C.P., L.R.C.S. Edin., L.F.P.S.Glas.; Honorary Physician to the Sussex County Homœopathic Dispensary; Honorary Physician to the Crescent House Convalescent Home; 49, Montpelier Road, Brighton.
- 1887 HILL, WILLIAM REED, M.B., C.M.Edin.; 38, Berners Street, Ipswich.
- 1902 HUGHES, EDMUND, M.R.C.S.Eng., L.R.C.P.Lond.; 102, Queen's Road, Liverpool. (P. *Liverpool Branch*, 1907.)
- 1909 HUSBAND, CHARLES EDWARD PERCIVAL, M.B., Ch.B.Edin.; 17, Bolton Road, Eastbourne.
- 1892 †HUXLEY, JOHN CHARLES, M.D., C.M.Aberd.; Honorary Surgeon to the Birmingham and Midland Homœopathic Hospital and Dispensary; 91, Harborne Road, Edgbaston, Birmingham.

Elected

- 1904 HYND, ALFRED JAMES, M.B., C.M.Aberd., D.P.H. ; 11A. Standishgate, Wigan.
- 1904 HYND, THOMAS CHALMERS, M.B., Ch.B.Aberd. ; 11, Standishgate, Wigan.
- 1882 *JAGIELSKI, VICTOR APOLLINARIS, M.D.:Berlin, M.R.C.P. Lond. ; 14, Dorset Square, N.W.
- 1894 *JOHNSTONE, JAMES, B.A., F.R.C.S.Eng., M.B., C.M., D.P.H. Aberd. ; Assistant Physician for Diseases of Women to the London Homœopathic Hospital ; 26, Sheen Road, Richmond, Surrey. (P. 1904. V.-P. 1902, 1903. C. 1896-97, 1900, 1908, 1909. S. 1898-1901.)
- 1887 †JONES, DAVID OGDEN ROEBUCK, M.D.Trin. Coll., Toronto, L.R.C.P.Lond. ; Physician to the Grace Hospital (Homœopathic) ; Surgeon for Diseases of the Eye, Ear, Nose, and Throat to the "Nursing at Home Mission" Dispensary ; 126, Carleton Street, Toronto, Canada.
- 1893 JONES, GEORGE REGINALD, M.R.C.S.Eng., L.R.C.P.Lond., Medical Officer to the Homœopathic Institution, Manchester ; Medical Officer to the Manchester Warehousemen and Clerks' Association ; 73, Withington Road, Whalley Range, Manchester.
- 1866 ‡JONES, JAMES, M.D.Edin., M.R.C.S.Eng., L.R.C.P.Lond., 157, Lewisham Road, S.E.
- 1881 JONES, THOMAS REGINALD, L.R.C.P.I., L.M., M.R.C.S.Eng. ; late Consulting Physician to the Wirral Homœopathic Dispensary ; Wayside, Colwyn Bay.
- 1909 KENNEDY, ARTHUR STODDARD, L.R.C.S., L.R.C.P.Edin. ; 64, Leinster Square, Bayswater, W.
- 1901 †LEWIN, OCTAVIA MARGARET SOPHIA, M.B., B.S.Lond., M.D.Chicago ; Assistant Physician to the London Homœopathic Hospital ; 25, Wimpole Street, W.
- 1907 †LOWE, EDWARD CRONIN, M.B., B.S.Lond., 31, Church Street, Southport.
- 1909 McCANDLISH, ALEXANDER HENRY, M.R.C.S.Eng., L.R.C.P. Lond. ; Medical Officer to the Kenley Street Dispensary, Notting Hill ; 43, Royal Crescent, Holland Park Avenue, W.

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- 1908 McCULLOCH, HENRY D., M.B., C.M.Glas.; Physician in charge of Electrical Department, London Homœopathic Hospital; 27, New Cavendish Street, W.
- 1902 ‡MACDONALD, DAVID, M.D.Glas., M.B., C.M.Glas.; Hon Physician to Hydropathic Hospital and North of England Children's Sanatorium; Rivington, Hoghton Street, Southport.
- 1886 ‡MCKILLIAM, ROBERT, M.D., C.M.Aberd.; 6, Grote's Buildings, Blackheath, S.E.
- 1892 McLACHLAN, JOHN, M.A.(Oxon.), B.C.L., M.D., C.M., B.Sc. Edin., F.R.C.S.Eng., L.S.A.; Physician to the Oxford Homœopathic Dispensary; 3, Keble Road, Oxford.
- 1893 *MACNISH, DAVID (*President*), M.A., M.B., C.M.Edin.; Physician to the London Homœopathic Hospital; Physician to the Kensington, Notting Hill, and Bayswater Homœopathic Dispensary, W.; 4, Leinster Square, W. (V.-P. 1906, 1907. C. 1901, 1902, 1904, 1905.)
- 1895 MARCH, EDWARD GERALD, M.D.Brux., F.R.C.S.Edin., M.R.C.S.Eng., L.R.C.P.Lond.; Hon. Medical Officer to the Box Grove Sanatorium, Tilehurst; Camden House, Castle Hill, Reading.
- 1885 ‡MASON, HENRY, M.D., C.M.Glas., M.R.C.S.Eng.; Medical Officer to the Leicester Homœopathic Cottage Hospital and Dispensary; 66, London Road, Leicester.
- 1893 ‡MEEK, WILLIAM OMBLER, M.B., C.M.Edin.; Oxford House, 70, Nelson Street, Oxford Road, Manchester, S.E.
- 1893 MILLER, ROBERT GIBSON, M.B., C.M.Glas.; 10, Newton Place, Glasgow.
- 1902 MINTER, LEONARD JNO., M.D.Brux., M.R.C.S.Eng., L.R.C.P. Lond., L.S.A.; 54, Marine Parade, Brighton.
- 1892 ‡MITCHELL, JOHN JAMES, M.R.C.S.Eng., L.R.C.P.Lond.; 1, Howard Place, Stoke-on-Trent.
- 1882†*MOIR, BYRES (*Council*), M.D., C.M.Edin.; Physician to the London Homœopathic Hospital; 16, Upper Wimpole Street, W. (P. 1894. V.-P. 1891, 1892. C. 1892-99, 1900-09.)
- 1892 ‡MOIR, DOUGLAS, M.D., C.M.Aberd.; 333, Oxford Road, Manchester.

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- 1889 **MOLSON, JOHN CAVENDISH**, M.D.Exam., Hering Med. Coll., Chicago ; L.R.C.P.Lond., F.C.S., F.R.G.S. ; 82, Wimpole Street, W., and 17, Vernon Terrace, Brighton.
- 1877 **MOORE, JOHN MURRAY**, M.D., C.M., L.M.Edin., M.R.C.S. Eng., M.D.New Zealand, F.R.G.S. ; Priory House, Church Street, Leamington Spa.
- 1867 **MORGAN, SAMUEL**, M.D.St. And., M.R.C.S.Eng., L.S.A. ; Consulting Physician to the Bath Homœopathic Hospital ; Consulting Physician to the Bristol Hahnemann Hospital ; 15, Oakfield Road, Clifton, Bristol.
- 1897 **MUNSTER, HAROLD VALDEMAR**, M.D.Edin. ; Medical Officer, Visiting Surgeon † and Anæsthetist to the Croydon Homœopathic Dispensary ; Hollywood, 109, St. James's Road, and 40, George Street, Croydon.
- 1882 **MURRAY, JOHN**, L.R.C.P., L.R.C.S., L.M.Edin. ; Physician to the Folkestone Homœopathic Dispensary ; 15, Trinity Gardens, Folkestone. (C. 1900.)
- 1895 **NANKIVELL, BERTRAM WRIGHT**, M.R.C.S.Eng., L.R.C.P. Lond. ; Surgeon and Registrar to the Hahnemann Convalescent Home ; Physician to the Cottage Home, Cotlands Road ; Visiting Surgeon and Physician to the Bournemouth Homœopathic Dispensaries ; Consulting Surgeon to the Victoria Home for Crippled Children, Westbourne ; Honorary Physician, Y.M.C.A., Bournemouth ; Honorary Surgeon to the Bournemouth Ambulance Association ; Woodstock, 2, West Cliff Road, Bournemouth.
- 1888 **NANKIVELL, FRANK**, M.D., C.M.Edin., M.R.C.S.Eng. ; 134, Auckland Road, Upper Norwood, S.E.
- 1888 ***NANKIVELL, HERBERT**, M.D.Edin., M.R.C.S.Eng. ; Consulting Physician to the Hahnemann Convalescent Home, Bournemouth ; Penmellyn, Richmond Hill, Bournemouth. (P. 1903. V.-P. 1901, 1902.)
- 1893 †**NEATBY, ANDREW MOSSFORTH**, L.R.C.P., L.R.C.S.Edin., L.F.P.S.Glas. ; Watrous, Sask., Canada.

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- 1885 *NEATBY, EDWIN AWDAS (*Hon. Secretary*), M.D.Brux., M.R.C.S.Eng.; L.R.C.P.Lond., Fell. Roy. Soc. Med., Fell. Hunterian Soc.; Physician for Diseases of Women to the London Homœopathic Hospital; Consulting Physician for Diseases of Women to the Buchanan Hospital, St. Leonards-on-Sea, and to the Leaf Cottage Hospital, Eastbourne; 82, Wimpole Street, W. (P. 1897. V.-P. 1894, 1895. C. 1896, 1902-4.) *Librarian*, 1890-1899.
- 1904 NEATBY, THOMAS MILLER, M.A., M.D., B.C.Cantab., M.A.Lond., M.R.C.S.Eng., L.R.C.P.Lond.; Registrar, Assistant Physician, and late Anæsthetist to the London Homœopathic Hospital; Physician to the Stratford Homœopathic Dispensary, 63, West Ham Lane, Stratford, E.; 107, Fairlop Road, Leytonstone, N.E.
- 1898 NEILD, EDITH, M.B.Lond., L.R.C.P., L.R.C.S.Edin., L.F.P.S. Glas.; Honorary Physician to the Tunbridge Wells Homœopathic Hospital; Mount Pleasant House, Tunbridge Wells.
- 1885 NEILD, FREDERIC, M.D., C.M.Edin., L.R.C.P.Edin.; Consulting Physician to the Tunbridge Wells Homœopathic Hospital and Dispensary; Mount Pleasant House, Tunbridge Wells. (C. 1905.)
- 1891 NEWBERY, WILLIAM FREDERICK HOYLE, M.D., C.M.University of Trinity College, Toronto, L.M.S.S.A.Lond.; Senior Physician and Physician for Diseases of Women to the Devon and Cornwall Homœopathic Hospital; 8, Queen Anne Terrace, Plymouth.
- 1892 NICHOLSON, THOMAS DICKINSON, M.D., C.M.Edin., M.R.C.S.Eng.; Physician to the Clifton Homœopathic Dispensary and Hahnemann Hospital, Bristol; 2, White Ladies Road, Clifton, Bristol.
- 1876 NORMAN, GEORGE, M.R.C.S.Eng., L.S.A.; 12, Brock Street, Bath.
- 1893 *ORD, WILLIAM THEOPHILUS, M.R.C.S.Eng., L.R.C.P.Lond., Physician, Hahnemann Home, Bournemouth; Physician, Bournemouth Homœopathic Dispensaries; Greensted, Madeira Road, Bournemouth. (V.P., 1907, 1908.)

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- 1895 †ORR, FREDERIC LAYTON, M.D.Lond., M.R.C.S.Eng.,
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stock Street, W.
- 1886 PINCOTT, JAMES COLE, M.R.C.S.Eng., L.R.C.P., L.M.Edin. ;
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- 1902 POWELL, JOSIAH CECIL, M.R.C.S.Eng., L.R.C.P.Lond. ;
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- 1898 PRITCHARD, JOSEPH JAMES GAWLER, M.R.C.S.Eng., L.R.C.P.
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- 1868 †PRITCHARD, JOSIAH, M.R.C.S.Eng., L.S.A. ; 77, Richmond
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- 1898 †*PRITCHARD, WILLIAM CLOWES, B.A., M.R.C.S.Eng.,
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- 1893 PROCTOR, PETER, M.R.C.S.Eng., L.R.C.P.Edin., L.S.A. ;
17, Hamilton Square, Birkenhead.
- 1884 †PULLAR, ALFRED, M.D., C.M.Edin. ; 184, Sheen Road,
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- 1883 PURDOM, THOMAS EADIE, M.D., C.M.Edin., L.R.C.P., L.R.C.S.
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George Street, Croydon.
- 1908 PURDOM, WILLIAM PERCY, M.B., B.S.Lond., M.R.C.S.Eng.,
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Elected

- 1892 REED, WILLIAM CASH (*ex-President*), M.D., C.M.Edin.; Joint Gynæcologist to the Hahnemann Hospital, and Honorary Gynæcologist to the Roscommon Street Dispensary, and to the Southport Hospital; 15, Princes Avenue, Liverpool. (V.-P. 1900, 1906. P. *Liverpool Branch*, 1902.)
- 1872 †REID, LESTOCK HOLLAND, M.R.C.S.Eng., L.R.C.P.Lond.; 472, Palmerston Avenue, Toronto, Ontario, Canada.
- 1894 †RENDALL, JOHN MURLY, L.R.C.P., L.R.C.S.Edin., L.F.P. & S.Glas.; 2, Coates Crescent, Edinburgh.
- 1885 RENNER, CHARLES, M.D.Würzburg, M.R.C.S.Eng.; L.R.C.P. Lond.; 75, Upper Gloucester Place, Dorset Square, N.W.
- 1908 ROBERTS, ARTHUR, M.D.St.And., M.R.C.S.Eng., L.S.A. Lond., D.P.H.Lond. Conjoint; Albert House, 16, Albert Street, Harrogate.
- 1893 ROBERTS, WILLIAM HENRY, L.R.C.P., L.R.C.S.Edin., L.M.; Physician to the Dublin Homœopathic Dispensary; 63, Lower Mount Street, Dublin.
- 1878 *ROCHE, ELEAZER BIRCH (*Vice-President*), M.R.C.S.Eng., L.R.C.P.Lond., L.M.; Physician to the Norwich Homœopathic Dispensary; Honorary Medical Officer to the Orphans' Home, Norwich, and to the Norwich City Mission; 27, Surrey Street, Norwich. (C. 1897.)
- 1892 ROCHE, WILLIAM, M.R.C.P.I., L.M., M.R.C.S.Eng.; The Limes, 10, Warwick Road, Upper Clapton, N.E.
- 1901 ROSS, PERCY ALEXANDER, B.A.Cantab., M.R.C.S.Eng., L.R.C.P.Lond.; Sudbury, Hamlet Court Road, West-cliff-on-Sea, Southend.
- 1891 ROSS, WILLIAM, L.R.C.P., L.R.C.S.I., L.M.; Physician to the Northampton Homœopathic Dispensary; 87, St. Giles' Street, Northampton.
- 1892 ROWSE, EDWARD LEOPOLD, M.D.BruX. (Honours), M.R.C.S. Eng., L.R.C.P.Lond.; Garryowen, Putney Hill, Putney, S.W.
- 1880 SANDBERG, ARTHUR GREGORY, M.D.Verm., L.R.C.P., L.R.C.S., L.M.Edin.; 72, Streatham Hill, S.W.

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- 1893 SANDERS, HORACE, L.S.A.Lond., L.M.S.S.A.Lond.; Clinical Assistant to the Gynæcological Department, and Clinical Assistant for Diseases of Children, London Homœopathic Hospital; 156, Haverstock Hill, Hampstead, N.W., and 77, Camden Road, N.W.
- 1892 SCRIVEN, GEORGE, M.D., B.Ch.Dub., L.M., J.P., F.R.G.S.; Physician to the Dublin Homœopathic Dispensary; 33, Stephen's Green, Dublin.
- 1885 SEARSON, JAMES, M.D.Brux., L.R.C.P., L.R.C.S.I.; Assistant Physician to the London Homœopathic Hospital; 64, Seymour Street, Portman Square, W. (C. 1903, 1904, 1906.)
- 1884 SHACKLETON, HENRY, B.A., M.D.Dub., M.R.C.S.Eng., L.M.K.Q.C.P.I., L.M.Rot.Hosp., Dub.; 12, West Hill, Sydenham, S.E.
- 1883 *SHAW, CHARLES THOMAS KNOX (*Council*), M.R.C.S.Eng., L.R.C.P.Lond.; Senior Surgeon and Ophthalmic Surgeon to the London Homœopathic Hospital; Consulting Surgeon to the Buchanan Cottage Hospital, St. Leonards; to the Tunbridge Wells Homœopathic Hospital; to the Phillips Memorial Hospital, Bromley; to the Lansdown Homœopathic Hospital, Bath; to the Hahnemann Hospital, Bristol; and to the Devon and Cornwall Homœopathic Hospital, Plymouth; Consulting Ophthalmic Surgeon to the Hastings and St. Leonards Homœopathic Dispensary; 19, Bentinck Street, Cavendish Square, W. (P. 1891. V.-P. 1890. C. 1900-09. S. 1892-98, 1900-04.)
- 1885 SHAW, FRANK HERBERT, M.R.C.S.Eng.; Surgeon to the Buchanan Hospital, and to the Hastings and St. Leonards Homœopathic Dispensary; The Gables, Pevensey Road, St. Leonards-on-Sea.
- 1888 ‡SIMPSON, THOMAS, M.D.St.And., M.R.C.S.Eng.; Honorary Consulting Physician to the Hahnemann Hospital, Liverpool; Hon. Physician to Southport Homœopathic Dispensary; Hon. Physician to the Evangelization Society; 2, Palatine Road, Birkdale, Lancs.
- 1885*†SMITH, GERARD, M.R.C.S.Eng., L.S.A. (*Travelling.*)
- 1896 †SMITH, PHILIP DOUGLAS, M.B., C.M.Edin.; Launceston, Tasmania.

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- 1909 SPENCER, CHARLES SAMUEL, L.S.A.Lond. (1907), L.M.S.S.A.Lond. (1908); Medical Referee to the Refuge Assurance Company; 226, Stamford Street, Ashton-under-Lyne.
- 1899 STACEY, FREDERIC GEORGE, B.A., M.B., B.C.Cantab., M.R.C.S.Eng., L.R.C.P.Lond.; 719, Ecclesall Road, Hunter's Bar, Sheffield.
- 1892 STACEY, HERBERT GLEESON, M.D.Brux., L.R.C.P., L.M. Edin., M.R.C.S.Eng., L.S.A.Lond.; Honorary Physician to the Leeds Homœopathic Dispensary; 28, Park Square, Leeds.
- 1890 STANCOMB, ERNEST HENRY MURLY, M.B., C.M.Edin., Westbourne, College Place, Southampton.
- 1908 STEINTHAL, WALTER OLIVER, M.R.C.S.Eng., L.R.C.P. Lond., L.S.A.; Gwynant, Withington, Manchester.
- 1889 *STONHAM, THOMAS GEORGE (*Vice-President*), M.D.Lond., M.R.C.S.Eng.; late Assistant Physician to the London Homœopathic Hospital; 128, Broadhurst Gardens, West Hampstead, N.W. (C. 1898, 1901, 1905, 1906.)
- 1887 STORAR, WILLIAM MORRISON, L.R.C.P., L.R.C.S.Edin., L.M.; 3, Sion Hill, Ramsgate.
- 1892 STUART, PETER, L.R.C.P., L.R.C.S.Edin., L.M.; Physician to the Hahnemann Hospital, Liverpool; 36A, Rodney Street, Liverpool.
- 1877 *SÜSS-HAHNEMANN, FREDERICK LEOPOLD ROBERT, M.D., Leipzig; Tweed Mount, Bath Road, Ventnor, Isle of Wight.
- 1892 †THOMAS, BERNARD, M.B., C.M.Edin.; Port Cygnet, Tasmania.
- 1886 †THOMAS, EDWARD JOHN HAYNES, L.R.C.P., L.R.C.S.Edin.; Physician to the Chester Free Homœopathic Dispensary; 18, Pepper Street, Chester.

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- 1895 †THORNTON, FRED WHITFIELD, M.R.C.S.Eng., L.R.C.P.I.;
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- 1896 TINDALL, ERNEST EDWARD PATRIDGE, R.N., M.R.C.S.Eng.,
L.R.C.P.Lond.; Medical Officer to the Devon and
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East, Exeter.
- 1904 TYLER, MARGARET L., M.D.Brux., L.R.C.P., L.R.C.S.Edin.,
L.F.P.S.Glas.; Homœopathic Dispensary, 311, Kentish
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- 1900 †WARREN, WILLIAM, M.R.C.P.I., L.R.C.S.I., L.M.;
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- 1895 *WATKINS, FRANK AUGUSTUS, M.R.C.S.Eng., L.R.C.P.Lond.,
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(C. 1904.)
- 1907 WATKINS, WALTER, M.R.C.S.Eng., L.R.C.P.Lond., L.S.A.
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- 1862 ††WATSON, CHARLES GEORGE, L.R.C.S., L.R.C.P.I., L.M.
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- 1909 WATTS, WILLIAM HENRY, M.R.C.S.Eng.; 1, Wellington
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- 1894 WHEELER, CHARLES EDWIN (*Council*), M.D., B.S., B.Sc.Lond.,
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- 1901 †WHITE, ADAM CRAWFORD, M.D., C.M.Glas.; 31, Union Street,
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- 1893 WILDE, FREDERICK GEORGE STANLEY, L.R.C.P., L.R.C.S., L.M.Edin.; Physician to the Cheltenham Homœopathic Dispensary; Ingleside, Bayshill, Cheltenham.
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- 1891 †*WILDE, PERCY ROBERTS, M.D., C.M.Aberd.; Physician to the Lansdown Hospital and to the Bath Homœopathic Hospital; 23, Circus, Bath, and 64, Seymour Street, London, W.
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- 1892 *WILKINSON, CLEMENT JOHN, M.R.C.S.Eng., L.S.A.; 3, Osborne Villas, Windsor. (V.-P., 1905. C. 1898-99.)
- 1892 WILLIAMS, LEMUEL EDWARD, M.R.C.S.Eng.; Surgeon to the Skin Department and Honorary Assistant Medical Officer to the Hahnemann Hospital, Liverpool; 229, Boundary Street, Liverpool.
- 1896 WILLS, REGINALD GRAHAM, M.D., C.M.Aberd.; late Visiting Medical Officer to the Bath Homœopathic Hospital; 8, St. George's Place, Canterbury.
- 1902 WILMOT, PHILIP MCKINNELL CORBOULD, M.B.Lond., M.R.C.S.Eng., L.R.C.P.Lond.; Honorary Surgeon and Surgeon to the Throat, Nose, Ear and Eye Departments, Devon and Cornwall Homœopathic Hospital, 2, Crescent Villas, Plymouth.
- 1892 WINGFIELD, JOHN, L.R.C.P., L.R.C.S.Edin., L.F.P.S. Glas., Elmhurst, Wake Green Road, Moseley; and 60, Newhall Street, Birmingham.
- 1889 WITHINSHAW, CHARLES WESLEY, L.R.C.P., L.R.C.S., L.M.Edin.; The Hydro, Bromley Hill, Kent.
- 1893 †WOLSTON, CHRISTOPHER, B.A.Lond., M.D.St. And., M.R.C.S.Eng.; 24, Connaught Street, Hyde Park, W.
- 1877 WOLSTON, WALTER THOMAS PRIDEAUX, M.D.Edin., M.R.C.S.Eng.; 6, Coates Crescent, Edinburgh.
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PHOSPHORUS.¹

BY THOMAS GEORGE STONHAM, M.D.LOND.

Vice-President British Homœopathic Society.

MR. PRESIDENT AND GENTLEMEN,—When I was asked by the Secretary of the Materia Medica and Therapeutic Section of this Society to read a paper it was represented to me that there was a desire that a materia medica paper should be read approaching the subject from the side of a drug rather than from the side of diseased conditions, that some drug should be chosen and its capabilities as a drug exhaustively treated, that in fact the paper should be a materia medica one rather than a therapeutic.

Though I acceded to the request, I am not sure that this way of treating the subject is the one that will prove the most interesting to the Society. It might be so had I the pathogenesis and therapeutics of a new drug to present to the Society, or even a quantity of new matter concerning an old one. But I have neither. I have only been able to

¹ Presented to the Section of Materia Medica and Therapeutics, October 7, 1909.

select one of our old and well-known drugs, viz., phosphorus, and to treat it as fully as time will allow, and though from a utilitarian point of view one can never hear the facts about any drug too often, repetition being the chief aid to perfection in the knowledge of materia medica, yet I am afraid the recital will not prove very entertaining.

Phosphorus is one of the elements and has a combining weight of 31. It is largely present in the animal tissues, especially in bone and nervous tissue. It is insoluble or soluble to only a very slight extent in water, but is more soluble in alcohol and still more so in ether. A saturated solution in alcohol contains 1 gr. of phosphorus in 550 m of absolute alcohol, and a saturated solution in ether contains 1 gr. of phosphorus in 200 m .

The British Homœopathic Pharmacopœia directs the primary solution to be of 3x strength, making it either with absolute alcohol or with equal parts of this and ether. Subsequent potencies are made with rectified spirit. A useful preparation can be made by dissolving phosphorus in cod-liver oil.

Phosphorus is a powerful poison, and death has resulted from the minimal doses of $\frac{1}{50}$ gr. in a child, $\frac{1}{8}$ gr. in a woman, and 1.5 gr. in a man.

The most commonly used antidote to phosphorus poisoning has been oil of turpentine, which combines with phosphorus, forming terebinthino-phosphorus acid, which is inert. It requires 1 grm. of turpentine to transform 1 cgrm. of phosphorus into the non-poisonous acid. The best kind of turpentine to use is that which has long been exposed to the air and which has become partially resinified in consequence, as this old turpentine is more highly oxygenated than the recent.

Dr. Antal has introduced a new antidote to phosphorus, viz., permanganate of potash, which he claims to be of superior efficacy to turpentine. It oxidizes the poison to phosphoric acid, which is comparatively harmless. He administered a fatal dose of phosphorus to seven dogs and treated them all without washing out the stomach with a pint of $1\frac{1}{2}$ to 2 per 1,000 solution of permanganate of potash

within two hours afterwards ; the dose was repeated three or four times. They all recovered. In human beings he would advise giving at once from a pint to a quart of 2 to 4 per 1,000 solution, and to repeat the antidote a few times at half-hour intervals. This method has been employed successfully in several cases.

Phosphorus differs from most poisons in acting mainly on certain phases of the animal metabolism, and in having comparatively little action at the point of application, or indeed upon any single organ. It has not the poisonous effect on cell life that many metals—copper for instance—have. Yeast infusoria and bacteria are little affected by it, and living microbes are found in large numbers on solid sticks of phosphorus. Most ferments also are unaffected by it, and both pepsin and pancreatin continue to act in the presence of phosphorus.

Phosphorus exists in the blood as such, and the effects on the tissues are due to the element itself and not to its oxygen or hydrogen compounds. As soon as it is oxidized it loses its specific action, all of the acids of phosphorus being comparatively harmless. It has no action on albumins in solution and has no immediate irritant effects such as are seen in poisoning with the heavy metals.

The way in which phosphorus poisons is by effecting a profound change in the processes of metabolism carried on by the cells ; metabolism is greatly deranged, the result being that an excess of sarcolactic acid is formed in the tissues. This sarcolactic acid is not oxidized into CO_2 and H_2O as in the normal organism. Consequently the alkalinity of the blood is reduced. There is a lack of oxygen in phosphorus poisoning, and this may have something to do with the fatty degeneration of the cells. The increased sarcolactic acid combines with the ammonia in the blood and is excreted in the urine, the nitrogen excretion of which is thus much increased. The phosphates and sulphates of the urine are also increased and the chlorides diminished. Leucin and tyrosin are often found and sometimes sugar.

The blood is not only diminished in alkalinity, but is also more fluid and clots less readily. This is due to a deficiency

of fibrinogen, which is owing to an increase of the autolytic ferment of the liver.

All these facts are evidences of a deranged cell metabolism caused by phosphorus, and the pathological result of this is a fatty degeneration of the tissues. This is characterized by the appearance of numerous fat globules in the cells of many organs, notably in those of the liver, kidney, gastric, and intestinal glands, and in the muscle fibres of the heart, stomach, intestine, smaller arteries, and often of the skeletal muscles. The process of fatty degeneration commences in cloudy swelling of the cells, followed by the appearance of granules which soon develop into fat globules. Eventually the degenerated cells break up into detritus.

A secondary result of the fatty degeneration of the cells, which can be seen best in cases of slow poisoning, is a proliferation of the interstitial connective tissue of the stomach, liver, and kidney, which finally induces typical cirrhosis of those organs.

In animals poisoned by the administration of small quantities of phosphorus, the ordinary effects of hepatic and renal cirrhosis have been induced, such as dropsy, anæmia, and cachexia.

One of the most important seats of the phosphorus fatty degeneration is the muscular coats of the arterioles. This fatty degeneration of the parietes of the vessels can be observed in all the organs, but most easily in the brain, in cartilage, in the marrow of the bones, and in the liver. In consequence of this and the increased fluidity of the blood, we get the numerous hæmorrhages which are so marked a feature in phosphorus poisoning. They may occur under the skin, from any of the mucous membranes, from the kidneys, and may even cause hæmatocele. Wegner in 1870 brought before the Berlin Obstetrical Society some cases of poisoning with phosphorus, and demonstrated from them preparations showing that hæmatoceles had been found of a size varying from that of a cherry to that of a man's fist; in two of these cases they lay within the ovaries, and in one there was a breaking out towards the pelvic cavity, and in the fourth perforation into the rectum had followed. In

nearly all *post-mortem* cases that have survived the poison for six or seven days the heart has been found enlarged from deposits of fat and its muscular fibres to abound in oil granules. There is no valvular or pericardial inflammation, but simply a rapid degeneration of tissue with numerous ecchymoses.

In acute poisoning the liver first becomes enlarged from the liver-cells becoming swollen and beginning to undergo fatty degeneration, and as this proceeds to cell destruction the enlargement of the liver rapidly gives place to shrinking and atrophy results. The liver is then soft, of a deep yellow colour, and of a small size and indistinguishable from its appearance in acute yellow atrophy. In chronic poisoning, where the fatty degeneration of the cells takes place slowly, interstitial hepatitis occurs. There are usually, in the acute cases, large amounts of ammonia, leucin, and tyrosin found in the liver, due, according to Jacobi, to augmentation of the activity of the autolytic ferment of the liver. The glycogen is rapidly much reduced. Icterus is a prominent feature of phosphorus poisoning, in the first stage of which a larger amount of bile pigment is excreted than usual; the swelling of the cells obstructs the bile capillaries, and there is absorption into the blood and deposition in the skin, and hence the jaundice. At a later stage scarcely any bile is formed, reabsorption takes place from the skin, and the jaundice goes.

There is also fatty degeneration of the renal epithelium and in the urine fatty casts and globules of fat and blood and hæmoglobin appear. In some cases there is albuminuria, apart from the presence of blood in the urine. The foetus in pregnant animals is found to undergo fatty degeneration, so that the phosphorus traverses the placenta.

Though phosphorus forms an important constituent of nervous tissue, and though the nervous system is greatly affected in its function by phosphorus, yet it seems to escape any gross organic change. The coma and convulsions which may appear before death are due rather to the disordered metabolism than to any direct influence. The brain on *post mortem* is found pale and bloodless, and softer

than natural: there are no inflammatory signs, but the sinuses are distended with dark fluid blood.

Meyer, from experiments on animals, concludes that phosphorus acts specifically on the nerves of voluntary motion and on the muscles themselves. It impedes, diminishes, and at last entirely destroys the irritability of the motor nerves and the contractility of the muscular fibres. It also acts specifically on the nerves of sensation, destroying sensibility from the periphery to the brain, the sensorium being in small degree disturbed. This shows how powerfully the nervous system is affected functionally, but it is without gross pathological lesion.

Next in importance to the fatty degenerations caused by phosphorus is its action on the bones, which is of a specific nature.

Attention was first called to this action by the occurrence of necrosis of the jaw in the workers in phosphorus at match factories. The disease usually begins in a carious tooth, which gnaws and throbs or shoots, with itching and bleeding of the neighbouring gums. Then gumboils form and discharge foetid pus in which are found granules of bone. Then the teeth fall out and the gums recede or melt away, and the bone appears in a state of caries or necrosis; there is a combination of new osseous deposits with the necrosis of the old bone. Inflammation of the neighbouring parts and irritative fever come on, and the case often terminates in death. That this action on the jaws is a specific one is proved by the fact that exposure to the fumes of other substances, of even more corroding nature, do not produce necrosis. It is due to a specific influence of phosphorus on bone tissue. Wegner found that by feeding animals with minute doses of phosphorus there occurred increased production of osseous matter, thickening of the spongy and greater density of the compact tissue of the long and short bones, and even in some instances the obliteration of the medullary cavity by the continuous fresh formation. He sums up as follows: "Phosphorus in minute doses operates on the osteo-genetic tissue as a specific plastic irritant. Brought topically in the form of vapour into contact with denuded

periosteum in moderate concentration it provokes ossifying periostitis, while if the fumes operate very energetically the irritation becomes so intense that suppuration is added to the ossificatory process." By the aid of the X-rays it can be demonstrated that bone formed in young people working at phosphorus processes during the growing period is much denser in character than it would otherwise be. The lower jaw is affected more easily and seriously than the upper.

Turning now from pathology to consider the more general action of phosphorus on the system, we find that its primary action is that of a stimulant to the nervous system. "About the second hour," writes Thompson, "after a dose of one-twentieth to one-twelfth of a grain sensations of exhilaration begin to make themselves felt. The capacity for exertion, both mental and physical, is increased, and a condition of *bien être* is experienced. If the subject has taken the dose while in a state of fatigue he finds his strength renewed, if while in a state of despondency he takes a cheerful view of things. The pulse becomes firmer and a little more frequent. With this there is often increase of temperature, perspiration, and diuresis, and sometimes venereal excitement. These effects pass off gradually in the course of a few hours and a state of depression does not ensue."

When a poisonous dose of phosphorus is swallowed, no effects are elicited as a rule for several hours. The first symptoms are pain and discomfort in the region of the stomach, nausea and eructation of the vapour with its characteristic garlic odour, and then vomiting, the contents of the stomach having the same odour and becoming phosphorescent in the dark. Later bile may be vomited, and some diarrhoea may set in, although this is not a common symptom. The nausea and vomiting often continue without further symptoms for several days, but frequently disappear, and the patient apparently recovers, particularly if the dose has been small, or if most of it has been removed by vomiting or by washing out the stomach. In the course of a few days, however, the symptoms recur, and are generally accompanied by some jaundice; the pain extends from the

stomach to the liver, and soon to the whole of the abdomen. The vomited matter no longer contains phosphorus, but may be bloody. The patient complains of general weakness and faintness, the pulse is weak, the liver extends far below the ribs, the urine shows characteristic changes; hæmorrhages occur from the nose, bowel, uterus and under the skin, and eventually a condition of collapse and fatal coma follow. Convulsions and delirium have been observed in a considerable number of cases towards the termination of the intoxication. Death may, however, occur in the first stage or early in the second, before complete exhaustion is reached, and in these cases would seem to be best explained by the direct action of the poison on the heart.

There are a great many interesting cases of phosphorus poisoning recorded in "The Cyclopædia of Drug Pathogenesis," most of them with suicidal intent, and generally either from taking rat poison or lucifer matches. One of the cases recorded by J. O. Müller, and which ultimately recovered, is valuable because it extended over a long period, exhibited a great many phosphorus symptoms, and illustrates the sequence in which they usually appear.

A lady, over 30 years of age, strong and healthy, swallowed at night on going to bed scrapings of lucifer matches containing about 3 gr. of phosphorus. After eight hours violent and noisy vomitings came on, and she soon became prostrate, pallid and unconscious, covered with cold sweat, with short respirations, and small, irregular, intermitting pulse; abdomen was distended, vomited matters, at first watery, then blood-clot and mucus, and diarrhœic stools of same character. She could only be roused by calling loudly into her ear. After acon. 1 she revived from the collapsed condition and reaction set in. She then complained of violent, burning pains in the lower part of chest, stomach and whole abdomen on touch or movement. Vomiting and diarrhœa ceased, but retching and tenesmus continued; a sensation like fire in large intestine and anus, and there was severe burning in urethra after passage of urine with garlic-like odour. Delirium occurred the next night, with frequent faintings. With acon. and bell. in alternation she rallied from this condition and symptoms all abated. On the tenth day she complained of drawing pains in right upper chest, increased by breathing, and then

a deep burning in a spot over sixth and seventh ribs, with painful cough. Bry. 3 cured this. From the fifteenth day for a fortnight onwards she had boring pains in the bones, particularly in the skull, palatal and nasal bones, jaws and teeth. Toothache, increased by warm or cold things in mouth, and chewing, sometimes numb feeling in teeth; sensation as if they would fall out. A similar burning experienced in the internal ear, buzzing, humming and ringing noises, and deafness; swelling of right temporal and superior maxillary bones. Blood and mucus blown from nose. Stools at this time contained bloody mucus and small faecal masses covered with blood and associated with burning in the anus, and constant urging and tenesmus. Urine passed in drops which burned like fire, sometimes mixed with blood. Pain in kidneys and bladder. These symptoms improved under merc. 1 and mezereum 6. In the eighth week, when the patient was beginning to get about, loss of muscular power came on. Every movement fatigued. She took to bed, and became quite apathetic, with alternations of anger. Drowsy, and in her sleep talked nonsense, or went into an erotic ecstasy; talked in a libidinous way, and touched herself so as to satisfy her sexual desires. Menses were regular, but scanty, attended with spasmodic pain in uterus and renal region, and followed by a burning, excoriating leucorrhæa. Then came on what the patient called "gouty pains" in the knees and ankles. She said she felt a gelatinous substance between the parts of the joints that were in contact, which offered great resistance to her movements. The soft parts of the joints were a little swollen, but not red or painful to touch. There was considerable rigidity of the joints. The skin took on a yellow tint, and there appeared bloated swellings in some places on the eyelids and face, which left a depression when pressed with the finger. Finally a peculiar exanthem appeared on the skin about the joints, consisting of small vesicles in groups, which rapidly turned to scabs and frequently recurred. Sulphur was given, and the patient gradually recovered.

With the exception of the jaundice, which in this case occurred late, but usually appears about the third or fourth day, the symptoms appeared in the sequence in which they ordinarily occur. First the gastro-intestinal symptoms, followed at an interval by the respiratory, later on the bone pains and hæmorrhages from fatily degenerated blood-vessels, later on still, the affections of the nervous system, and, last of all, the skin eruptions.

I will follow this order in considering the symptoms more minutely and in connection with their therapeutic application.

(1) *Gastro-intestinal Symptoms.*

The tongue is dry and white, especially down the middle, or it may be yellow, brown, or black in typhoid conditions; it is apt to become swollen, but always dry, and when swollen loaded with a brownish-black coating. The throat is dry, with smarting and burning; the tonsils, and especially the uvula, may be swollen, and there is much white, transparent mucus.

In the œsophagus there may be burning and also a spasmodic stricture at the lower end. There is a bitter or sour taste in the mouth, especially after a meal, the sour taste occurring very often after taking milk. There is generally a good deal of thirst, with craving for cooling things. Food swallowed often comes up immediately as if it had never been swallowed—it seems to get no lower than the cardiac end of the œsophagus, and then to be returned by a reverse peristalsis, coming up unchanged into the mouth like rumination. The phosphorus patient is a hungry patient, cannot go long without food; if he does so he feels utterly faint and exhausted, and must have food to relieve this; he does not want much at the time, but must have it often. Hunger returns soon after a meal, and he becomes very hungry at night and cannot rest until he has roused up and taken food. Risings are frequent and generally empty, or sour with taste of food. There may be nausea coincident with hunger, which disappears after eating or drinking water; but as soon as the water or food becomes warm in the stomach it is thrown up. This is very characteristic of phosphorus vomiting. The desires are all for cold things, for cold food, for ice-cream or ice-water, which relieve temporarily, but, when they become warm, are violently vomited. Phosphorus resembles natrum muriaticum in counteracting the craving for salt. The vomited matters may be simply the food or drink, or there may be ejection of

large quantities of offensive, sour fluid looking like water, ink, and coffee-grounds; or it may be of bile and blood. Food lies heavily at the epigastrium, and the stomach feels full, and there may be burning and shooting pains. This burning and pressure come on soon after eating.

Pathologically, phosphorus produces fatty degeneration of the epithelial cells of the stomach and intestines, and this occurs when it is injected hypodermically. Virchow describes the condition as a serious disease of the stomach glands—a gastro-adenitis. In chronic poisoning the mucous membrane becomes hyperæmic and swollen, with hæmorrhage here and there, or hæmorrhagic infarcts; later it becomes much thickened and indurated, the interstitial connective tissue hypertrophied, and the peptic glands atrophied.

So that phosphorus is suited for chronic rather than for acute dyspepsia, and is very useful in broken-down states of the constitution, with chronic dyspeptic symptoms. The following is an illustrative case taken from the *British Journal of Homœopathy*, vol. xxxvii., p. 302.

A woman, aged 33, had been long under treatment for dyspepsia. In the morning she had nausea and much sour eructation, constant empty feeling in the stomach relieved by a small morsel of food. Otherwise loss of appetite; obstinate constipation; some pain when urinating, tenesmus afterwards. The third and sixth dorsal vertebræ sensitive to pressure. The pain in stomach usually burning. She must sit in a bent position; at the same time oppression in the chest, as from a tight band. This sensitiveness dates from her seventeenth year, and had hitherto been treated as a rheumatic affection. Menstruation painful. Phos. 4, then 3, then 2. In fourteen days she was quite cured.

Cases suggestive of cancer of the stomach are sometimes curable by phosphorus, as for instance this case by Bolle :—

A robust, muscular man, aged 40, began to suffer from indigestion, and had been getting worse for six months. He then had many of the symptoms of cancer in the stomach. He was extremely emaciated and weak, complexion earthy-looking; vomiting occurred after everything he took, and consisted of sour, foetid fluid, looking like coffee-grounds. Thirst, no appetite, fulness and tenderness of the stomach, insuperable

constipation, He was quite cured by phosphorus 3. A relapse eighteen months later was soon cured by the same medicine."

There was probably some ulceration in this case, and phosphorus meets this condition well.

In the abdomen the principal symptom is a weak, empty, gone sensation felt in the whole abdominal cavity, and according to Guernsey is a sure indication for phosphorus when associated with a sensation of heat in the back between the shoulder-blades. The abdomen is usually flaccid, and there may be intermingled sensations of heat and coldness. There is a painful sensation of weakness across the abdomen, especially in the hypogastrium, which is worse from walking; she must lie down. There may be pinching, cutting pains in association with diarrhoea, which is always exhausting to the patient; in fact, the patient feels exhausted after every stool, whether loose or constipated. The diarrhoea may be one of two or three varieties. It may be profuse, pouring from the rectum as from a hydrant, with lumps of white mucus, like grains of tallow, in it, and occurring in the morning; or it may be an involuntary diarrhoea, with a lax open sphincter through which blood-stained mucus and soft fæces are constantly oozing; or a dysenteric diarrhoea with frequent and painful urging, with stools like the scrapings of intestines; or mucus mixed with blood, with painful tenesmus lasting a long time afterwards, with burning pains in the rectum and anus.

When there is constipation the characteristic stool is long, hard and dry, and is flattened; it has been compared to a dog's stool, and its evacuation is accompanied with much straining and trembling of the limbs. The following case of diarrhoea is recorded by Dr. R. T. Cooper:—

W. M., aged 60, a cabinet maker, has complained for six months of advancing debility, losing flesh rapidly, cannot eat anything; solid food lies heavy on the chest, and makes him feel sick. He has a pain coursing from the chest to the back, and is much troubled with an accumulation of phlegm on the chest at night; is nearly choked with it. Bowels are much relaxed day and night; warm drinks bring on a stool which is painless; lessened by lying down, increased by walking about.

Tongue rough, white and dry ; urine high coloured. Phosphorus 12x given. Next week he reported himself as being much better ; the bowels were quite regular, the diarrhœa having left the second day after taking the medicine. The following week quite well.

Dr. Cooper also records this case of hæmorrhage from the bowel :—

A very stout plethoric man, a worker in a brewery, had for three months past quantities of blood discharged with stool, sometimes bright and sometimes dark. Merc. sol. for a time had given relief, but then failed to do so. He was quite cured by the phosphorus.

Dr. Proctor, of Birkenhead, says phosphorus was of great service in arresting the drain of brownish fluid from the bowels after the other symptoms of cholera were removed. He gave the 1 c. dilution.

We have already noticed the fatty degeneration of the liver caused by phosphorus, with the primary enlargement and subsequent shrinking of that organ, going on in chronic cases to a condition of cirrhosis. There are jaundice, shooting pains over the liver region, painful pulsation in the right hypochondrium ; sensitiveness over the liver, increased by lying on the right side. Phosphorus is accordingly one of our principal remedies, if not the principal, for liver diseases. There have not been many opportunities for giving it in acute yellow atrophy, but Dr. Pope cured a case he thought was the beginning of the disease, and Dr. Bayes relates a case. Dr. Selzer, of Calcutta, speaks warmly of the use of phosphorus in cirrhosis, and Dr. Midgley Cash has put a case on record :—

S. W., aged 61, a teetotaller for the last ten years, but formerly took a bottle of whisky a day for five or six years. The conjunctivæ were jaundiced, the skin dusky ; there was slight ascites, the legs œdematous as far up as the knees ; a girdle of varicose veins round the abdomen ; has had piles ; liver dulness diminished. Stools of bright colour ; short of breath and drowsy. Phosphorus 3x ordered. In a fortnight the œdema had gone from the legs and he felt better but weak. He was then given ars. iod. 3x, and in three weeks reported himself quite well.

In cases of catarrhal jaundice phosphorus is serviceable, as also in those of hepatitis, as is shown by this case of Dr. Pope :—

A child, aged 11, soon after the appearance of the eruption of scarlet fever became suddenly jaundiced, the liver enlarged and tender; there was whitish diarrhoea and mild wandering delirium. Phos. 3x in drop doses, frequently repeated, was followed by rapid amelioration. In three days he was practically well.

In idiopathic jaundice and in jaundice caused by emotions such as anger, or by nervous excitement, phosphorus is the remedy; also in the enlarged fatty livers of heart diseases or beer-drinkers, and in the waxy liver of prolonged suppuration.

Respiratory System.

In many of the provers, phosphorus set up a laryngeal cough and, in others, cough excited by soreness and tickling in the trachea.

Various pains of shooting character generally appeared in the chest, there was oppression of breathing, and in two or three cases congestion of the lungs, and signs of the first stage of pneumonia. Clinical use has amplified the indications for the use of phosphorus in respiratory affections.

It is good for chronic nasal catarrh when the patient frequently blows small quantities of blood from the nose.

Very characteristic is the laryngeal cough due to a definite laryngitis. The larynx is painful to pressure and feels sore and raw; the cough, which is excited by tickling in the larynx or trachea, is hard and dry and very painful; it is shaking and accompanied by trembling and prostration from exhaustion; its very shaking causing pains in the chest, and in the head a sensation with each cough as though the head would burst. The cough may cause involuntary stool. The patient is hoarse and there may even be aphonia; the hoarseness and aphonia are worse in the evening. The cough is excited and made worse by talking, laughing, eating or drinking, going from warm to cold air, mental emotions such as nervousness from a stranger entering the room, from strong odours. This

laryngeal cough is dry, but with the bronchitis of phosphorus there is a good deal of mucous secretion which is often blood-streaked; there are shooting pains in the chest, or rawness and burning behind the sternum. Expectoration may taste salt or sour and may be mucoid or purulent. When the capillary bronchioles or air-cells are affected as in broncho-pneumonia the sputum becomes rust-coloured and viscid. Experiments with rabbits showed that phosphorus can cause points of hepatization in the lungs. Phosphorus was introduced as a remedy for pneumonia by Fleischmann, of Vienna, and ever since it has been one of our chief remedies for it. It is best suited to catarrhal pneumonia with associated bronchitis, and in the conditions of acute pulmonary congestion and acute oedema pulmonum. In pneumonia it is of most use in the first stage of hepatization and again in the late stages, when the hepatization is breaking up. When large areas of lung are involved in a solid lobar pneumonia bryonia or some other medicine is more suitable. Phosphorus comes in well for the pneumonia of typhoid fever or that occurring in other typhoid states. The base of the right lung is the area of selection of phosphorus; often there is circumscribed redness of the cheek of the same side as the inflamed lung. The delicacy of constitution indicative of phosphorus makes it a good remedy in scattered inflammation round developing tubercle; the patient catches cold easily, has rushes of blood to the chest, pain through the apex of the left lung, where there is dulness and some râles: he has a dry cough with pains in the chest, hectic cheeks, cannot lie on the left side, and is hungry at night.

In cases of hæmoptysis, too, in suitable cases phosphorus is a good remedy; and also in pleuritis of the left side, when the patient cannot lie on that side. Dr. Wheeler has shown that phosphorus causes a rise in the opsonic index to tubercle, and Dr. Neatby obtained a well-marked negative phase, succeeded by a heightened opsonic index, after taking one dose of $\frac{1}{20}$ gr.

With phosphorus the patient may have fits of suffocation at night, as if his lungs were paralysed; fits of asthmatic

breathing brought on by cough, so that it is a remedy for cardiac asthma.

Two cases by Dr. Andrew Neatby may serve to illustrate the action of phosphorus in respiratory affections.

(1) The case of a child, a girl aged 15 months, who had had measles, which was followed by bronchitis which had not cleared up. She had been wasting for a month, and the respirations when she was first visited were laboured and 60 to the minute; the cough was loose, frequent and exhausting. Bowels irregular; motions offensive with earthy smell. Phos. 4x *ter die*. Improvement in one week, cure in four weeks.

(2) A girl, aged 12, had for three months had a cough provoked by substernal irritation. No expectoration. There was pain in the right side of the chest on coughing or taking a deep inspiration. Loss of flesh and strength. Feverish at night. Catches cold easily. One sister died of phthisis. Vertex headache aggravated by the cough. Physiological examination negative except some flattening under the right clavicle. Phos. 6, pil. ii., night and morning. At once improved and the cough was gone before the end of a month.

Heart and Blood-vessels.

The symptoms referable to the heart and blood-vessels all arise from the power of phosphorus to cause fatty degeneration of the muscular fibres of the heart, and of the muscular coats of the arteries. The heart becomes dilated, especially the right side, with congestion of blood to the venous system; its action is weakened so that the pulse becomes small, feeble, irregular and intermittent, and the cardiac sounds are wanting in tone; there may even be a hæmic murmur. The heart is easily excited to palpitation by the least exertion, any emotion, or a meal being sufficient to cause it. It is accompanied by a sensation of blood rushing to the chest and a feeling of warmth at the heart. So that in fatty degeneration of the heart or in weakness of heart produced by exhausting illnesses or other causes phosphorus is a thoroughly homœopathic remedy.

Dr. Pullar has recorded the following case of fatty degeneration of the heart :—

Mrs. G., aged 56, complained of persistent giddiness as of falling forwards, and when standing a sensation of swaying to and fro aggravated by looking around. Increased in the morning when rising from bed; slight faintness, palpitation at times; dyspnœa on exertion, a sensation when falling asleep as if the heart would stop. Heart sounds extremely feeble, and cardiac impulse barely perceptible. Phos. 6 every four hours soon effected great improvement, which was afterwards continued by digitalis 2x.

Dr. Lade gives the following case of fatty degeneration :—

The patient, a married lady, aged 54, had been an invalid for two years. She was tall and fairly plump, but not corpulent. Muscles soft and flabby. Could walk well for a short distance on level ground, but hurrying, excitement, or going upstairs caused palpitation and breathlessness. Occasionally distressing dyspnœa would come on suddenly during the night and force her to sit up in bed. Heartbeat feeble and intermittent, sounds indistinct. Pulse feeble, slow, soft and intermittent. Bowels sluggish. Urine contained oxalate of lime. Tongue with brown fur on the posterior half, the anterior half clean, slightly livid. Very abstemious, and took no malt liquors or spirits and very little wine. In each cornea was a broad and well-marked arcus senilis. Phos. 4x, one drop two or three times a day, was prescribed, and was continued with some intermissions for eight months, by which time the heart's action had become regular and firm, the breathing natural and unaffected by ordinary exertion, the arcus senilis had disappeared, leaving the cornea clear and transparent throughout, while the subcutaneous adipose tissue was sensibly reduced.

The diminished coagulability of the blood and the fatty degeneration of the walls of the small arteries afford the pathological basis for the symptom "small wounds easily bleeding."

The following case of poisoning by phosphorus occurred in the practice of Hebra, of Vienna, and shows its influence in producing hæmoptysis :—

The patient was a shoemaker's apprentice, and of previous good health. For six days before coming under observation he had noticed isolated red spots on various parts of the body, soon becoming bluish and increasing in number. These were

easily recognized as hæmorrhages and affected all parts of the body, including the conjunctiva and other mucous membranes. The gums were slightly swollen. The urine contained blood. The resemblance of the case to one of purpura hæmorrhagica was recognized, but no hypothesis of its formation could be formed. In two days slight paralysis of the right side was noticed, and a difficulty in pronouncing certain letters; but the mind remained clear, and locomotion and the special senses were unimpaired. The paralytic symptoms rapidly increased; vomiting, complete aphasia, and then aphonia set in, ending in death the next day. The necropsy confirmed the diagnosis of hæmorrhages, including one in the middle of the left optic thalamus, and one towards the surface of the left parietal lobe. Capillary hæmorrhages were numerous throughout all the tissues of the body, and in the bronchi, pericardium, myocardium, and all the mucous and serous surfaces, as well as in the muscles of the extremities. A microscopical examination showed the pathological changes met with in phosphorus poisoning. In the apoplectic region of the brain granules of fat and other evidences of fatty degeneration and infiltration were found; and the same condition existed in other parts of the brain in different degrees. The small cerebral arteries and capillaries exhibited the same changes. Deposits of fat granules were found in the cells of the liver, and in the epithelium of the urethra. In all the muscles, voluntary and involuntary deposits of fat granules were found. Further investigation showed that it is the custom among the shoemakers' apprentices in Vienna to put the heads of matches into the bread and beer of their fellow apprentices, and this patient, who was particularly fond of operating on his fellows, had no doubt fallen a victim to their reprisals.—*The London Medical Record*, M.H.R., 1883.

This case shows that hæmorrhages may occur into any region or from any mucous surface, and the discharges are commonly streaked or mixed with blood. The peculiar disease called hæmophilia is probably due to a very similar pathological state, and it is therefore not surprising that phosphorus has been found to be its best remedy. I quote a case by Dr. Simpson, of Liverpool:—

A lady, aged 35, with the characteristic blonde hair, blue eyes, fair skin with the blood-vessels shining through, which so often indicate the predisposition, had five teeth extracted on

March 5, at 3 p.m. The teeth being brittle it was necessary to press the forceps well down into the gums, which were consequently much lacerated during the operation. The subsequent oozing of blood was slight until the following evening, when it increased and continued during the night so as to induce faintness. A medical man who was summoned applied liq. ferri pernitratidis freely to the bleeding cavities, which he afterwards plugged with cotton-wool, but to no purpose, the hæmorrhage continuing profuse. I saw her thirty-six hours after the operation. Her face was pale and swollen, with diffuse ecchymosis around the mouth and eyes and over the abdomen and extremities. Pulse 140, almost imperceptible, very foetid odour from the mouth, which was opened with great difficulty, the gums being swollen, spongy, and bleeding. I ordered one drop of phosphorus 12 every quarter of an hour. Within one hour signs of reaction set in; the passive hæmorrhage from the gums ceased; the urine passed three hours afterwards contained much less blood, and blood departed from the stools. In eight days from the extraction she was quite well.

When the phosphorous hæmorrhages occur under the skin we get a condition resembling purpura. The skin hæmorrhages of phosphorus are a bright red as distinguished from those of arsenic, which are of a dark colour. In purpura, phosphorus is our chief medicine.

Dr. Speirs Alexander has related a good case:—

On September 8, 1892, L. C., aged 17, a servant in a hotel where she had hard work, late hours, indifferent food, for some time past had been increasingly weak with dyspnœa and palpitations. No catamenia for several months. The day before admission dark spots had appeared all over the body, followed by an attack of hæmatemesis. On admission she was somewhat anæmic. The face, shoulders, arms, trunk, and lower extremities were covered with petechiæ and blotches of a deep purple colour, varying in size from $\frac{1}{8}$ to $\frac{1}{4}$ in. in diameter, and unaffected by pressure. They were largest about the hips and thighs, and a few of them running together had formed ecchymoses. Vomiting of blood occurred after each attempt to eat. The urine was loaded with blood. Patient was put on a milk and soda diet, and phos. 6 was given every two hours. Next day hæmatemesis had ceased, but there was blood in the urine. In four days the urine was free from blood, and substantial food could be taken. No fresh

spots had appeared. Three days later the catamenia appeared after being absent for six months. The petechiæ all faded away, and there was no return.

The following is a case by Dr. Oscar Hansen :—

The patient was a girl, aged 10, who had been ill for five weeks, and had been treated with ferruginous preparations without success. The disease began with loss of appetite and pains in the stomach, but as soon as the purpura had developed the appetite returned and the gastralgia disappeared. On both thighs and legs was an eruption which consisted of bluish-red and oval spots, situated on the inner sides where they formed large groups of ecchymoses. No hæmorrhages from the gums, lungs or other organs. Phos. 2c., gtt. iii. *ter die*. In three weeks all eruption had disappeared and she was quite well.

Phosphorus would be indicated in those cases of hæmorrhages and œdema into the coats of the intestines which cause symptoms of obstruction and are liable to be mistaken for intussusception. In connection with the influence of phosphorus on the blood-vessels may be mentioned its power over fungous growths. Dr. Hughes records a case of fungous tumour of the breast, which was cured by phosphorus and thuja. Dr. Shipman had the following case :—

A man, aged 32, had a swelling on the inner and upper surface of the right thigh near the groin. It had a scab on it which he picked off, and on squeezing the swelling it opened out like a cauliflower with everted edges. It was bluish-red, elliptical, 2 in. long and 1 in. wide, and projected about $\frac{1}{4}$ in. above the surrounding skin, in which were several little purplish prominences of the size of a pea. Extremely sensitive to touch, and it discharged blood, but no pus. Phos. 30 every four hours. Improvement began in four days. In three weeks the fungous tumour had disappeared, only a scar being left.

The fact that phosphorus causes proliferative periostitis and caries, and that young animals when fed on it exhibit the disordered bone growth known as rickets, makes phosphorus a leading remedy in those complaints. The provers, too, had many tearing, burning, and boring pains in the bones, and especially burning pains in certain portions of

the spine, with inability to tolerate heat near the back. It has proved its value in caries of the spine, in bony tumours of the jaws, in hip-joint disease, and in fistulæ about joints. The fistulæ exude a thin ichorous pus, have high edges from exuberant granulations, and an erysipelatous blush radiates from the opening. It is, next to calcarea, our best remedy for rickets.

Dr. Mandelstama, of Kazan, in Russia, published his results of the treatment of rickets with phosphorus. During two years he gave it to 214 patients of different ages suffering from the various forms of the disease. Of these 120 were cured, forty-three showed much improvement, and for the rest the medicine had to be withheld owing to the development of intercurrent disorders. The children were given the phosphorus for several months: 1 cgrm. was dissolved in 1,000 grm. of cod-liver oil, and one dessertspoonful given once or twice a day. After two months of this treatment the bones of the skull became more compact and the fontanelles and sutures less prominent, the nervous crises and paroxysms of laryngeal stridor less frequent and pronounced. The patients increased in weight and the general health manifestly improved.

The cases of rickets suitable for phosphorus are those in which the child has tubercular tendencies or is emaciated; the pale, clear-skinned, delicate-looking children of quick intelligence, in contradistinction to the fat, flabby, apathetic children for which calcarea is the remedy.

Nervous System.

Phosphorus produces on the brain and nervous system, firstly, a state of stimulation, and this is followed by depression, and the symptoms correspond to one or other of these states, but chiefly to the latter.

There is great susceptibility to external impressions, to light, sound, odours, touch, electrical changes, and to thunder storms, which make him anxious and fearful, and aggravate all existing symptoms. The patient fears to be left alone, and is afraid in the dark. He is excitable, and any excitement puts him in a heat all over, with perspiring head and

hot, perspiring hands. He is anxious and restless, especially at twilight. He cannot sit still a moment, but must be continually moving about. He is fidgety all over, but especially in the hands. He is easily angered, and is then vehement and passionate. Sometimes he enters into a state of ecstasy and clairvoyance. He can stand no mental tax, but is prostrated from the least unpleasant impression. Fanciful notions ; imagines he is some great person, or sees faces grinning at him from every corner ; has a notion that his body is in fragments and that he cannot adjust the fragments. Lascivious thoughts come into his mind, and he cannot control them. Great desire for sexual intercourse ; uncovers the person ; satyriasis or nymphomania. There is at first physical excitement of the sexual organs corresponding to the mental state, but this afterwards gives place to a condition of weakness or impotence, though the mental sexual desires still remain.

Profound mental depression comes on. The patient is apathetic, dislikes to be talked to, will not or cannot answer questions unless roused to do so ; repugnance to all labour ; forgetfulness ; involuntary and spasmodic weeping and laughter. These are the principal mental symptoms. In the sensorium we have giddiness and headache. Attacks of vertigo are frequent, and are brought on by any movement, and are associated with faintness very frequently. The giddiness is mainly an up-and-down movement ; things seem to be moving up and down, or the patient seems to be sinking through the floor ; when seated the chair appears to rise. The head feels stupefied or weak, or there are shooting pains or shocks in the head with a shattered sensation as if something had exploded. The headaches are worse from any movement, and from noise, mental exertion, pressing during stool, or from coughing, which seems to shatter it ; from stooping ; better after a meal for a short time, in the open air, from lying down. Heat and congestion of the head, which seems to come up from the spine in a hot wave. In the ears there may be strong, echoing sounds, especially of the human voice. The spine is sensitive to touch, there are tingling and formication along the spine, which extends

to the extremities. Heat and burning along the spine, especially between the shoulder-blades. The back feels weak as if it must give out. The limbs are weak, trembling on beginning to walk ; the patient stumbles, catching his toes in projections on the ground.

Many of these nervous symptoms are illustrated in the following case of poisoning recorded by Dr. Gallavardin :—

After an explosion of matches in process of manufacture a man, while endeavouring to extinguish the burning material, inhaled the fumes and fainted from suffocation. On recovering from the faint he experienced a sensation of weakness in the back and then in the extremities, with trembling at every effort, and creeping beneath the skin. At first there was great sexual excitement, but subsequently complete impotence. On admission to hospital his general health was good, but his legs were so weak that he could only walk a few steps, and even those he did with a tottering gait and as if he was not sure of himself ; if he tried to stand upright his legs trembled and knees bent ; his hands and arms trembled on making any effort. In a state of repose the muscles started out all over the body, especially down the extremities ; they appear to twitch up and down under the skin—not the muscle in its entirety, but only single bundles of fibres at different times, like playing on a piano ; if they are quiet for an instant the slightest touch suffices to set them going again ; there was a constant feeling of formication. The spine was not sensitive or painful, but so weak that the patient cannot straighten himself, nor remain standing when once straightened. The pronunciation of words was embarrassed from paresis of the tongue. Other organs and functions normal. The patient lived three or four years in the full enjoyment of his senses, whilst the paralysis increased and extended, but all attempts at treatment were unavailing.

The cases in which phosphorus has been most successfully used therapeutically are those of brain and cord exhaustion from overwork of the brain, excessive drain on the nervous system, especially seminal losses ; exhausting diseases, such as typhoid fever ; symptoms and conditions arising from an overtaxed nervous system. The following cases illustrate its use :—

(1) A case of nervous exhaustion recorded by Dr. Andrew Neatby.

A boy, aged 14, had pain in the spinal column at the level of the waist, felt only on Sundays and worse when standing in chapel. Often feels faint; weariness; loss of energy and cheerfulness. Pain in the lower part of the back as if the spine were broken; worse moving. Feeling as if the popliteal tendons were drawing the leg up. Deterioration of memory. Occasional sensation as if something burst in the head, with a taste of blood in the mouth. Aching over the vertex, increased by movement, disappears on lying down. Masturbates. Phos. 30, pil. ii., n. and m. In three weeks symptoms had gone.

(2) Case of paralysis following typhoid fever, by Trinks :—

A strong, well-built man had hepatitis in 1857, and in September, 1858, typhoid fever. In October he had the following symptoms: complete anæsthesia of the upper limbs as far as the elbow, and of the lower up to the gluteal, which had come on progressively, beginning in the fingers and toes. At the same time the capacity for movement was largely lost; he could grasp nothing firmly, and could not stand. Muscles flaccid and wasted. No mental impairment. Phos. 2x was continued for two months. First sensation returned, then motor power. In three months he was quite well.

(3) Case by Dr. W. Arnold, of Heidelberg :—

A farmer, aged 40, delicate from infancy, had been married for ten years, but had had no issue, and since marriage his bodily vigour had been failing; coition always weakened him for several days, and latterly even for weeks. For the last two months he has developed symptoms of brain softening, and when I saw him for the first time in February I found him paralysed on the left side, the extremities being mainly affected, the face and tongue less so. Paralysis was not total, and there was sensitiveness to touch, and he felt pain, which sometimes became severe, in the affected arm and leg, with short involuntary movements. There is stiffness in the affected parts, so that it requires some effort to flex or move them. He complains of paroxysms of giddiness; there is dulness; thinking is slow and memory imperfect; little appetite. Defæcation seldom and difficult. Sleep restless, and felt worse after sleep. The right side was always weak, and trembled on grasping anything. Veil before his eyes. Features pale, overspread by transient redness on exertion, or talking, or taking food. Heat and cold were both disagreeable,

and when chilly he felt inclined to stretch, in which the paralysed limbs participated. Phos. 2x, gtt. x. *ter die*. After sixteen days he was much improved, both generally and in his paralysis, and was able to walk about the room when well supported. He continued to progress for the next two weeks, when the affected limbs became covered with red spots like scarlatina. The phos. was omitted for a week and belladonna substituted. The rash went away, but no further improvement occurred, and phos. 3x was given again twice a day. Under this he gradually but steadily improved, till at the end of ten days he was able to walk without support in his garden, had a good appetite and refreshing sleep, and was much brighter mentally.

Painful paresis of the arm cured by phosphorus, by Dr. Sorge:—

Meder, a master carpenter of Welton, aged 50, complained to me on May 6, 1860, that for a year he had suffered from a most distressing pain in the arm and shoulder of the right side. Early in the morning on rising from bed the arm felt paralysed and weary, sometimes from the shoulder to the elbow; it improved after work and he felt nothing of it all day, but it felt worse in the evening, although it did not disturb his night's rest. It was worse for some days after unusual exertion. The upper arm was morbidly sensitive to pressure, but it had not become thinner and there was no morbid appearance. He was given four drops of phosphorus every evening in water. After six days he returned with the posterior surface of the lower part of both forearms and hands exhibiting a spotted, itching, erythematous eruption. The phosphorus was discontinued, and in the course of three days the erythema and with it the affection of the arm had permanently left him. The patient had no recollection of having, before the pain in the arm, ever had any affection of the skin.

In both these two cases a rash was produced by the phosphorus given in the one case in the 2x strength and in the other in the 4x.

There is a disease where, without organic spinal cord disease, there is loss of muscular power associated with enlargement of the muscles, due to deposition of fat from fatty degeneration of the intermuscular connective tissue, and probably of some of the muscular fibres also. I refer to pseudo-hypertrophic paralysis. This combination of

paralysis and fatty degeneration has suggested its treatment by phosphorus, and this remedy seems to be more efficacious than any other drug, especially if used early before the muscular fibres are much atrophied. Dr. A. C. Clifton has recorded an interesting case :—

The patient, a girl, aged 18, who a year before had noticed purple spots the size of a shilling on her legs and felt very weak. She bathed her legs for several days with cold water without relief. At the next menstrual period the discharge was pale and slight, and lasted only a few hours. She became weakly, lost appetite, had headache and palpitation ; gradually became worse. When Dr. Clifton saw her she could with much difficulty walk only a few yards ; when walking the shoulders were thrown back, the abdomen prominently forward, the legs separated, she waddled in a side-to-side manner ; her legs felt as if they would give way if not widely separated. She could not rise from a chair without help. Numbness and pins and needles in the lower extremities ; some stiffness. She could grasp objects for only a short time. Face pale and anæmic. Stools pale and constipated, one action in three or four days. Catamenia delayed, scanty and pale. When standing a deep anterior curve occurred in the lumbar vertebræ, much diminished when prone. Glutei muscles firm, hard and enlarged, as also the oblique abdominal muscles. Muscles of upper arm enlarged, firm, and hard. Muscles of thigh much harder and larger than normal. As a child she had been subject to violent attacks of epistaxis and diarrhoea. Her growth between 12 and 15 had been very rapid, with weakness and fainting. Given phos. 3x t.d.s. In a month she was stronger. In fourteen months could walk two miles. The affected muscles became normal, the arms improving first. Five years later she remained quite well with the exception of slight spinal curvature.

Dr. R. T. Cooper records the following case of headache :—

C. A., aged 26, a labourer, had suffered from headache for five years. The pain was shooting from one temple to the other and at times flying through to the occiput, came on at irregular intervals, was brought on by stooping, and was worse in front of the head. The paroxysms of headache were preceded by dimness of sight and accompanied by a feeling of sickness. Food appears not to digest properly and appetite is indifferent. Bowels irregular, relaxed for a day or two and then confined for a week. Phos. 3x given. A week later was better, the headache very slight and

confined to the forehead. Bowels regular, no dimness of sight. Repeat the medicine. A fortnight later was well in every respect and headache quite gone.

Phosphorus has obtained a reputation for the treatment of neuralgia. Ashburton Thompson treated fifty cases of neuralgia with doses of $\frac{1}{2}$ gr. every hour with great success. In this dose it acts as a nerve stimulant like food or wine. But its homœopathic use is equally efficacious in suitable cases, as the following case of Dr. Cooper shows :—

F. C., aged 36, a thin, spare woman, had suffered for six weeks with intense pains in the face and head. The pains were darting and in different parts of the face, beginning at various points. Increased when exerting herself and when nursing her child. The pains move about very much and are generally protracted and very severe when they commence at night as well as when she is eating, at which time the face is very tender, but the tenderness does not continue long after. Gums are not sore, but teeth are decaying rapidly. Suffers much from flatulence and a weak feeling in the chest. Bowels regular; tongue clean; urine rather thick. August 10, phos. 30x was given. August 25, face not so painful and darting pains much reduced in violence; is never kept awake by them now. Chest still feels very weak. September 1 much better; has scarcely felt any pain and chest feels much stronger. Slight aching on right side over the liver. She then had sac lactis for one week, and afterwards phos. 30x again for one week, and was quite well.

In connection with this direct action of phosphorus in neuralgia it will be in the memory of members that Dr. Goldsbrough, in a paper read before the Society last session, spoke of the nerves sometimes acquiring a pain habit and that he had found this condition relieved or cured by phosphorus given in the form of extract of malt and unoxidized phosphorus, a preparation which contains $\frac{1}{4}$ gr. of phosphorus to the ounce. Taking the hint thus given, I prescribed this preparation in the case of an old lady, aged 78, who had for years been constantly complaining night and day of pain in the back, so much so that she rarely obtained more than ten minutes sleep at a time, and was continually wishing to change her position. No lesion of the back

could be discovered, and the pain seemed to have rather a mental than a physical origin. She was given a table-spoonful of the phosphorized malt extract twice a day and quickly improved in a marvellous manner, almost entirely losing her pain and experiencing quite a renewal both mentally and physically.

Alopecia areata is considered by many to be a disease of nervous origin. However that may be, phosphorus is a good medicine for it, as instance Dr. McLachlan's case :—

A boy, aged 11, with capricious appetite and hardness and fullness of the stomach region after meals, had patches of alopecia areata on the occiput and behind the ears. They were circular, sharply circumscribed, perfectly bald, of ivory whiteness, smooth and shiny. One dose of phos. 100x was given. In three weeks the hair began to grow on the bald patches. By the end of two months they were completely covered.

Eyes.

Phosphorus has several eye symptoms. Pressure in the eyes and smarting, especially of the external canthi; shooting and burning pains in the eyeball, which feels too large for the lids to slide over it comfortably; dimness of vision, vanishing of sight. Halo of various colours round the candle; objects appear green. In connection with this green appearance of objects it is of interest to note some remarks by Dr. Woodruff, of Long Beach, California, in a paper in the August number of the *North American Journal of Homœopathy*. He says that the spectrum given by phosphorus is of a light green colour, and that it throws a faint green light wave on the screen, and that this indicates that the electrotonic atomic vibrations of phosphorus are in the same key as the light green wave. Printed matter looks red. There is hyperæmia of the choroid and retina, and phosphorus has been found useful in retinitis from suppression of menses, retinitis albuminurica, glaucoma, in amblyopia from loss of fluids; blindness from lightning, cataract; amaurosis from excess of venery, or from overuse of tobacco.

Female Sexual System.

Menstruation is usually too soon and too copious, but there may be amenorrhœa, which is then frequently associated with epistaxis or some other form of vicarious menstruation. Phosphorus is useful in chronic mastitis when sinuses have been left in the gland after extensive suppuration, an erysipelatous blush surrounds the orifice of the sinuses.

Nash gives the following constitution as especially indicative of phosphorus. Tall, slender persons of sanguine temperament, fair skin, blonde or red hair, quick, lively perception, and sensitive nature. Tall, slender, phthisical patients, delicate eyelids, soft hair.

Tall, slender women, disposed to stoop.

Young people who grow too rapidly and are inclined to stoop.

Nervous, weak persons who like to be magnetized.

Suddenness is a feature of phosphorus. Sudden prostration, sudden faints, sudden heats, sudden shooting pains, joints suddenly give way. Symptoms generally are worse from touch, lying on left side, motion, noise, walking, physical or mental exertion, laughing, coughing, talking, in the evening, especially in twilight, from warm food and drink, thundery or wet weather, washing clothes; better from rubbing, rest, mesmerism, lying on the right side, cold food and drink (temporarily), open air, washing with cold water.

Dr. BYRES MOIR (in the chair) first of all thanked the author in the name of the Society for taking the place of the President at the opening meeting of the Session and contributing such an interesting paper to the proceedings. The paper was such a complete one that it was very difficult to find points for criticism. The author, however, stated that the ordinary dose of phosphorus used was 3x, but he then mentioned that Dr. Proctor used the first centesimal. It would be interesting to know how the latter solution was obtained. It was most useful to have the actions of a particular drug put before them in the way Dr. Stonham had done, because practitioners nowadays required a picture of symptomatology before their eyes, drawing attention to the cases where

the drug was likely to act. They were too apt to think that symptoms were bothersome and not worth troubling about. A few weeks ago an eminent lawyer, a K.C., a first-rate musician, and a man of good repute, came into his room, burst into tears, and said he was terrified because he thought a thunderstorm was going to happen. Dr. Stonham had stated that for such a condition phosphorus was a valuable drug to use, and he (Dr. Moir) wished he had known it at the time. His own practical experience bore out exactly the author's as to the cases in which the most benefit from the use of phosphorus was obtained. For instance, it was most useful in pneumonia, neuralgia, and more particularly in cases where there was a certain amount of arteriosclerosis. He remembered the case of an old lady, whom he saw six or seven years ago, which illustrated the use of phosphorus. The patient was white and emaciated, weighing a little over 6 st., and she suffered from neuralgic pain in the head, with loss of vision. He sent her to Mr. Knox Shaw, and received the report that there were numerous hæmorrhages in both retinae and that the sight was evidently going. Under phos. 6 and 12 the condition had entirely subsided; the patient had put on 2 st. in weight; and except in one eye, which was very defective, she had had very good vision ever since. That was not the only case where he had seen such benefit result, and it encouraged one to persevere more with drugs. Another interesting point of study was in reference to what blood changes were produced by phosphorus; were changes produced in the serum or blood corpuscles themselves, or what was the actual change which took place? In pernicious anæmia sometimes arsenic and sometimes phosphorus was of much benefit. Practitioners required to know what were the blood conditions which drugs caused in the healthy person if efficient use was to be made of them in disease.

Dr. EADIE thanked Dr. Stonham for reminding them of the many conditions to which phosphorus was applicable. With reference to the case of phosphorus fumes, to which the author had referred, Dr. Stockman, of Glasgow, had found that the phosphorus only predisposed the jaw to a condition which was now generally believed to be tuberculosis of the bone. It was rather interesting that phosphorus should do that, because in his experience phosphorus was a very useful drug in tuberculous conditions of any kind. In purpura hæmorrhagica he had used phosphorus several times with good results, always in the 200 potency and single dose. He thought the most interesting case he ever saw where aggravation was produced was that

of a girl suffering with tubercular ulcers of the intestines. She was put on phos. 3x, and within five minutes of taking each dose she was in excruciating agony. He remembered a case of profuse hæmaturia which benefited greatly from phosphorus. When the patient first came to him the water he passed contained a quantity of blood. He was given a single dose of phos. 200; the next time he micturated blood was still present, but four hours later it was not. He had recently received a letter from the patient saying that he had not passed blood in his urine for two years, whereas before the single dose of phos. 200 he had been passing it profusely every alternate week for eighteen months. The case Dr. Moir had mentioned reminded him of a lad he once treated who was so tall and thin as to emulate Euclid's definition of a line. He put him on phosphorus, as he was a typical phosphorus case, and in two months he had gained 2 st. in weight. He used the 200 potency in all his cases. Phosphorus was especially useful in tall, fair, slender, stooping persons with a phthisical tendency.

Dr. E. A. NEATBY thought a paper of the kind which had been read was urgently required to refresh the memory of the members of the cases in which such a drug as phosphorus should be given, and it also had the advantage of drawing forth the experience of those present, which must necessarily differ, but the information thereby gained was of great value. There were one or two points which the author alluded to in the action of phosphorus which were to be found in other drugs, particularly the differing or alternate actions. For instance, Dr. Stonham had mentioned mental excitement and depression, and menorrhagia and amenorrhœa. The question as to which of those symptoms could be used as indications for the drug in treating the sick was of some interest, particularly whether the primary or the secondary symptoms should be used. Supposing both could be used, should one not be very careful in the selection of the drug from one set of symptoms only? If secondary symptoms were made use of, such as amenorrhœa, should they not try to find out what were the other symptoms, and prescribe only on the basis of secondary symptoms in the case where the leading indication was a secondary one—*i.e.*, not mix up primary and secondary symptoms as indications? Instead of taking any odd symptoms in a long list and prescribing from one symptom which was a primary symptom and another symptom which was a secondary symptom, he thought they should be careful to have all primary or all secondary. Then he wished to ask the author for his opinion as to what dose should be

used when prescribing on either primary or secondary symptoms. For instance, in phosphorus, if secondary symptoms were being used, such as amenorrhœa, should a high dilution or a low dilution be given, or would either do? The same question applied to other drugs. He wished to point out how very strikingly many of the symptoms mentioned resembled neurasthenia, especially the form described by Clifford Allbutt in his book as the cerebral variety of neurasthenia. While Dr. Stonham was drawing his drug picture, it had struck him (Dr. Neatby) very forcibly that it resembled many neurasthenic patients, especially those where the cerebral and nerve symptoms were prominent.

Dr. PURDOM, after thanking Dr. Stonham for his useful paper, mentioned a case of the misuse of phosphorus, in which a leading West End physician prescribed for one of his patients with Graves' disease a phosphorus pill, which invariably made her sick. Subsequently the patient was given only a half pill, and that also made her sick. That proved that the first symptoms were gastric, as the direct action of the pill produced sickness and stomach symptoms. His attention was first called to homœopathy when, as a medical student at Edinburgh in 1872, he had a mild attack of typhoid. A few doses of baptisia acted like magic, and phos. 3 had the same effect in curing a very bad barking cough and a sore chest. Personally, he had generally been regarded as a phosphorus patient, as he was somewhat tall, thin, and lanky, with a weak lung, and he had proved the value of the drug many times in his own experience. He came back from his holidays in the middle of August, and was immediately thrown into double work, with the result that he had several attacks of giddiness, so much so that he could hardly get up from the bedside of one patient he was visiting, while at the next patient's house he was violently sick. It looked like a bilious attack. It was complicated by deafness and noises in one ear and faintness, quite apart from the attacks of sickness. He did not succeed in curing himself, although he tried several medicines. His son, however, came to visit him, and after studying his symptoms for a little while and spending an hour over "Kent's Materia Medica," gave him three powders, the composition of which his son would not tell him—one of which he was to take in the morning, another the next morning, and the third one the following night, and no other medicine. He did so; he had no further attacks of giddiness and the other troubles with which it was accompanied. His son subsequently informed him that the powder was phos. 200, and that he

had used nothing but the 200th dilution since he came back from America. The late Dr. Duncan Matheson, in giving a list of the medicines he used in Newcastle, said that he used phos. 3 to 6 and nothing lower. In his later experience he (Dr. Purdom) had gone a little lower than that—from 4x to 6x, with very satisfactory results. He had found the drug useful in nearly all the diseases to which the author had referred—such as rickets, congestion of the lungs, incipient phthisis, and, in his own case, cough with pain in the right lung. He had published a case of Henoch's purpura in which it was also useful.

Dr. STONHAM, in reply, after thanking those present for the kind way in which they had received his paper, said he was afraid it was rather an infliction to give a paper of an hour on one drug. But he thought it might be useful, because however much the materia medica was studied, it was always beneficial to repeat that study. There were so many symptoms to be remembered that time was never wasted in going over them again, as one was sure to find something that he had forgotten, or something that was applicable to a case being treated at the moment. In reply to Dr. Moir's question as to the dilution which Dr. Proctor used in the cholera cases, he should imagine that the first centesimal was made from the 3x as the basis. It could hardly be the 100th of a grain of phosphorus, because poisonous symptoms would have been obtained if that was constantly used. He thought if Dr. Moir had given the K.C. who visited him phosphorus in any dose from 6 to 200 he would have greatly benefited the patient and relieved him of his dread of thunderstorms. That was a very well-known symptom of phosphorus, and had been shown to be of value in many cases. The question of the influence of phosphorus on the blood required working out. From present knowledge one would think that phosphorus had no direct influence on the blood corpuscles, but that it acted indirectly through its action on the small capillaries. In that way it caused hæmorrhages, which tended to impoverish the blood and produce anæmia. He was glad to hear the interesting piece of news from Dr. Eadie with regard to phosphorus predisposing to tuberculosis of the jaw. That was an important point, but the jaw must be affected directly by phosphorus. The jaw might be affected by tuberculosis from the predisposition caused by phosphorus. There were so many cases of direct phosphorus poisoning which were not at all tuberculous that one must think that phosphorus had a direct action on the jaw in causing necrosis. Dr. Neatby had raised the very interesting question of alternation,

and the primary and secondary influence of drugs. The same question arose with every drug. Every drug had a primary and secondary action, and could be used curatively on either indication. Dr. Neatby had enquired whether they should collect all the primary together and all the secondary together, and not use the drug except in cases where the symptoms were either all primary or all secondary. He did not think that would quite do, because in a drug like phosphorus, for instance, it might have produced its primary effect on one organ and gone on to its secondary, while it was still producing its primary effect on some other organ. Phosphorus was a drug which had a very long-continued action, and the symptoms followed one another in fairly definite sequence, extending, it might be, over weeks. It was quite possible, for instance, that the alimentary system might have had all its primary symptoms and be in the secondary stage; while in another system, such as the respiratory or the skin, the primary symptoms were appearing. He did not think, therefore, it would be altogether good practice to confine themselves entirely to either primary or secondary symptoms in the selection of the drug. He did not know that any rule could be laid down with regard to the dose. Personally he should feel inclined to give a higher dilution for primary than for secondary symptoms. The cerebral symptoms were very much those of many cases of neurasthenia, and phosphorus was no doubt a good remedy for neurasthenic conditions. Possibly the old lady he mentioned was suffering from a pain somewhat allied to neurasthenia. She was cured with material doses of phosphorus. Dr. Purdom's personal experiences were very interesting, and quite bore out the action of phosphorus therapeutically.

GENERAL TUBERCULOSIS IN ADULTS.¹

(Based upon an Analysis of 110 Cases.)

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PRELIMINARY.

By "general" or "generalized" tuberculosis is understood for the purposes of this paper tuberculosis found in four or more organs. "General" states a fact; "generalized" commits us to a belief, probably correct, in an original focus. Miliary tuberculosis is necessarily included; but in adults there is much general tuberculosis in which miliary tubercles either play but a minor part or are not found at all. It may here be stated that in 65 out of the 110 cases of the present series miliary tubercles—usually accompanied by tubercles of other grades—were found.

With Harbitz, of Christiania, I draw the line between childhood and adult life at the end of the fifteenth year. Harbitz says ("Studies in the Frequency, Localization, and Modes of Dissemination of Tuberculosis"): "To draw the line at the fifteenth year, as is perhaps most generally done, seems to me more correct, as in regard to morbid anatomy the behaviour of tuberculosis before and after this age varies considerably, though naturally there is no sharp distinction."

General tuberculosis in children either exists as an acute miliary process or is so dominated by symptoms due to meningeal invasion that it is, clinically at any rate, tuberculous meningitis. The special frequency with which the meninges are attacked in children is brought out by the observation that, whereas out of 110 adults suffering from general tuberculosis only 40 (36·3 per cent.) had tubercle in the meninges, 56 out of 64 children whose

¹ Presented to the Section of General Medicine and Pathology, November 4, 1909.

cases were investigated (87·5 per cent.) had tuberculous meningitis.

If general tuberculosis in adults may be called an entity, it is a rather nebulous and elusive entity. There is no sharply defined clinical picture, either from the subjective or from the objective side. The "symptoms" or sensations of which the patient complains vary widely; the "physical signs" vary widely, or may be conspicuous by their absence. Serious illness with a striking absence of physical signs should always raise the suspicion of general tuberculosis. In rapid cases even this hazy picture has not time to materialize, and the fatal event finds the physicians still groping among "initial symptoms." These initial symptoms are at best inconclusive, at worst positively misleading.

A few cases may be quoted from this series which illustrate this judgment. Thus, a man came up complaining merely of "swelling of the left leg and foot." It was at first taken to be a surgical case. The swelling was probably due to thrombosis—a condition noticed in three cases of this series. Four patients came up whose sole complaint was loss of the use of their legs. This symptom appeared to be due merely to profound debilitation. A woman was admitted complaining of "deafness and inability to pass her water." There is certainly nothing illuminating in this. The deafness was probably due to overdosing with quinine for supposed influenza; the inability to pass water is a symptom sometimes seen in general tuberculosis. Again, a man came up complaining of joint pains, deafness and prostration. Here, again, the deafness was probably due to quinine, as the onset of the illness had rather resembled influenza; the joint pains were due to tuberculosis, though they marvellously mimicked acute rheumatism. "Excessive drowsiness" without headache or any other cerebral symptoms was the strange complaint of one patient; it turned out to be the very sudden onset of coma, the disease precipitately beginning and ending with the last stage. "Sciatica" was the simple—and yet after all complex—complaint of two patients. "General muscular pains

and headache" was the complaint of three patients; it might have been but a feverish cold, but in point of fact it was general tuberculosis.

It is not, therefore, surprising that general tuberculosis is often not diagnosed before the autopsy. In only seven cases of the present series was a correct and complete diagnosis given. But of diagnosis we shall speak later.

ETIOLOGY.

Some interesting observations have been made on the etiology of general tuberculosis.

Sex.—Men appear to be much more liable to the disease than women. Out of 110 cases, 80 (72·7 per cent.) were men, and 30 (27·3 per cent.) were women.

Age.—The majority of the men (49 out of 80) were between the ages of 20 and 40; 21 out of 29 women were between 16 and 30. Altogether 82 out of 110 victims of general tuberculosis (74·5 per cent.) were under 40. The age-incidence is what might have been expected. But the great preponderance of men over women is remarkable.

Occupation.—An analysis of occupations and vital conditions shows that exposure to weather (that is, to *vicissitudes* of weather) and to dust is an important determining factor. The largest figures for men's occupations are: "Labourers," 10; "coachmen, grooms and stablemen," 11; "indoor-servants," 7; "waiters and potmen," 6. "Labourers" is a term usually meaning navvies or labourers on roads and railways. Their work is dusty and exposes eminently changes of weather and temperature. In several other cases a special mention was made of the *dustiness* of the calling pursued. The incidence on coachmen, grooms, stablemen, indoor-servants (male), waiters and potmen, is partly due—except in the case of indoor-servants—to exposure, but very largely to alcoholic indulgence. Of the 30 female victims, on the other hand, 21 would seem to have been particularly exempt from exposure; for 3 were married women, 3 were single women without occupation, and 15 were domestic servants. The number of domestic servants is noteworthy.

As there was evidence or probability of alcoholism in only one of these fifteen cases, the main factor was perhaps the want of sufficient exposure, *i.e.*, too little fresh air and sunshine.

Alcohol.—Reference has been made to the part played by alcohol. It is remarkable that in 24 out of 110 cases (21.8 per cent.) there was a history of alcoholic indulgence. As this failing is often not insisted upon by the patient, the true percentage may well be higher. It is convenient to notice here that the course in 6 out of these 24 cases (25 per cent.) was extraordinarily short—from one to fourteen days. In the 86 sober cases of this series there were only 15 cases (17.4 per cent.) of this very rapid kind. These observations illustrate the well-known diminution of resistance found in the alcoholic.

Influenza.—Of antecedent and disposing illnesses *influenza* is in this series the most striking. It is true that influenza is often somewhat loosely “diagnosed” both by patients and by physicians, and that only when the symptoms are of a very clear-cut nature or Pfeiffer’s bacillus has been detected in some secretion can we be quite certain that we are dealing with influenza. Nevertheless the clinical value of the observation remains. Often there has been a short while before the beginning of general tuberculosis an attack of illness simulating influenza or diagnosed as influenza; sometimes also the onset of general tuberculosis itself is taken to be influenza. In 13 cases of this series there was a history or diagnosis of influenza. In 6 of these cases there had been “influenza” within periods varying from three to eight weeks; there had been no recovery, and it was in consequence of this failure to recover that the patients had presented themselves at the hospital. In some of these cases it is probable that the onset of general tuberculosis was mistaken for influenza. In 4 cases the complaint for which the patient sought admission was itself diagnosed, either confidently or tentatively, as influenza. In 4 cases there was a history of influenza having occurred several months (four, five, six, and seventeen) previously; in all of these, except one, it was stated that the influenza had been

followed by more or less of weakness and poor health. These observations yield confirmation of the familiar truth that influenza is not so formidable in itself as in its consequences. They also point to a strong resemblance between a certain type of influenza and a common form of onset of general tuberculosis, both characterized by general aching pains in the bones and muscles, headache, shivering, fever and prostration. In one case there was intense pain at the back of the eyeballs—a symptom often complained of in influenza.

Puerperium.—Of the 29 women in this series of cases 3 were married. In each of these cases there was found to be tuberculosis of the womb and its appendages, and in two cases the generalization of the tuberculous process seemed to be directly dependent on child-bearing, occurring as it did four months later in the one case and immediately after in the other.

Operation.—The causal association of general tuberculosis with some injury, whether that of child-bearing just referred to or that of a surgical operation, is of great interest. A case was reported in the *Edinburgh Medical Journal* a year or two back, in which the scraping of a sinus connected with a tuberculous bursa near the knee-joint was followed very shortly by general tuberculosis. Longcope, in his article on "Tuberculosis of the Thoracic Duct," in the *Bulletin of the Ayer Clinical Laboratory of the Pennsylvania Hospital* (June, 1906), mentions the case of a young Italian who was admitted to the hospital complaining of swollen cervical glands. The glands were first of all opened, and about a week later were removed. Sixteen days later he was dead of "generalized acute miliary tuberculosis." Longcope also mentions a case of a young man, who, after ten days' illness, was operated on for tuberculous peritonitis, but died less than two months later of "subacute generalized tuberculosis."

A very striking case in the present series was that of a young girl brought into hospital with symptoms of perforated gastric ulcer. The patient was promptly operated upon, a gastrorrhaphy was performed, the whole peritoneal cavity was copiously irrigated, and, in addition, a tube was

inserted through a suprapubic incision into the pelvic cavity. The girl did well for eleven days and then died suddenly from pulmonary embolism. The *post mortem* revealed thrombosis of the right iliac vein, a primary caseating focus in the right Fallopian tube, and a widespread diffusion of very early miliary tubercle (lungs, pleuræ, liver, spleen, and peritoneum). Primary tuberculosis of the Fallopian tube is in itself interesting, and dissemination of tubercle from this starting-point, caused either by irrigation of the peritoneal cavity, or by the tube that was thrust into the pelvic cavity, is still more interesting. The thrombus in the right iliac vein offers food for speculation, since tuberculous matter from the right Fallopian tube, getting into the venous blood-stream, would be carried by the right uterine plexus to the right iliac vein; but no investigation was made at the time to determine whether the thrombus was simple or infective. This case has a further point of interest—unique in this series; the patient undoubtedly had general tuberculosis, but she did not live long enough to die of the disease. She did not even live long enough to show any symptoms of the disease.

Another case was that of a woman who was admitted on the surgical side for tuberculous wrist. She had had pain in the wrist for two years. She complained, moreover, of a troublesome cough, and signs of commencing phthisis were found at both apices. Nothing else appeared to be the matter. The unciform bone and the bases of the fourth and fifth metacarpal bones were removed. A month later, as the patient's condition, both local and general, was deteriorating, an amputation through the upper third of the forearm was performed. Surgically this was very successful, and the wound healed well. But as the local condition improved the patient began to complain of headache, giddiness, and increasing weakness. She steadily sank, and died seven weeks after the amputation. After death there was found extensive tuberculous invasion of lungs, brain, meninges, uterus and adnexa, peritoneum and glands.

A groom, otherwise healthy, manifested tuberculosis of

the left elbow-joint. The elbow was excised. The wound healed well except for a small persistent sinus at the inner side of the humerus. Six months after the operation the man was dead of general tuberculosis. No old focus of disease, except the sinus referred to, was found at the *post mortem*.

A man, otherwise perfectly healthy, was admitted to the hospital for chronic pulpy disease of the left knee. The leg was amputated above the knee, and the wound healed well. Three months later he took to bed with great weakness, shivering, and sweating; six months after this he was dead of general tuberculosis. It was plain from the *post mortem* that dissemination must have taken place from the knee-joint, although the amputation stump was healthy.

Another case that illustrates the familiar truth that an operation may be perfectly successful, and yet the patient may die, was that of a servant girl, otherwise healthy, who was operated on for tuberculous peritonitis with effusion. The abdominal symptoms subsided, and the patient went to Margate to convalesce. Soon after her return she began to lose strength and to show a temperature always elevated. Eight months after the operation she was dead. The autopsy showed the measure of success that had attended the operation; for the peritoneal cavity was almost obliterated, and though there was a recent eruption of miliary tubercle there was comparatively little to be seen of the older deposit.

A case in which a surgical condition was successfully treated, only to make room for general tuberculosis, was that of a man admitted with a discharging ulcer on the right side of the chest. An abscess had formed some time previously, and for some three months the sinus had been persistently discharging. The patient's general health was good, and according to his own account it had always been good. The sinus was probed and antiseptically dressed, and it at once began to heal. But as the ulcer healed the patient began to show signs of illness. Without physical signs he developed a cough, and his temperature rose. In less than a month after his admission he was dead of general

tuberculosis. The arm of coincidence, proverbially long, may be invoked in this case; for there were other old tuberculous foci besides the ulcer of the chest wall. Indeed, the case was altogether paradoxical. For this man who had never been ill was found after death to have extensive chronic tuberculous peritonitis, much tuberculous ulceration of the bowel, advanced spinal caries and a double psoas abscess. Almost as remarkable is the discrepancy between the *ante-mortem* and the *post-mortem* judgments. The former says tersely, "No evidence of spinal disease." The latter says, "Advanced caries of the eighth dorsal vertebra and commencing caries of the third lumbar. Left psoas is occupied by an abscess, and there is commencing suppuration in the right psoas near its origin from the spine." The case is instructive as showing how symptomless extensive and advanced tuberculous lesions may be.

That the removal of fluid from the peritoneal cavity does not always work for ultimate good has been already shown. The same lesson may be learned from the case of a painter who was admitted into hospital for a very considerable swelling of the abdomen. As there was evidence of free fluid, he was promptly tapped, and seven quarts of clear fluid were drawn off. The tapping was an immediate success, for there was no re-accumulation of fluid; but eight days after the tapping friction sounds were heard over the lower lobe of the left lung. The *post-mortem* showed that this friction was due to an outbreak of miliary tubercle on the pleura. The patient died of general tuberculosis between three and four weeks after the tapping.

Another case is in point. A hard-drinking stonemason had suffered some months before admission from dropsy of the belly, genitals, and legs. Under medicinal treatment the dropsy had disappeared, but the man had become greatly reduced in strength during the process. This was his own statement, confirmed in part by observation. On admission he had no ascites, but a considerable pleural effusion, and he was ill and weak. Tapping the chest seemed to have an unfavourable effect upon him; for it was soon followed by

orthopnoea, and by a rather characteristic mark of general tuberculosis—pronounced cyanosis. About six weeks later his belly, which had filled up, was tapped. This tapping was followed by delirium, rapid wasting, and in nine days by death.

Another hard drinker, with an enlarged liver, a distended belly, and a furred and tremulous tongue, was admitted to hospital. These physical signs and a temperature of 100° F. were the only manifestations of illness. He remained under observation in much the same condition for eighteen days. Then he was relieved, by tapping, of about a pint of fluid. Ten days later he began to have delirium and rather profuse nose-bleeding—the latter a symptom not very uncommon in general tuberculosis; these symptoms kept recurring after slight respites, and were complicated later by a left pleural effusion, and for a few days before his death by epileptic fits. His death occurred less than three months after the abdomen was tapped.

If the releasing of effusions from the pleura and peritoneum sometimes acts disastrously by disseminating tubercle and causing a local process to become general, it seems also to be true that a very rapid subsidence or absorption of such effusions may have similar disastrous effects. This was illustrated in at least two cases of the present series. In the one case there was a rapid absorption of a pleuritic exudate, with clearing up of all the symptoms and apparent recovery. About a fortnight later the abdomen presented the typical appearance of tuberculous peritonitis. Three weeks later the boy was dead, and much tubercle, mostly miliary, was found in a large number of organs. In the other case there was also a rapid absorption of a pleural effusion, not diagnosed at the time as tuberculous; four months later the patient was re-admitted with general tuberculosis.

Spinal Caries.—Of antecedent conditions that are “surgical” spinal caries occurs most frequently in the present series. Perhaps the most remarkable feature of these cases is that the spinal caries was seldom detected. Out of eight cases only two were diagnosed, and in one of these two there was an angular curvature that could not

escape notice. In four cases there was an undetected psoas abscess. A specially remarkable case was one in which in addition to spinal caries and psoas abscess there was caries of the pubic arch and rami, "with abscesses in the top of the inner part of both thighs"—all undetected in life and all symptomless. Where there are symptoms referable to the spinal caries, they are chiefly sciatic pains, less often lumbar pain, sometimes abdominal pain and tenderness. Sciatica as a special symptom will be considered later.

Onset and Course.—The onset may be gradual, or it may be sudden. It is difficult to be statistical on this head, as it is often impossible to infer from the histories elicited from patients or their friends the particular date at which a localized tuberculosis became general. Most often the onset is gradual. Sometimes it is appallingly sudden, and the course rapid. In four cases of this series the whole illness lasted less than ten days. In one case a man, said to have been quite well when he went to bed, was found delirious in the morning and was dead five days later. The majority of cases of sudden onset were of meningeal type. In seven cases the disease began suddenly with chill and shivering (but not rigors); in four cases with acute pulmonary symptoms.

Symptoms.—The symptoms most commonly complained of were cough, shortness of breath, wasting, progressive weakness, vomiting, headache, and abdominal pain or swelling.

I proceed now to discuss in detail the symptoms and physical findings in general tuberculosis of adults.

SYMPTOMS IN DETAIL.

Temperature.—[A temperature note was found in eighty-eight cases only.] High temperature does not appear to be common in general tuberculosis. In only one case did the temperature touch 105° F. for any length of time; in six other cases it reached 104° F., and in nineteen more 103° F. The usual range was from 99° to 102° F., and within these limits a more or less irregular remittency from 102° or

101.5° F. in the evening to 100° F. in the morning was perhaps the commonest type—the *irregularly remittent* or *continuous* type of Cornet. In nine cases of the series the inverse type was more or less well shown. Inverse temperature is of some diagnostic value. In only two cases was there a steady ascent at all suggestive of enteric fever, and in only two cases was there a more or less perfect imitation of the intermittent or hectic types.

Twelve cases were of the *afebrile* type, two of these only during a part of the time. Cornet says that afebrility “does not materially delay” the fatal termination. If one may judge by the present series of cases, he might have expressed himself more strongly. If it does not itself actually hasten the end, it is probably the expression of a profound debility that cuts short the resistance of the organism. In six of these cases the course was very rapid. In eight prostration was particularly marked. In one case sweating was very profuse, and in three cases there was considerable hæmorrhage, from the nose, from the lungs, and from the bowel respectively. In only one afebrile case was there no marked prostration, sweating, or hæmorrhage. Cornet speaks of the tendency to afebrile temperature in the old and also where meningitis exists. As a matter of fact, in our afebrile cases the age never rose above 48 (but only four patients in the entire series were over 60 years of age), and although meningitis was very common—being found in about 37 per cent. of the series—only one of the afebrile cases had it. Leichtenstern observed an afebrile course in a child with cirrhosis of the liver. Five of the afebrile cases under consideration had cirrhosis of the liver.

The great mark of the temperature in general tuberculosis is its irregularity and want of conformity to types.

Pulse.—[There was a record of the pulse-rate in eighty cases only.] The observation that the pulse-rate is usually accelerated out of proportion to the elevation of temperature is confirmed by the records of the present series. But the number of cases in which the pulse-rate is not greatly increased is larger in a series which, like ours, includes subacute and more or less chronic cases, than in an exclusive

series of acute cases. Whereas in thirty-one cases the pulse-rate was 120 or more, it was below 100 in as many as twenty-four cases; in fifteen of these cases the low rate was accounted for by meningitis, in one case (a patient aged 66) possibly by age. In a patient aged 29, with marked meningitis, the pulse remained extraordinarily low, ranging between 36 and 44, and only a little while before death rising to 60.

Respiration, Dyspnœa, and Cyanosis.—[There was a record of the respiration-rate in sixty-six cases only.] The rate of respiration ranged usually between 20 and 30. In a minority of cases it was exceedingly rapid. In seventeen cases it ranged between 40 and 60, and in seven cases it was even above 60.

Dyspnœa and cyanosis naturally fall to be discussed at this stage, though they are not necessarily pulmonary symptoms.

Dyspnœa is one of the commonest symptoms of general tuberculosis. It was more or less urgent in twenty-seven cases of this series; in two cases only did it amount to severe orthopnœa. The most usual cause of this dyspnœa appears to be the general dissemination of miliary tubercle throughout the lungs; this was present in twenty-two of the twenty-seven cases, and although in some of the cases other factors, such as pleural and peritoneal effusions, fibrosis of the lung, and cardiac lesions, were at least contributory causes, general miliary tuberculosis of the lungs was the factor most uniformly present. In four of the five remaining cases the dyspnœa was accounted for by some other condition of the lung (acute caseating broncho-pneumonic tuberculosis, with abscess), or by the state of the larynx or heart. In one case the dyspnœa, which was considerable, did not appear to be accounted for by any physical signs or *post-mortem* findings.

As against the opinion that generalization of tubercle in the lungs is the chief cause of the dyspnœa under consideration, it must be stated that in twenty-seven cases of this series the lungs were stuffed with miliary tubercles without any dyspnœa being noticed. Perhaps the dyspnœa

is a toxæmic symptom (due to absorption of tuberculins) with which the general dissemination of miliary tubercle throughout the lungs is often, but not always, associated. This might account for the case referred to above in which the dyspnœa was not otherwise explained. Reinhold's suggestion that severe dyspnœa in general tuberculosis may be due to tubercles on the diaphragm is not confirmed by any case in the present series.

Cyanosis is a noteworthy symptom of general tuberculosis. It was present altogether in twenty-two cases of this series. In only three was there any serious heart-mischief that might account for the sign. In nearly all the cases there was a general dissemination of miliary tubercle throughout the lungs. Here again, as in the case of the dyspnœa, there are facts unwelcome to the hasty generalizer. On the one hand a great many cases show widespread miliary tuberculosis of both lungs without any accompanying cyanosis; on the other hand, two cases showed cyanosis (one of them to a marked degree) in the absence of heart symptoms and in the absence of any universal invasion of the lungs by miliary tubercle. (By "universal" invasion I mean extensive invasion of all the lobes.) In one of these cases there was a large pleural effusion on the left side which might have been thought an important factor in the cyanosis, but that tapping so far from relieving appeared to aggravate both the cyanosis and the orthopnœa.

The cyanosis is not apparently directly related to the dyspnœa, as Cornet says it is in acute miliary tuberculosis. In 13 of the 22 cases of cyanosis—these 13 including 2 of marked degree—there was no observed dyspnœa, and in 1 case in which the cyanosis was very deep the dyspnœa was only slight.

Physical Signs in the Lungs.—Fugitive râles heard now in one part, now in another part, of the lung, are as a rule the only "physical signs" of miliary tubercle in the lung, and even these are often absent. It follows that miliary tubercle in the lungs often eludes diagnosis. A dyspnœa, therefore, which seems out of relation to physical signs,

should always suggest a widespread dissemination of small tubercle in the lungs. Of course, any form of pulmonary tuberculosis may be present in general tuberculosis, and the physical signs will accord therewith.

Cough.—As almost any variety and phase of pulmonary tuberculosis may exist in a case of general tuberculosis, it follows that there may be almost any kind of cough, and almost any kind of sputa. The usual cough, however—and especially the cough associated with the dissemination of small tubercle—is a dry hacking cough which results in the expulsion of scanty mucous sputa, often viscid, occasionally frothy, and occasionally blood-stained or rusty. The cough was often noticed to subside towards the end of the illness, especially as the cerebral symptoms increased.

Common as cough is in general tuberculosis, the absence of it is nearly as common. There was no cough at all in fifty-one cases of the present series. Both lungs may be crowded with miliary tubercles, and yet there may be neither “physical signs” nor cough.

Hoarseness.—Hoarseness is sometimes one of the earliest symptoms of tuberculosis. Hoarseness and more or less complete aphonia were present in five cases of the present series. In three of these there was tuberculous ulceration of the larynx. In two there was no ulceration or tuberculous deposit in the larynx, but there were greatly swollen bronchial and posterior mediastinal glands, which might cause paresis of the adductors of the glottis.

Heart.—Heart-signs are not marked in general tuberculosis. A flabby or fattily degenerated heart was found in a few cases, usually in association with adrenal tuberculosis. In one case the symptoms of mitral stenosis completely masked the tuberculous symptoms. In another case there was recent endocarditis with hypertrophy, and in a third case there was a fibrosed and dilated heart.

Nervous Symptoms.—The ordinary cerebral symptoms of general tuberculosis are headache, delirium, and torpor deepening into coma. In the later stages the “typhoid” state may be very faithfully imitated. When, as often happens, tuberculous meningitis dominates the scene,

vomiting, strabismus, pupillary changes, retraction of the neck, and various palsies (aphasia, *e.g.*, was found in two cases) may also be present.

Cornet speaks of convulsions as an occasional symptom of acute miliary tuberculosis. Fits or convulsions of some sort were reported to have occurred in five cases of the present series, but in only one case were they actually witnessed in hospital. In that case they were described as "epileptic," and they were preceded for several days by acute pain in the forehead; *post-mortem* tuberculous meningitis was found. Chorea—or the movements characteristic of chorea—was noticed in two cases. This is interesting in connection with the observation—to be referred to later—that general tuberculosis may mimic acute articular rheumatism, and also with Reinhold's observation that it may present a picture of typical erythema nodosum with moderate fever and rheumatoid symptoms. If in any patient these manifestations in the joints and skin should happen to be accompanied by choreic movements, the case for rheumatism would be additionally strong.

In both these cases of chorea tuberculous meningitis was found, and in one of them two tuberculomata in the parietal lobule.

Weakness. Loss of Power in the Legs.—A general rapidly increasing weakness is a very pronounced symptom of general tuberculosis. Sometimes a patient complains of nothing but an extraordinary and unaccountable prostration of the physical forces, and sometimes also the weakness is as unaccountable to the doctor as it is to the patient. More often the weakness is merely the most prominent feature amongst many, but even so it is nearly always out of proportion to the other symptoms. A young labourer stated, on admission to the hospital, that six months previously he began to complain of lassitude and a slight cough. The lassitude was such that for four months he had done no work. In the out-patient department, which he had been attending for some months, only slight signs were found in the chest, but an extraordinary debility was noticed which could not be explained away as ergophobia. As he had

latterly lost flesh and the cough had increased, he was recommended for admission into the wards.

Sometimes the weakness is local. In five cases of this series the complaint for which the patient was admitted was "loss of power in the legs." One of the cases was a genuine paraplegic, and may be excluded from the present category. The remaining four suffered from intense weakness in the legs, which they described as loss of power or loss of use of the legs. In two of these cases there was pain in the legs as well, but the predominant symptom throughout the illness was in each case the weakness. In two cases the onset of the local weakness was quite sudden. A young labourer was seized quite suddenly with pains in the legs and an inability to stand. He took to his bed and was never about again. An elderly cook had what was described as a "fit" a week before admission, and never regained the use of her legs. (There was no paralysis in this case.) In the two remaining cases the onset of the weakness in the legs was more gradual. An elderly law-writer had for six months felt a dull aching pain in both legs and experienced some difficulty in walking; fourteen days before admission he had suddenly felt his legs give way under him, and from that time he had been unable to walk. A waiter, aged 43, had for three weeks noticed a weakness of the legs, chiefly when he was going upstairs. Eight days after admission he fell down in the ward, "apparently merely from weakness." This case had a special interest in that a conjectural diagnosis of early tabes was hazarded on the strength of absence of the knee-jerks and a slight inco-ordination of the gait. The latter symptom was probably due to pure weakness.

In two of the four cases there was a loss of sphincter control—of the sphincter of the bladder in one case, and of the sphincters of both bladder and anus in the other.

In three of the four cases there was a strongly marked history of alcoholic indulgence, and this, when combined with the loss of power in both legs, led, in one case at least, to a not unnatural suspicion of alcoholic peripheral neuritis.

Emaciation.—A rapidly progressing emaciation is one

of the most unfailing symptoms of general tuberculosis. In the cases of sudden onset and swift course, in which the body politic was compelled to surrender to an overwhelming force of toxins before its own contingents could be marshalled to the conflict, this emaciation was often not seen, and the body would be described by the pathologist as "fairly nourished," "well nourished," and in one or two cases even "fat."

Abdomen.—Abdominal *distension* was noted in 29 cases. In 18 of these cases there was tuberculous peritonitis; in the remaining 11 there was no peritonitis at all. In 10 of the 18 cases of tuberculous peritonitis the distension was due to tympanites, and in 8 to ascites. (In 4 of these ascitic cases cirrhosis of the liver was a contributory factor.) In the 11 cases not marked by peritonitis the distension was tympanitic in character, sometimes only slight, but sometimes considerable. In a few cases there was marked abdominal *pain* and *tenderness*. In this connection it is interesting to note that in several cases the pain, tenderness and resistance were localized to the ileo-cæcal region, and that in one case the pain developed acutely and suddenly. It is obvious that such a case might run a considerable risk of being diagnosed as ordinary appendicitis. Tuberculous ulceration, moreover, seems especially liable to occur in the last part of the ileum and the first part of the colon, and it is not very rare in the appendix. Pain in the left hypochondrium is sometimes due to tuberculous perisplenitis.

Retraction of the abdomen was noticed in five cases; in three of these there was tuberculous meningitis.

Alimentary Tract.—The appetite is usually considerably impaired in general tuberculosis.

Vomiting is most often found in association with cerebral or meningeal invasion. This was so in 20 cases out of 31. In 2 cases the vomiting was uræmic, and in 1 case it was perhaps due to alcoholism. In 7 cases there was a vomiting independent of any of these factors—a genuine symptom of general tuberculosis.

Bowels.—Costiveness is the rule, but diarrhœa is not uncommon. Thus of 75 cases in which there is a note of

the state of the bowels, 32 had constipation, and 20 had a diarrhœa other than terminal; in 15 cases the bowels acted normally throughout, in 1 they alternated in a fitful way between the two extremes, and in 7 cases there was a terminal diarrhœa. There were 2 cases of diarrhœa, and 1 of constipation, in which terminally the bowels acted normally.

Analysing the 32 cases of constipation, we find that in 23 of these there was meningeal or cerebral invasion, in which conditions constipation is to be expected. In 5 of the remaining cases the constipation existed in the face of tuberculous ulceration of the bowel. (It has been recognized that extensive ulceration of the ileum may exist without diarrhœa, but in 4 of these 5 cases the large bowel, either alone or in addition to the small, was extensively ulcerated.)

In 6 of the 15 cases in which the bowels acted normally, this normal action was maintained in spite of more or less ulceration of the bowel.

Coming to the cases of diarrhœa, we find that, in a majority of them, there was either abundant tuberculous ulceration of the bowel or undoubted alcoholism, either of which conditions might be held to account for diarrhœa; but in seven cases there was neither ulceration of the bowel nor alcoholism, nor any condition generally recognized as causing diarrhœa.

In three cases there were offensive typhoid-like stools, and in one of these there was also hæmorrhage from the bowel. The importance of such cases from the point of view of diagnosis is obvious.

Altogether there were blood-stained motions in five cases. Three of these cases confirm the observation that blood may be found in the motions in tuberculosis apart from ulceration of the bowel.

Spleen.—The spleen was enlarged to a greater or less extent in at least twenty-six cases of this series. As a rule it was only slightly enlarged, but in three or four cases it was of very considerable size. In two cases it constituted a marked abdominal tumour, and in one case it gave rise to a tentative diagnosis of leukæmia. The enlargement was painless, except where there was marked recent perisplenitis.

Liver.—In twelve of these cases of general tuberculosis cirrhosis of the liver was present. That hepatic cirrhosis is liable to be complicated by tuberculous peritonitis and tuberculous pleurisy has often been remarked, but in four of the twelve cases now under consideration there was neither peritonitis nor pleurisy.

Nine of the twelve cases were alcoholics, self-confessed or incriminated on good evidence. In the three remaining cases alcoholism seemed excluded. In five of the nine alcoholic cases there was abundant tubercle, mostly miliary, in the liver, which might account for a part of the cirrhosis. In one of these cases, in addition to miliary tubercle, there was adhesive perihepatitis, which is a recognized cause of hepatic cirrhosis.

Of the three non-alcoholic cases one displayed numerous miliary tubercles, but no perihepatitis, the other two neither tubercles nor perihepatitis. In one of these latter cases the patient was a messenger boy, aged 16, who, on admission, presented a liver enlarged considerably below the costal margin, but no other abdominal signs. About ten weeks after admission free fluid for the first time was detected in the abdomen. After death, which occurred about a fortnight later, the liver was found to have become atrophic. There was no history or evidence of syphilis, or indeed of any "dyscrasia" except that of which he died. At the autopsy atrophic cirrhosis was found, but no tubercle in the liver and no perihepatitis. He had, however, abundant ulceration of the small bowel—a symptom also present in five of the nine alcoholic cases of hepatic cirrhosis, and the interesting question emerges whether, under particular disposing conditions, the bacterial products of such ulceration can, after absorption, produce a portal cirrhosis resembling the ordinary cirrhosis due to alcohol. There must, of course, be certain disposing or adjuvant conditions, since many patients have tuberculous ulceration of the bowel without hepatic cirrhosis; but the same is the case with the poison of alcohol (or perhaps one ought rather to say, the poisons produced by, or in association with, that gastrointestinal catarrh to which alcohol gives rise)—not all

alcoholics get cirrhosis of the liver, even though they may have been "of very drunken habits" and "scarcely sober for many years," as were two men in the present series, in whom, nevertheless, after death no signs of cirrhosis were discovered. In the messenger boy, whose liver has given rise to the foregoing speculations, there was yet another mimicry of alcoholic disease, to which more detailed reference is made elsewhere, namely, a marked tenderness and loss of power in the legs.

Joint Symptoms simulating Acute Rheumatism.

One or two interesting cases in this series illustrate the striking resemblance that the onset of general tuberculosis may bear to acute or subacute articular rheumatism.

A labourer was admitted into hospital complaining of pains in the joints, feverishness, and prostration. Both ankles, both wrists, and the right shoulder were greatly swollen, painful and tender, and the patient was sweating profusely. Nothing abnormal was found in the heart or abdominal organs. The illness resembled acute rheumatism, except in the course it ran. It was fatal in five days. *Post-mortem* abundant miliary tubercle was found.

A clerk who had been an inmate of the hospital some six months previously for pleurisy with effusion was re-admitted with a temperature of 100° F. and tender swellings, causing great pain on movement, of the left sterno-clavicular joint and of the left wrist. He was ill for six weeks. During that time his temperature varied irregularly between 100° and 103° F., and he steadily grew weaker; but the joint symptoms were the predominant feature of the clinical picture. The swelling of the sterno-clavicular joint was twice aspirated. On the second occasion—three days before death—tubercle bacilli were found in large numbers, and a correct diagnosis was inferred.

Sciatica.

Sciatica was mentioned under spinal caries, but a fuller consideration of it has been postponed until now. The

symptom was definitely present in four cases, and the pathological condition underlying it was in most cases caries of the sacrum or of the neighbouring part of the ilium, with or without sacro-iliac disease. I say "in most cases," for in one case nothing was found accounting for the particular symptom; but, unless a special search were made for it, an amount of osteitis sufficient to set up pain in the sciatic nerve might elude the ordinary methods of *post-mortem* investigation.

Two of the cases stand out as having a special interest, because they were, on admission, and for some time after, cases of almost pure "sciatica." They were admitted as "sciatica," and were labelled as "sciatica," and throughout their course sciatic pain was the dominating symptom. In the one case fæcal accumulation and prostatic tumour were in turn suggested as causes of the sciatica, but the true cause was never determined in life; as the only obvious symptoms besides the sciatica were an irregularly remitting temperature and loss of flesh, the failure to diagnose was not surprising. In the other case, although upon admission and for a fortnight after there was absolutely no symptom—not even an elevation of temperature—beyond the severe sciatic pain and much tenderness over the sacrum and left buttock, a correct diagnosis was eventually made.

Another case in which severe sciatic pain was complained of presents some interesting features. The patient was admitted on the surgical side for caries of the left tarsus. The swelling of the ankle was first of all lanced; afterwards parts of the tarsus and metatarsus were removed; finally, the leg was amputated. During her stay in hospital the patient complained of severe sciatica on the *right* side; *post mortem* a collection of pus was discovered in the *left* buttock, and the posterior surface of the ilium on the *left* side was found to be carious. Moreover, the left ovary was caseous. Nothing abnormal was noticed on the right side of the pelvis.

These cases confirm the importance of regarding sciatica steadily as a secondary condition until it be proved to be primary.

It may be added that no changes in the hip-joint were noticed, but examination with the X-rays, as practised and recommended by Dr. Ironside Bruce (*Practitioner*, April, 1908), was not resorted to.

Muscular Tenderness.

An interesting feature of five cases in this series was a very definite tenderness of the muscles. As a good many cases of general tuberculosis are found amongst the alcoholic, it has been suggested that this tenderness is due in fact to alcoholic neuritis. But in no case was there any paralysis, and in only one of these five cases was there any suggestion of alcoholism.

A Church Army worker, who was a total abstainer, complained of great tenderness in the muscles, especially the muscles of the limbs, which she could not bear to have moved. A labourer had "widely distributed tenderness of the muscles." A young married woman was so tender about the pectoral muscles that any firm pressure of the stethoscope was acutely resented. A young laundrymaid complained of tenderness in the calves of the legs. The last case of this group is instructive. A potman by calling, he had for many years scarcely ever been sober. Yet it did not appear that he had ever had alcoholic neuritis or indeed any of the ordinary symptoms of alcoholism, and the tenderness in the muscles of his legs did not begin until after he had been in hospital for three weeks, three weeks of enforced abstinence. Moreover, it came on suddenly, unlike alcoholic neuritis which comes on gradually, and it was unaccompanied by paralysis or by mental symptoms. The tenderness, too, was much more definitely limited than in ordinary alcoholic peripheral neuritis, being mainly confined to the peronei muscles. In none of these cases, it may be added, was there any thrombosed vein.

The one point common to these various cases was a widespread dissemination of very early tubercle, a fact that points to the tenderness being caused by small or miliary tubercles in the muscles, or, in other words, by a tuberculous myositis. It is interesting to note at the same time that

this great tenderness of the muscles has been observed by Osler in enteric fever, a disease that is more liable than any other to be confounded with general tuberculosis; and that Osler thinks that some of such cases may be instances of myositis.

Skin.

The skin was more often moist than dry, but dryness and roughness, sometimes a scaliness amounting almost to desquamation, were noticed in five cases. In five cases the skin was hot and pungent. In one case the face and palms were damp and clammy, while the rest of the body was hot, hard and dry. Sweats, mostly nocturnal, were a very common feature, but were never accompanied by a collapse temperature.

Cyanosis is not uncommon, but is referred to elsewhere. Pallor is common. Jaundice occurs occasionally; it may be due to tubercles in the liver, but it may sometimes be due to associated alcoholic cirrhosis. Brown pigmentation, which is a recognized symptom of abdominal tuberculosis, was observed in two cases.

Rashes were found in seven cases, sometimes purpuric or petechial, sometimes papular and imitating the typhoid roseola, sometimes erythematous, sometimes macular, sometimes sudaminal. In one case a single crop of rose spots broke out over the chest and abdomen.

Œdema.

Œdema was complained of or noticed in six cases of this series. In two or three cases it was a prominent subject of complaint on the part of the patient seeking admission. In one case the patient's sole complaint was stiffness and swelling of the left calf and foot. In three of the six cases the swelling was in both legs; in the other three it was only in the left leg or left foot and ankle. Cornet regards œdema of the extremities as merely a terminal event, in acute miliary tuberculosis. It was terminal only in two of these six cases of general tuberculosis. In three cases the cause appeared to be thrombosis, in one case anæmia, in

one case chronic kidney disease, and in one case heart trouble.

Urine.

Albuminuria is not uncommon in general tuberculosis. Thus it was found in twenty-eight cases of this series. But cases in which the albumin exists in quantity are not common; there were, indeed, only three in this series, one a case of lardaceous disease, and two cases in which abscesses were found in the kidneys. In the twenty-five remaining cases there was but a trace of albumin. Tubercles were seen in the kidneys in twenty-one of these twenty-five cases.

Pyuria was found in two cases, in both of which there were tuberculous abscesses in the kidneys. One of these cases was specially remarkable because, although the left kidney was found *post mortem* to be nothing but a bag of opaque liquid, it had never given rise to any symptoms.

Hæmaturia was found in two cases and was due in both to caseating tuberculosis of the kidneys. Anuria and uræmia were found in one case only, the case referred to above, in which the kidneys showed lardaceous change.

Ehrlich's diazo-reaction was obtained in five out of the nine cases in which it was sought. It is evident, therefore, that this reaction is not diagnostic of typhoid fever. But it is probably fairly safe to say that, where the reaction is obtained, the diagnosis lies between typhoid fever and general tuberculosis. The reaction ought to be looked for at different stages of the same case, as it may be curiously elusive. Thus, Longcope in his article on "Tuberculosis of the Thoracic Duct," already quoted, gives a summary of a case of general tuberculosis, in which the following entries occur: "September 21, intense diazo," "October 1, diazo-reaction reappears in urine after several days' absence"; "November 16, diazo-reaction again appears; had been absent for several days."

Retention of urine was found in eight cases of this series. It is interesting to note that retention is an early symptom in many cases of typhoid fever. In two of these eight cases retention was a terminal manifestation, occurring within

the last forty-eight to seventy-two hours, a stage at which incontinence rather than retention would be looked for. In the other six cases the symptom occurred earlier. In one of them the retention was not constant; at times the patient was able of herself to pass water. In three cases there was during a part of the time incontinence of fæces as well as retention of urine.

It is an interesting surgical observation that purulent peritonitis—in children, at any rate—is very often associated with inability to pass water; and it has been thought that the retention of urine in general tuberculosis is due to invasion of the peritoneum, more especially the peritoneum that covers the fundus of the bladder. But as a matter of fact, tuberculous peritonitis was only found in one or two of these cases. Vere Pearson ("Tuberculous Meningitis in Adults occurring as a Terminal Event in Chronic Pulmonary Tuberculosis," *Clinical Journal*, December 24, 1902) is inclined to connect this retention of urine with meningitis. He has observed that in the late stages of chronic pulmonary tuberculosis there is a liability to *incontinence* of urine if the disease is without complication; but that if it is complicated by a terminal meningitis *retention* is more likely to occur. In four of the eight cases of retention that occurred in the present series meningitis was found; in one case there was apparently no examination of the contents of the cranium; in the three remaining cases there was no obvious meningitis. Pearson, however, thinks that meningitis is probably nearly always present in some degree in general tuberculosis. He says: "Although general tuberculosis without meningitis is a common *post-mortem* appearance, this is no evidence that tuberculous meningitis has not occurred without producing visible deposits" (that is, visible to the naked eye). It may be added that in the cases under consideration the spinal meninges, which might have shown tubercles, even though none were to be seen at the base of the brain, were not examined.

It may be, however, that retention of urine in these cases is due to atony of the bladder, an expression in a

single organ of that general muscular debility which is so marked a lineament of general tuberculosis, or—to put it otherwise—an expression in unstriped muscle of that weakness which has been already noticed in striped muscle under the heading of “Loss of Power in the Legs.”

Hæmorrhages.

Hæmorrhages are not uncommon in general tuberculosis. They were found in thirty cases of this series. Hæmoptysis, usually only slight, was found in fifteen cases. Nose-bleeding, which Osler asserts to be rare in acute general tuberculosis, was found in twelve cases of the present series (which includes subacute and more or less chronic cases as well as acute cases); in six of these, however, it should be mentioned, there was a history of alcoholism, which might of itself account for the symptom. Hæmorrhage from the bowel was found in five cases, none of them alcoholic; hæmatemesis in two cases, neither alcoholic. Hæmaturia was a symptom of two cases; purpura and petechiæ of one case.

Choroidal Tubercles.

Choroidal tubercles are a diagnostic point of great importance. They were found in nine cases of this series, but only once before death. No regular investigation, however, was made of the eyes either before death or after. In two of these nine cases the eyes were examined with some care before death, and certain abnormalities were observed, but the tubercle was not detected. In most cases the tubercles are found in *both* eyes.

DIAGNOSIS.

In only fifty-four cases of the 110 analysed was a diagnosis given, or at any rate recorded. In only seven cases was a correct and complete diagnosis given. In fewer cases still was the diagnosis confident as well as correct and complete. In several cases the disease was masked by the dominance of a particular set of symptoms, as, for

instance, the pulmonary symptoms, or the meningeal, or the peritoneal. Hence a diagnosis, correct as far as it went, but only partial, was often given. Pulmonary phthisis was "diagnosed" in twelve cases, laryngeal phthisis in two, tuberculous meningitis in two, tuberculous peritonitis in three, cirrhosis of the liver in four, mitral stenosis in one. Similarly, in most of the cases admitted on the surgical side, the "surgical" trouble was readily diagnosed, but the deeper-seated "medical" trouble found physicians and surgeons equally at a loss. In several cases the diagnosis was only a pseudo-diagnosis. Thus, "meningitis" was "diagnosed" in three cases—in one falsely. "Hæmaturia" was "diagnosed" in one case; it was really hæmaturia due to tuberculous ulceration of the bladder. "Sciatica" was the diagnosis of one case, but the cause of the sciatica (tuberculous osteitis of the pelvis) was not suspected. The commonest mistaken diagnosis was "enteric fever"; this was given in eight cases, but never confidently. "Malignant disease" was "diagnosed" twice, "influenza" twice, "broncho-pneumonia following influenza" once, "Bright's disease" twice, "malaria" once, and "malarial cachexia" once. In one case the diagnosis wavered between "early tabes" and "multiple alcoholic neuritis."

In order to make a diagnosis of general tuberculosis, the symptoms, as already set forth, must be carefully observed and weighed. In addition, certain investigations—physical, historical, and bacteriological, must be made. The personal and family history of the patient must be investigated, with special reference to glandular swellings, bone-disease, pleurisy, and lung trouble. The patient's body, and more particularly his neck, his corneæ, his testicles, and the apices of his lungs, must be examined for scars or other vestiges of old tuberculosis, and the choroid coat of the eyes for tubercles. The hypodermic injection or ophthalmic instillation of tuberculin may be resorted to for diagnostic purposes; but it is not absolutely certain that either of these methods is free from danger. The opsonic index of the blood may also be calculated, but inferences from it must be drawn with caution. The sputum (if there is any).

must be examined for the tubercle bacillus, and so must the blood. If there is evidence of cystitis or other affection of the urinary tract, the urine may be examined bacteriologically, and in any case the diazo test should be applied to the urine. If there is diarrhoea or bowel trouble, the motions also may be investigated bacteriologically. If there is a doubtful meningitis, the cerebro-spinal fluid may be searched for the specific organism.

It has been already noticed that a diagnosis—right or wrong—was recorded in only about one-half of the total number of cases. But in many of the cases in which no diagnosis was recorded there can be no doubt that the minds of professional observers were led by the trend of the symptoms—for a time, at least—waveringly and with much doubt, in certain definite directions. Most often they were led in the direction of enteric fever. “Enteric fever” was the *recorded* diagnosis in eight cases. But general tuberculosis may be confounded with the train of symptoms produced by latent suppuration, with infective endocarditis, with malaria, with influenza, and even with acute mania, delirium tremens, chronic alcoholism, and acute rheumatism.

Diagnosis from Enteric Fever.

The great outstanding features of enteric fever are the rose-pink spots, the abdominal distension, the diarrhoea with “pea-soup” stools and intestinal hæmorrhages, the enlargement of the spleen, and the peculiar mental state known as “typhoid.” As all of these may be, and some of them often are, present in general tuberculosis, it is obvious that the diagnosis may be a matter of difficulty. As an illustration of this difficulty, one case of the present series may be quoted. The points in favour of enteric fever were: A supposed pneumonic condition of part of the lungs (suggesting the pneumonic type of enteric fever), a very offensive diarrhoea (with “pea-soup” stools on at least one occasion), hæmorrhage from the bowels, distension of the abdomen, splenic enlargement, marked headache, a dicrotic pulse, dry, glazed, cracked tongue, a

positive diazo-reaction, and in the fourth week after admission subsultus and the "typhoid" state.

Where the diagnosis is supposed to lie between enteric fever and general tuberculosis, a careful investigation should be made of the patient's history—the history communicated by the patient or his friends, and the history written by old disease upon the patient's body. A history of possible infection by the typhoid bacillus—of an epidemic in the neighbourhood—may point to enteric fever. Old scars in the neck, a healed lesion at the apex of a lung, a quiescent epididymitis, may point the finger of possibility towards tuberculosis, and tubercles in the choroid coat of the eye may place the finger of diagnostic certainty upon it. Recent history can often be read in the blood, in the urine, and in the fæces, and may point definitely to one or other of the diseases in question. Thus a positive Widal reaction is a very strong point in favour of enteric fever (but it was obtained in one case of the present series), and typhoid bacilli found in a suspicious roseola are conclusive. Typhoid or tubercle bacilli found in the urine yield also decisive evidence; but a positive diazo-reaction speaks with a much more uncertain sound, though declaring, on the whole, for enteric fever. (In Osler's typhoid cases the diazo-reaction was obtained in 84·7 per cent.; in the nine cases of general tuberculosis in the present series in which it was looked for it was found in five, *i.e.*, 55·5 per cent.)

Next, a careful investigation should be made of the symptoms. The temperature does not rise so high in general tuberculosis as in enteric fever, and is far from displaying the same steady ascent; indeed, irregularity is the most conspicuous feature of the temperature. Still, in one or two cases of this series the temperature chart was rather suggestive of enteric fever. An inverse type would point to general tuberculosis.

A rapid pulse, accelerated out of proportion to the elevation of the temperature, would point rather to general tuberculosis. Dicrotism points to enteric fever, though two cases of this series showed this condition of the pulse.

A very high respiration-rate points to general tuberculosis. Dyspnoea and cyanosis are common in general tuberculosis (and especially significant if unaccompanied by marked physical signs), but they are rare in enteric fever. Nevertheless, as Osler points out, a severe initial bronchitis may produce both these symptoms in enteric fever. A severe and distressing cough points to general tuberculosis, but in nearly half the cases of this series cough was entirely absent. Pleuritic symptoms, as Cornet observes, point to tuberculosis.

Coming to the abdomen, we find a considerable mimicry by general tuberculosis of the symptoms of enteric fever. Thus, meteoric distension is not at all rare in tuberculosis, though it is not usually great. Cornet, speaking of acute miliary tuberculosis, says that there is often gurgling in the ileo-cæcal region, and in three or four cases of the present series abdominal pain and tenderness were curiously localized to that region. The spleen is very commonly enlarged in general tuberculosis, but not usually to the same extent as in enteric fever; nevertheless in three or four cases of this series the enlargement was very considerable.

Herpetic and petechial eruptions are certainly more common in general tuberculosis than in enteric fever, but what is called the characteristic roseola of typhoid is very rare in general tuberculosis. It is, however, occasionally found, but it does not occur in successive crops. The roseolous rash occurring in successive crops on the abdomen and chest is very weighty evidence of enteric fever; but it must be remembered, in considering the difficulties of diagnosis, that in genuine enteric fever the rash may be slight and not characteristic.

The bowels in general tuberculosis are most often costive, whereas diarrhoea is one of the prominent features of enteric fever. Nevertheless, diarrhoea is frequent in general tuberculosis, and it is sometimes absent from enteric fever. The nature of the stools is important. The so-called "pea-soup" stools are occasionally found in general tuberculosis, but a succession of such stools tilts the scale decidedly to the side of enteric fever. Hæmorrhage from the bowels was

present in five cases of this series, but it is not so common a feature of general tuberculosis as it is of enteric fever.

Nose-bleeding, which is well known to be common in enteric fever, is also not rare in general tuberculosis. It was found in twelve cases of this series. Retention of urine may occur at any stage of general tuberculosis; it is an occasional symptom of the early stage of enteric fever. Tenderness of the muscles is occasionally found in enteric fever, but it is probably more common in general tuberculosis. Parotitis points to enteric fever. Severe headache is a symptom which helps us very little. The "typhoid" state is common in both diseases.

Some features develop only with time. The time, however, may be very short. A very rapid progressive loss of strength and weight points rather to general tuberculosis, in which this symptom is usually outstanding. Time may help us in another way; thus, improvement with a fall of temperature in the fourth or fifth week is significant of typhoid, as Dr. Sidney Martin points out.

Latent Suppuration.—In the next place general tuberculosis may need to be distinguished from the effects of latent suppuration, as, *e.g.*, of the cavities accessory to the nose or of the Fallopian tubes. Both conditions may be marked by fever and little else—the one may be as "latent" as the other, so far as "physical signs" go. Attention must be paid to the temperature chart. The temperature of pus absorption usually follows definite lines, whereas that of general tuberculosis is conspicuously irregular. Nevertheless, the temperature is occasionally distinctly intermittent, and might not afford the desired criterion. Leucocytosis would be suspicious of latent suppuration; but here again diagnosis may be baffled by disconcerting foci of suppuration in general tuberculosis. The "typhoid" state and a very rapid emaciation and loss of strength will speak strongly for general tuberculosis, as also will very great rapidity of respiration, dyspnoea, and cyanosis. The history and the body of the patient must be searched with diligence for information relating on the one hand to old tuberculous lesions and on the other to foci of lurking suppuration.

Infective Endocarditis.

A well-developed text-book infective endocarditis, with its audible and changing murmurs, its cardiac pain, and its multiple embolisms, is readily identified; but these symptoms may all be absent. Dr. Tirard says of infective endocarditis (*Practitioner*, November, 1908) that "The mode of onset and the prominent symptoms often present the utmost variations, and it is frequently almost impossible to avoid forming an erroneous diagnosis." The same might be said of general tuberculosis. Indeed, both complaints may at times present fever and very little else. The temperature, too, is irregular in both, but in infective endocarditis it tends to run higher and is marked by wider oscillations. Moreover, the higher ranges of temperature in infective endocarditis are often marked by rigors—a symptom very rare in general tuberculosis. Sweating is a marked feature of infective endocarditis—more so than of general tuberculosis. Profuse sweating, though by no means rare in general tuberculosis, seldom occurs in connection with a rapid fall in temperature, and this furnishes a real diagnostic point. An abrupt onset is more often seen in infective endocarditis. A "typhoid" type of infective endocarditis has been pictured, in which the symptoms are irregular temperature, early prostration, delirium, stupor, coma, diarrhoea, sweating, petechial and other rashes. Such a picture might almost hang unchanged for a picture of a great many cases of general tuberculosis. But constipation is more common in general tuberculosis than diarrhoea is, though diarrhoea is not rare. Petechial rashes, erythemata, and the like, though sometimes found in general tuberculosis, are certainly more frequent in infective endocarditis. Parotitis would point to infective endocarditis. Leucocytosis is marked in infective endocarditis, but slight or absent in general tuberculosis. A "cerebral" or "cerebrospinal" type of infective endocarditis is described, which simulates meningitis and might be almost impossible to distinguish from that type of general tuberculosis in which the main stress of infection is on the meninges. Those cases in which infective endocarditis is grafted upon, or

associated with, an acute or subacute rheumatism might strongly resemble those rare cases of general tuberculosis in which the features of rheumatic fever are mimicked. In all cases in which infective endocarditis is suspected the blood should be examined for micro-organisms. The positive results of such examination are of the highest value; negative results count for little. The antecedents of the disease must be carefully investigated. Sources of infection must be looked for—tuberculous on the one hand; septic on the other, as puerperal or osteal infection. Great care, however, must be exercised in drawing inferences from these investigations. Thus, two cases of the present series developed soon—one, indeed, immediately—after child-bearing. Again, it is known now that the influenza bacillus is responsible for a certain number of cases of infective endocarditis; but influenza is also not very uncommon as a precursor of general tuberculosis.

Lastly, the progress of infective endocarditis, apart from the occurrence of embolisms, is not diagnostically illuminating. It is doubtful if it tends any more to recovery than general tuberculosis does.

Influenza.

Not only is influenza sometimes an antecedent condition to general tuberculosis, but general tuberculosis may itself need to be diagnosed from influenza. This is not to be wondered at, when the protean character of both diseases is considered. A common mode of onset in influenza is with general aching pains in the bones and muscles, shivering, rise of temperature, headache, and great prostration. In a number of cases in the present series general tuberculosis sets in after the same manner, and in one case there was also the intense pain at the back of the eyes which is often so marked a feature of influenza.

Again, one of the types of influenza is the "typhoid" type, and it is generally recognized that with such a symptom-complex as fever, abdominal distension, diarrhoea with blood in the stools, enlarged spleen, "typhoid" state, and

even rose-spots, influenza may be very difficult to distinguish from enteric fever. There is the same difficulty in general tuberculosis of the "typhoid" type. In other words, both influenza and general tuberculosis may show the above collection of symptoms.

It has been already noticed that various hæmorrhages—viz., hæmoptysis, epistaxis, hæmatemesis, and hæmorrhage from the bowel—may occur in general tuberculosis. Dr. West has recently pointed out that hæmoptysis may occur in the pneumococcal pneumonia that often complicates influenza; and Dr. Dalton has drawn attention to the occurrence of epistaxis, hæmatemesis and hæmorrhage from the bowels in influenza.

Again, an influenza of mixed type, such as was reported by Weichselbaum (quoted by Dalton in *Practitioner*, January, 1907), in which there were symptoms of enteritis—viz., fever, abdominal distension, ileo-cæcal pain and diarrhœa, accompanied by pulmonary and cerebral symptoms—could be paralleled from general tuberculosis. Further, the catarrhal form of influenza is often associated with pulmonary signs—in particular, scattered and erratic crepitations, unattended with percussion dulness, but associated with a paroxysmal cough—which Sir Richard Douglas Powell tells us he mistook at one time for the manifestations of miliary tubercle. These pulmonary signs are extremely common in general tuberculosis.

There are yet other points of resemblance between the two diseases. The fever in influenza, as Sir Clifford Allbutt has said, is erratic and irregular and bears no proportion to the malignancy of the attack. This is precisely and accurately true of the fever in general tuberculosis. Moreover, as the temperature in influenza may exceptionally be subnormal, so there is an afebrile type of general tuberculosis. The condition of the bowels is very similar—usually constipated, but not seldom relaxed. Sweats are common in both diseases. The muscular hyperæsthesia, to which as occurring in general tuberculosis special attention has already been drawn, is also found in influenza. In regard to prostration and debility, influenza fairly competes with general tuberculosis.

So much for the resemblances. We come now to the differences. The prostration which is so great in both diseases is more sudden in influenza—in sharper contrast with the preceding state of health; in general tuberculosis it is more progressive. The quality of suddenness belongs eminently to influenza. Again, rigors may occur at the outset of influenza, and later on as well; but they are very rare in general tuberculosis. Again, it is notorious what a grip the influenzal poison lays upon the heart, whereas it is remarkable to what an extent the heart escapes in general tuberculosis. In emaciation general tuberculosis certainly leads. The state of the arterial tension may help in diagnosis; for increased arterial tension, leading even to attacks of angina, may, as Sir Clifford Allbutt and Sir Douglas Powell have recently remarked, be found in influenza, whereas in general tuberculosis the arterial tension is always low.

Dyspnoea and cyanosis point in the direction of general tuberculosis. Time, too, comes to our aid. Influenza usually soon clears up, and the patient recovers; but general tuberculosis goes from bad to worse, and from worse to death. Here a caution is needed; for bronchitis or broncho-pneumonia may follow hard on the heels of influenza, and by supplying such symptoms as dyspnoea and cyanosis may help materially to fill out the picture of general tuberculosis. "Broncho-pneumonia following influenza" was, in fact, the diagnosis in one case of the present series.

In addition to this consideration of symptoms, one must take into account the epidemicity of influenza and a history of possible infection therewith on the one hand, and on the other hand one must search for old vestiges of tuberculosis and a history of tuberculous lesions in the patient or his family. Lastly, bacteriology should be invoked; for some positive evidence of Koch's or Pfeiffer's bacillus or the *Micrococcus catarrhalis* may in this way be wrested from the patient's secretions.

Malaria.

Rigors and intermittent fever are so notably absent from general tuberculosis that there can very seldom be any

chance of confounding the disease with the regularly intermittent type of malaria marked by rigors, heats and sweats. In only two cases of the present series was there even a plausible imitation of intermittent pyrexia, and in these cases the other symptoms did not at all correspond to malaria. More often general tuberculosis mimics either the more irregular or continued type of malaria, or the condition known as malarial cachexia; and in such cases malaria is very likely to be the diagnosis, especially if there is a history of residence in malarious countries.

(1) The irregular or continued type of malaria is admitted to bear often a very strong resemblance to enteric fever—a resemblance to which the splenic enlargement, always present, and the initial bronchitis, often present, may materially contribute. It is to be expected, therefore, that this type should often bear a strong likeness to general tuberculosis. The main diagnostic points are the therapeutic and the hæmatological. On the one hand, in malaria, but not in general tuberculosis, improvement is effected by quinine. On the other hand, the examination of the blood is helpful in two ways: first, if malaria is present, the malarial parasite will be present, and if general tuberculosis is present, this parasite will be absent, but possibly the tubercle bacillus will be present; second, in malaria the leucocytes are diminished in number, in general tuberculosis there is slight leucocytosis. Other diagnostic points are that in malaria the splenic enlargement is greater and occurs more suddenly than in general tuberculosis; and that the wasting and loss of strength are more marked in general tuberculosis than in malaria.

(2) "Malarial cachexia"—the diagnosis in one case of this series—is characterized by irregular fever, marked anæmia, and a much enlarged spleen. Here the diagnosis would hinge on the following points: the degree of anæmia, the size of the spleen, and the blood test. Anæmia is not uncommon in general tuberculosis, but it is rarely so profound as in malarial cachexia. The spleen is not usually *greatly* enlarged in general tuberculosis (although in three cases of the present series it weighed 29, 33, and 48 oz.

respectively, in one case giving rise to a suspicion of leukæmia); whereas in malaria cachexia it is very large.

Acute Mania.

Cornet observes of miliary tuberculosis that, when it begins with violent delirium, it may be confounded with acute mania. In one case of the present series the patient was apparently well when he went to bed on the night before admission, but in the morning he was found to be in a state of active delirium resembling acute mania and accompanied by a temperature of 103° F. He was dead in five days. Such cases are so rapid as to make diagnosis almost impossible.

Delirium Tremens.

General tuberculosis may be confounded with delirium tremens. Tremors, furred tongue, loss of appetite, constipation, or constipation alternating with diarrhoea, enlarged liver, and delirium, are all common symptoms of general tuberculosis as well as of *mania a potu*. The history must be investigated both as regards drinking habits and as regards the possibility of tuberculous infection, and the patient must be examined for old tuberculous lesions. The type of delirium must be carefully studied, as undoubtedly the "horrors" are highly suggestive of alcoholism. Marked emaciation and prostration, dyspnoea and cyanosis, would point rather to general tuberculosis. The problem becomes more complicated when it is remembered that the two conditions may be blended, and that when, as often happens, general tuberculosis overtakes an alcoholic, the delirium may be a mixed effect of alcohol and tuberculin.

Acute Rheumatism.

Cornet quotes a case of Reinhold's that presented a typical picture of erythema nodosum with moderate fever and symptoms suggestive of rheumatism. No such case as this is to be found in the present series, but two cases strongly resembled acute articular rheumatism. In the one the toxæmia was so severe that the patient was dead before

any symptoms pointing to the true diagnosis could come to light. In the other case a bacteriological examination of fluid aspirated from one of the swollen joints settled the diagnosis. A diagnosis can, indeed, generally be arrived at by a careful consideration of the history and the symptoms, by the bacteriological test just referred to, by the therapeutic test of the salicylates, and by the course of the disease.

Malta Fever.

The likeness to acute rheumatism leads us by a natural stage to another disease—a tropical disease—characterized by arthritic effusions. This is Malta or undulant fever. It is recognized that Malta fever has to be carefully distinguished from enteric fever and from malaria; small wonder, then, that in the case of patients who have lived on the Mediterranean seaboard or sailed in Mediterranean waters, general tuberculosis should have to be differentiated from Malta fever. Malta fever is characterized by a peculiarly irregular temperature curve, profuse sweats, rheumatic pains, arthritis, enlarged spleen, constipation, anæmia, weakness, and often by neuralgic symptoms referred to the peripheral nervous system. In general tuberculosis there is irregular fever, profuse sweats are not rare, rheumatic and arthritic symptoms are occasionally found, the spleen is very commonly enlarged, constipation is the rule, anæmia is common, debility is strongly marked, and neuralgia is well represented by the cases of sciatica in the present series. On the other hand, the typical temperature curve of Malta fever, with its intermittent waves or undulations of pyrexia lasting one to three weeks, with an apyrexial interval, is certainly rare in general tuberculosis. Nevertheless, apyrexial intervals do occur in this disease, and a temperature curve might conceivably be produced that was comparable to that of Malta fever. Dyspnoea, cyanosis and pulmonary symptoms point to general tuberculosis. A case that is getting steadily and progressively, though not of necessity rapidly, worse, is probably general tuberculosis. Malta fever is erratic and very liable to relapse, but patients usually recover. There is no therapeutic test as in malaria,

but the blood should be examined for *Micrococcus melitensis* and for the characteristic serum reaction of Malta fever.

Leukæmia.

Some cases of general tuberculosis are not unlike leukæmia. If the spleen is so much enlarged as to constitute a considerable abdominal tumour—as was the case in one patient of this series—this splenic tumour, together with a temperature of moderate elevation, anæmia, dyspnœa, and epistaxis, or other hæmorrhages, may give rise to a suspicion of myelogenous leukæmia. Lymphatic leukæmia is perhaps more often simulated. In this disease there is a moderate enlargement of the spleen, together with enlargement of the glands—features which are common in general tuberculosis. Add to this the moderately elevated temperature, the dyspnœa, the hæmorrhages, the wasting which is often extreme, the course which is nearly always downward, and the possibilities of peritonitis (leukæmic) and of hepatic enlargement (leukæmic) and dropsy; and it will be seen that a case of general tuberculosis might in its clinical aspects follow closely in the lines of lymphatic leukæmia. The diagnosis is settled by the examination of the blood.

TREATMENT.

Of treatment I do not propose to say much. The old school are fairly agreed, I think, in regarding the disease as hopeless. It is not our custom to regard any disease in that light. Nevertheless, I strongly suspect that the great value of homœopathic treatment in this connection is prophylactic—it prevents local tuberculosis from ever becoming generalized. That is doubtless why in our own records there are so few cases (I was only able to find three or four) of general tuberculosis. In particular, the fact that operation is far less frequently resorted to amongst us than amongst our friends of the old school must eliminate many of those cases in which generalization of the tuberculous process is directly attributable to operation.

Dr. BYRES MOIR, in opening the discussion, said it was an interesting fact that, at the November meeting of the Society two years ago, Dr. Hervey Bodman read a valuable paper on "The Curability of Acute Tuberculosis." In that paper Dr. Bodman laid down the principle that any acute form of the disease, whether localized or general, should be taken as descriptive of the cases, whereas Dr. Miller Neatby had stated that four organs should be selected. The author had asked him to speak about diagnosis, but Dr. Neatby had gone so fully into the subject that very little was left for him to say, except that the narration of the cases given brought back to his mind many cases which had been among the most difficult with which he had had to deal in his practice. The author had shown clearly the difficulty of diagnosis in general tuberculosis. Personally he would go further and say that it was impossible, except on *post-mortem* evidence, to give a certain diagnosis of the disease in some cases. With regard to tuberculosis in a case resembling typhoid, he remembered being called to see a girl, aged 18, at about the beginning of the second week of what appeared to be typhoid. The temperature was 103° to 104° F., and the chart was a steady typhoid chart. There was distension of the abdomen, pea-soup stools, bronchitis, and the whole appearance of the patient was that she was suffering from typhoid. He quite confidently diagnosed the case as typhoid. A Widal test was made, which gave a negative result. The case ran a course of three or four weeks. The temperature came down, and he thought the trouble was over. But an irregular type of fever set in, and gradually symptoms of tuberculosis in the abdomen became manifest. The patient lingered on for some months and gradually died of acute tuberculous meningitis. That case taught him the great lesson of the difficulty of correct diagnosis in general tuberculosis, and, looking back, he could not decide whether it was really typhoid or an early tubercular condition. The next case to which he wished to refer was that of meningitis in a man of nearly 60. Most of the cases of that kind occurred in children, but in this instance an elderly patient was suddenly smitten down with acute mania, one of the worst forms of mania he had ever seen. The man died in five days from acute miliary tuberculous meningitis. He had also experienced great difficulty in cases of infective endocarditis. A good many years ago, before much pathological help in these cases was afforded, a patient in the hospital had every appearance of phthisis. There was the usual type of fever, with a temperature running from 99° to 101° F., marked dulness, and an absence of breath sounds at one apex.

The temperature began to run up, and after some time he was able, from the aortic murmur, to diagnose the condition as infective endocarditis. Another case which he wished to mention was one that Dr. Hervey Bodman referred to in his paper. He saw the case twice in consultation with Dr. Bodman, and it bore a great deal on the relationship of influenza and the difficulty of diagnosing it from tubercular conditions. When he saw the patient, who was a man aged 45, for the first time he had a temperature of 102° to 103° F., and he had not lost flesh, although he had been in bed for a week. There was no marked dyspnoea, nor cough, and no indication of the trouble could be obtained from the lungs. There was, however, a very soft, systolic murmur, and the patient had all the appearance of infective endocarditis. When he saw the patient later on, his condition was much worse, and within a month he was dead. The *post-mortem* disclosed acute miliary tuberculosis of the lungs and pleura. An interesting point in the history of the case was that the trouble had followed a sharp attack of supposed influenza, which laid the patient up for a week or ten days, and then for a fortnight he went about his work just as usual. It is a question whether the preliminary attack was influenza. There was slight pleurisy, and, as is nearly always the case in acute miliary tuberculosis, there must have been some focus of tubercle in the body beforehand. It was during the breaking-up period that the acute deposition in the body occurred. Then the question arose of how far the later pathological work helped them in solving the problem. He was sorry to say that practitioners did not get the help in the acute cases that they did in the chronic conditions. Some pathological work at the present time had to be taken with a great deal of caution. A few weeks ago he was treating a lady with some bladder trouble and vaginal discharge. Wishing to be sure about the nature of the latter condition, he sent a diphtheria swab to the nursing home, told the nurse to dip the swab in the discharge, and send it back to him. Somehow the swab was sent to the laboratory without any letter, and the same afternoon he received a telegram saying, "Diphtheria bacilli separated." On writing to the laboratory, the explanation he received was ingenious but not satisfactory. Coming to the question of tuberculin, Koch's original tuberculin reaction could not be relied upon in fever. In eight out of twelve cases of typhoid the Calmette reaction in the conjunctiva was obtained. He did not think, either, that the opsonic index could be relied on much. It was sure to be high because auto-intoxication was going on, and definite information

which could be relied upon could not be obtained in acute cases. Coming back to the question of treatment, of late very much better results were being obtained in the chronic forms of tubercle, in fact, practitioners were now beginning to look upon tuberculinum in some form or other as a specific. When the nosodes were first brought out he strongly objected to them, and for years would have nothing to do with them, thinking it was a filthy habit to put such things into the human body, although in such infinitesimal doses. A reference to Dr. Burnett's book would show in a very striking manner how very much ahead of the time he was. Burnett was working for five years on the subject before Koch brought out his treatment. The second edition of Burnett's work came out when Koch had failed, and in that edition he said that, although they had just seen the failure of Dr. Koch's treatment, it would return as soon as members of the orthodox school learned to use the infinitesimal dose. He felt it was a duty upon himself to mention those facts, as he thought homœopathists ought to claim that they had been the leaders in that form of treatment. At present there was no specific for the acute condition, but he threw out the suggestion that in those cases better results would be obtained by using the bovine tubercle. With regard to their own medicines, in children calcaria was a most valuable remedy in meningitis, and another drug which he had always used with advantage was lachesis, while phosphorus and iodine were also valuable remedies.

Dr. BLACKLEY said the paper had suggested to him how very often he might have had his attention centred upon the local manifestation of tuberculosis, usually of the lung, and have failed to appreciate the fact that the tuberculosis was, in fact, a generalized one. This was probably the experience of many present. Diseases that were manifested by gross lesions could be appreciated, but a disease which was all-pervading was frequently neglected. There was one thing that did not seem to be insisted upon nowadays in the students' study of tuberculosis which was very much to the fore thirty or forty years ago. It was known as Louis' law. Students were taught that if there was tuberculosis of the abdomen and the patient was beyond the age of puberty, they might be absolutely sure that the disease would be found in other places as well. Nowadays one did not hear even the title of that law referred to. In the investigation of the objective symptoms in a case of tuberculosis the author had, very properly, referred to such points as should be borne in mind, but he had omitted to mention one important factor. In enumerating the

objective symptoms to be borne in mind in investigating a case of tuberculosis the author had omitted all reference to the necessity for an examination of the vesiculæ seminales, which were, perhaps, quite as frequently involved as the testicles. The vesiculæ seminales were very frequently so extensively disorganized as to be for all practical purposes useless. He had seen a few cases where operation had been resorted to and the diseased vesicles removed, not, however, with the dire effects which seemed to have followed upon operations of all kinds in the cases to which the author had referred. He saw a patient about eight years ago—a young man, aged 30—who had the seminal vesicles removed by Mr. Godlee, and who was now a picture of rude health, in fact he had never looked behind him since his tuberculous vesiculæ were removed. Dr. Moir had referred to the interesting question of the relations between influenza, enteric fever, and generalized tuberculosis. Personally he (Dr. Blackley) appreciated the difficulties of differential diagnosis, which were frequently extreme. There was always, however, a little help to be obtained from the fact that epidemics occurred. Twenty years ago this autumn the last influenza epidemic appeared in England, and medical men had had a good deal of experience with the disease since then. They had seen it constantly run through families, and in some cases it had been of the lingering type where it was extremely difficult to say positively whether it might not be generalized tuberculosis. Medical men did not have the same amount of experience of enteric nowadays that they used to have. Epidemics were few and far between, but not infrequently, if medical men took the trouble to ascertain the history of their patients, it was possible to trace the disease back to accidental infection, as, for instance, during travel. He had seen a few cases of what was at first thought to be general tuberculosis which had turned out in the long run to be enteric fever contracted during a holiday from the drinking of infected milk. Another point which must not be forgotten was that enteric might exist in a patient who was predisposed to tuberculosis or who belonged to a tuberculous family, but he had seen a few cases of death from tuberculosis which had followed an attack of enteric fever brought on from infection from a known source. The same thing might be said of all severe febrile diseases. In connection with the symptomatology of the subject he had often noticed that *palpitation* was a constant and troublesome symptom in patients suffering from chronic tuberculosis of the lung, even where the mischief was not very extensive. If a medical man suspected tuberculosis of the

lung, but could not locate it, palpitation on the slightest exertion was a symptom which would help to keep attention riveted on the possibility of local trouble. Personally, he very much objected to the use of the terms tuberculin and bacillin almost indifferently. He believed Dr. Burnett treated the two as synonymous. In his opinion they were very far from it; while they knew something about tuberculinum, everyone would like to know more about bacillinum.

Dr. MOIR stated that the reason Dr. Burnett adopted the name bacillinum was because it contained the bacilli.

Dr. BLACKLEY said it was precisely for that reason that he emphasized the fact that the terms tuberculin and bacillin should not be used indifferently; the latter contained bacilli (of various kinds), whilst tuberculin, as now prepared, was a pure toxin and contained no bacilli at all.

Dr. ORD, after expressing his regret that there was such a small attendance to listen to the author's exhaustive and admirable review of the subject and thanking Dr. Moir for his very helpful remarks, said that one point which clearly came out from the paper and the discussion was the extreme difficulty, and even impossibility, of diagnosing the condition. He had been reminded of cases that had puzzled him very much during his attendance on them in which tubercular symptoms seemed to be present. Before the modern methods of diagnosis were perfected, and before tuberculinum was used as it was at present, many such cases he had failed to recognize. In the next place, he wished to emphasize the great danger which seemed to exist of stirring up latent tubercle by surgical operation. That emphasized the importance of using drugs as much as possible in tubercular cases, and so avoiding operation. All present had seen cases of simple removal of glands or the opening of abscesses which had, in tuberculous patients, had lamentable results. It would appear in these cases that tuberculosis arose from the stirring up of an unsuspected latent focus of tubercular deposit somewhere in the body. It seemed to him that the relationship of influenza, and possibly even of typhoid, to the condition was that the attack of influenza lowered the resistance of the body to the tubercle bacillus, and from an unsuspected focus the infection then spread throughout the whole system. If that were true it explained the circumstance that tubercle very often followed a bad attack of influenza. Phthisis often followed influenza, and probably could be explained in that way, and he did not see why typhoid should not act on the same principle, bearing in mind the case to which

Dr. Moir had referred, which he thought had probably been one of true typhoid. He (Dr. Ord) had a case under his care at the present moment which he was beginning to think might be one of general tuberculosis, and his fears had been confirmed by what he had heard that evening. A young married woman came to the Bournemouth Dispensary two months ago with the history that after an attack of influenza six months previously she had never recovered her health. She was exceedingly emaciated, very anæmic, and had pains which she thought were due to rheumatism in her legs. She had become increasingly weak, and was very ill when he saw her. He sent her home to bed, and then examined her chest. He found that she had no cough, but some tubercular deposit and infiltration in the upper lobe of the left lung. Her evening temperature was 102° F. Under treatment she improved to a certain extent; the anæmia was somewhat less, but she did not gain flesh, although the lung condition improved; in fact she was rather weaker than before, and he thought there were somewhat ominous symptoms of general tuberculosis. He had not tried her urine with Ehrlich's diazo test, but he began to wonder whether it was not possible that this was one of the subtle cases of general infection which the author had described.

Dr. EADIE said that six months ago he saw a case of a child suffering from paraplegia, the cause of which could not be ascertained for two months, and then a psoas abscess was found. He presumed the cause of the paraplegia was that the abscess had been pressing on the spinal cord. Recently he saw another case in which the paraplegia had been of twelve months duration, and yet it had not been diagnosed till twelve days ago, when an abscess causing pressure was discovered. He desired to ask the author whether, in the cases he mentioned, the possibility of localized disease of the cord was excluded. The author's references to cases in which retention of urine occurred were very interesting, and brought to his mind the fact that he lately saw a boy who had been catheterized for retention of the urine, and who had tuberculosis of the peritoneum. With regard to the question of contra-diagnosis on a diagnosis of urethral obstruction, it was not only in the case of tubercle that such results occurred. In one of the large London hospitals a physician recently demonstrated to his class a patient as a typical case of cancer of the pylorus. An hour later one of the surgeons took round the men going in for the Final Fellowship examination, and demonstrated the same case as undoubtedly one of pancreatic

cyst. The case was operated on two days afterwards, and was found to be carcinoma of the liver. He wished to mention one of the most striking cases he had ever seen of the result of tuberculin treatment. The case was under a surgeon at one of the London hospitals, and was successfully operated on by him about three months ago for abdominal growth. Some weeks after the operation the scar showed the appearance of being infected with lupus. The temperature went up to 105·5° F. every night, but dropped again every morning. This continued for some weeks. The surgeon did not think there was enough in the scar to account for the temperature. The patient was examined by four or five physicians and gynæcologists, and they could not find anything to account for it. On the presumption that it might be a case of latent tuberculosis, a dose of tuberculin was given internally—allopaths were now coming into line with the homœopathic method of administration. The day afterwards the patient's temperature was normal, and has remained so since. The surgeon said he had never seen such a case before. Then Mr. Eadie wished to enquire whether it was possible that the cases which were often diagnosed as tubercle following enteric fever might really be miliary tubercle from the first, which got into a subacute or chronic condition. There was no doubt, as Dr. Ord had stated, that tuberculosis was frequently stirred up by operation. One saw this, especially in cases of instrumentation where there was tuberculosis of the bladder.

Dr. GRANVILLE HEY, after adding his quota of thanks to the author for his admirable and instructive paper, remarked that from what had been already said it seemed it was not necessary to go outside their own hospital for experience on the subject. A little while ago there was in the wards a case that Mr. Shaw had operated on several times for tuberculous hip. The patient was sent to the Convalescent Home at Barnet, being healed to a certain extent, although she had three discharging sinuses. The patient returned to the hospital apparently considerably improved in general health, but with no sign whatever of the closing of the three sinuses, one of which was a very wide-mouthed one. As the sinuses showed no signs of closing after a further period of treatment, he (Dr. Hey) hit upon the unlucky decision of scraping them again. He scraped them thoroughly, with the result that although they closed up very rapidly to a certain point, from the time of the operation the patient gradually lost strength. As Dr. Blackley had pointed out, one of the most prominent symptoms, apart from weakness and emaciation, was constant tachycardia.

Miliary tubercle was suspected because of rapid breathing ; there was no marked dyspnoea, but in spite of all that could be done the patient gradually sank. Unfortunately an autopsy was impossible, and there were no means of confirming the diagnosis, but he had no doubt whatever it was a case of general tuberculosis caused by the scraping of the sinuses. In another case, a man came to the out-patient department, complaining of stiffness and pain in his hip-joint. He said he had been at various other hospitals complaining of his hip, and had been variously treated for sciatica, rheumatism, and tuberculous hip-joint. He was treated according to his symptoms for some time, and made a slight improvement ; and as observation showed no temperature that indicated tubercle, and there were no other signs of tubercle, he was anæsthetized and the adhesions of the hip-joint were broken down. The patient partly recovered the use of the hip-joint, but unfortunately he got weaker and weaker and thinner and thinner. What eventually happened to the patient he did not know, because when he got exceedingly weak, his wife took him away from the hospital. Personally he thought it was a case of general tuberculosis started by breaking down the adhesions of the hip-joint. The paper had brought out the probable explanation of the connection between influenza and tubercle, and of a fact that Dr. Clarke mentioned some years ago in one of his lectures. Dr. Clarke stated that for the long-lasting weakness which was often met with as the after-effects of influenza, tuberculinum gave splendid results in some cases, whereas if influenzinum was given it only served to aggravate such. He had often wondered what was the relation between tuberculinum and such cases of influenza, and thought it most probable, from what had been said that evening, that the treatment benefited the cases for the reason that tubercle and influenza were very closely associated. With regard to Dr. Blackley's remarks on the subject of Burnett's bacillinum and Koch's tuberculinum, he thought he was right in saying that Koch's original tuberculinum contained the dead bacilli as well as the toxins ; it was only his new tuberculinum that did not contain them. Burnett's bacillinum, in addition to containing tubercle bacilli, contained other organisms, present in the sputa, and from the antitoxin point of view, theoretically it had an additional advantage in that respect, although in practice one seemed to get better results from tuberculinum pure. Bovine tuberculinum, to which Dr. Moir had referred, was now prepared in homœopathic attenuations by both Epps and Ambrecht Nelson, and he thought from what he had seen of its use it gave

better results than the ordinary human tuberculinum. He desired to ask the author's opinion on an old idea that held the ground for many years as to the want of relationship between rheumatism and tubercle. It was very prominently taught for a number of years in Edinburgh that a patient who suffered from rheumatism was very unlikely to suffer from tuberculosis, and it would be interesting to know whether the author's experience substantiated or contradicted that idea. In connection with Dr. Eadie's reference to the mouth administration of tuberculinum, he (Dr. Hey) recently heard that the head of one of the sanatoria—he believed Midhurst—although he was an avowed allopath, insisted on all tuberculinum being given by the mouth, having given up injection altogether, as he obtained just as good results by the new method.

Dr. JAGIELSKI thought it would be of interest if the author would state his opinion on the question of the hereditary predisposition of patients to general tuberculosis. In these modern times of bacteriology the study of the nature of the life-history of the bacillus of tuberculosis has become a speciality of scientific medicine. Indeed, it has become a duty for the eradication of tubercular disease to make all efforts to kill off the germ by "tuberculinum" treatment, rather than to uphold heredity as the predominating factor with an admission of parental responsibility bequeathing mental, moral or physical predisposition, and to arrange our treatment accordingly. The symptomatology of the disease had been excellently stated. When a practitioner had not arrived at an exact conception of the disease with which he had to deal, it was a good plan to fall back upon the homœopathic principle of dealing with the symptoms which were regarded as the most urgent. Dyspnoea had always given him great trouble. This symptom occurred in many patients, particularly in old people, and the best treatment then was a systematic daily breathing exercise with massage of a special mode. In some cases with which he had dealt, it was unexplainable how the dyspnoea became such a prominent symptom; but when combined with rheumatism, gout, joint symptoms, sciatica, &c., he had found that koumiss and massage treatment gave wonderful results. It would be too long to describe how the koumiss and sour milk treatment, which he had introduced in this country in 1870, had been accepted in all its varieties, and how Professor Metchnikoff, the great apostle of *healthy* bacteria in *ill-health*, had shown the utility of the sour milk prepared from pure cultures of lactic bacteria in his recent writings. These bacilli may be swallowed in a pure culture without milk in persons who cannot

take milk. The belief that all bacteria are harmful must thus be abandoned.

Dr. WEIR (a visitor) said that a lady came into the hospital on Saturday with an anal fistula which had been scraped and stitched up. The patient now had phthisis. In his opinion, it would have been much better to have left the fistula alone, because once it was operated on latent tuberculosis was stirred up in the body. The fistula had been Nature's endeavour to get rid of the tuberculosis in the patient, and only damage had resulted from interfering with it. On the other hand, it might be argued that if the patient had not been treated by operation she would have suffered from degeneration of the liver. In his opinion, the totality of the symptoms must be borne in mind and some indicated drug given, and in all probability it would be found that the fistula would heal. If it was found that a fistula or sinus was healing under medicinal treatment, a practitioner could be quite sure that the remedy he was using was the right one and that the patient would recover. Thus the giving of a remedy might become an important help in diagnosis.

Dr. MILLER NEATBY, in reply, said he was extremely obliged to the members for the kind things they had said about his paper, and he was sorry the time was so late that it would be impossible for him to completely answer the many questions which had been asked. In reply to Dr. Moir, he did not understand that Dr. Bodman's paper was on generalized tuberculosis; it was on acute tuberculosis, whether in the meninges, or in the peritoneum, or in the lungs, but he did not understand that the cases mentioned were suspected of being at all generalized. With regard to the difficulty of diagnosis, he perfectly realized that many cases were absolutely impossible of diagnosis. Some parts of the paper which he had been unable, owing to shortness of time, to read might have helped to throw a little light upon the diagnosis. For instance, the very irregular nature of the temperature was usually a marked feature of general tuberculosis in adults; it was very seldom that the sustained typhoid temperature was obtained. The case Dr. Moir had mentioned, where the typhoid temperature was followed by the irregular temperature of general tuberculosis, was a very instructive one. The inverse type was seen in many cases of general tuberculosis, namely, the type in which the temperature was up in the morning and down in the evening, and he thought that had some diagnostic value. He thoroughly agreed with Dr. Moir's remarks as to the value, or want of value, of Calmette's tuberculin test and the unreliability of the opsonic

index in the present state of knowledge. He was disposed to think bovine tuberculin might often be of use where the other kind of tuberculin was not, because present evidence tended to the establishment of the theory that tuberculosis was more often of bovine origin. At any rate, it was remarkable how opinion had swung round from the old air-borne theory to that of ingestion through the alimentary tract. He was afraid he had never heard of Louis' law, to which Dr. Blackley had referred, and he rather doubted its truth. There was no doubt, as Dr. Blackley said, that the vesiculæ seminales ought to be investigated by a rectal examination. The suggestion was new to him that there might be some moral effect produced by tuberculous invasion of the vesiculæ seminales. One had heard of the effects of enlarged prostate, and it would be interesting if anybody could throw further light on the question. With regard to the question of the effects of operation, he did not mean it to be understood, as Dr. Blackley evidently thought he did, that all operation was to be avoided because of the possibility of dissemination of tubercle throughout the body. The cases he had cited had that effect, but there were many cases in which no deadly results of the kind followed. There was, however, a danger in operations, and it had been very well illustrated by Dr. Hey's and Dr. Weir's remarks. Some time ago Marmaduke Shield, at St. George's, used to warn students against tampering with anal fistula if there was any reason to suspect tubercle or the tuberculous diathesis. Dr. Blackley had mentioned palpitation and tachycardia. It was one of the symptoms referred to in the parts of his paper he had not read;¹ the pulse-rate was accelerated out of proportion to the temperature. The temperature in general tuberculosis seldom went much above 101° or 102° F., but the pulse as a rule was extremely rapid, and on the slightest exertion it became still more so. Dr. Eadie had enquired whether the question of localized pressure on the cord had been taken into account in considering the question of the loss of power in the legs. There was no evidence obtained at the *post mortem* of pressure on the cord, and he could not gather from any of the records that myelitis was suspected. He thought it was quite possible that cases of enteric which had got well had been mixed with tuberculosis, or it was possible there might from the outset have been tuberculosis on which typhoid was engrafted. Dr. Hey had referred to tuberculin as a remedy for the after-effects of influenza. He thought Dr. Hey was right in saying that the probable explanation was that the two diseases,

¹ The whole paper is printed herewith.

influenza and general tuberculosis, in some of their types, at any rate, were very similar, and it was natural that the remedy should be a similar one, according to their great law. With regard to the relationship of rheumatism and tubercle, he did not fancy that rheumatism excluded tubercle. Of course, associated with rheumatism, particularly in children, there was very often endocarditis and mitral disease. It was generally allowed, he thought, that the clogging up of the lungs which followed mitral disease prevented the tubercle bacillus from getting a footing.

THE SELECTION OF THE REMEDY.¹

BY DAVID RIDPATH, M.D. EDIN.

THE subject of the paper to-night is "The Selection of the Remedy." We find full instructions as to how this object is to be attained in Hahnemann's "Organon of the Healing Art." In the first paragraph of this monumental work we have it stated, "The physician's high and only mission is to restore the sick to health, to cure, as it is termed." Now, here is an aphorism on which you might say all are agreed, but on fuller examination many considerations are involved. The old-school physician's mind revolves round the idea of the disappearance of a pathological state, *e.g.*, the disappearance of an eruption from the skin he would call a cure, or, if of constipation, the aperient action of the bowels. Also for some diseases of the knee-joint he would remove the joint by amputation, and if the patient survived he would call that a cure. These conditions—viz., the skin eruption, tumours, constipation, diseased joints, &c.—however, are not the disease, they are merely the ultimates or results of the sickness, or "out of healthness" of the individual patient. What we have really to treat in order to cure the patient is *the disordered vital force* which is the *cause* often of pathological conditions and appearances.

This disordered vital force is the primal cause of sickness, and the manner in which we are to effect the cure of the

¹ Presented to the Section of Materia Medica and Therapeutics, December 2, 1909. Dr. Ridpath, as a visitor to the Society, was introduced by Dr. R. M. Le Hunte Cooper, Secretary to the Section.

sick is by taking into account the whole of the symptoms—mental, moral, and subjective—of the patient, and from these finding a remedy which is paralleled by or contains all, or the greater number, of these symptoms. By giving this remedy the appearance of these ultimates, or results, or pathological states, is often prevented; and when the vital force receives the necessary stimulus in the proper direction the patient is cured.

Frequently we have to prescribe for cases in which the ultimates have already developed. In such cases, when the similimum has been prescribed, the symptoms disappear in the patient, if it is a curable case. This does not mean that the ultimates of the disease have likewise disappeared. They may not have done so, *e.g.*, in painful varicosis of the leg the similimum can remove all the pain and discomfort, but it cannot always remove the varicose condition of the vein. It may remove all the pain and bleeding of hæmorrhoids and yet not always remove the little growths. It may remove the pain caused by a carious tooth, which, however, it cannot heal. In such cases the surgeon may be called in, but as the disordered vital force has been set going in the right direction there is often no necessity for his interference, for if the patient has no symptoms he is best left alone. In the great majority of the cases with which we have to deal in practice, the similimum cures the ultimates too, *e.g.*, in pneumonia, pleurisy, adenoids, hæmorrhoids, &c.

It is an erroneous assumption that tissue changes constitute the disease. The doctrines of homœopathy make it apparent that morbid anatomy, no matter where it occurs, must be considered a result of the disease. This is also apparent when we consider the matter philosophically. "The Organon" of Hahnemann is a most elaborately and fully worked up code of directions for the curative treatment of patients by an infallible system of medical treatment. A knowledge of the principles contained in the "Organon" is necessary to the successful practice of homœopathy.

Now, in order to select a remedy, we must first proceed to elicit a complete picture of the condition of the patient. For this, full instructions are given in the "Organon,"

paragraph 84, which tells us how this examination is to be carried out. This case-taking is one of the most important things which the medical man has to carry out and requires the greatest care. It is, indeed, an essential. Volumes could be written on this subject, but the time at our disposal to-night requires that the matter be given only in broad outline.

Hahnemann insists on the necessity for the physician to write down all the symptoms of the case. The physician tells the patient to describe his symptoms in his own words, merely telling him to describe them slowly, to enable the physician to have time to make notes of all that is said in the patient's own words. The friends of the patient are then requested to state what they know or have observed in the patient, the physician keeping silence himself unless they wander off to irrelevant matters, when they must be pulled up and made to keep to the matter in hand. When the patient and friends have finished what they have to say of their own accord, the physician reverts to each particular symptom in the following manner, *e.g.* : At what time did this symptom occur? Was it previous to his taking the medicine he was using? While doing so; or only some days after leaving off the medicine? Did the pain come in fits and starts and by itself, or was it continuous, or accompanied by any other symptoms? How long did it last and in what position of the body was it worst? And so on. Many details necessary to be observed in the examination of the patient are given in paragraph 84 and succeeding paragraphs. Then in paragraph 153 directions are given as follows : " In this search for a homœopathic specific remedy, that it is to say, in this comparison of the collective symptoms of known medicines, in order to find among these an artificial morbid agent corresponding by similarity to the disease to be cured, the *more striking, singular, uncommon* and *peculiar* (characteristic) signs and symptoms of the case of disease are chiefly and almost solely to be kept in view, for it is *more particularly these that very similar ones in the list of symptoms of the selected medicine must correspond to*, in order to constitute it the most suitable for

effecting the cure." These more striking, singular, uncommon and peculiar characteristic symptoms are to apply to the *patient*, not to apply to any peculiar *local symptom* or *keynote* that may be observed.

In this country there is no college or school where a person wishing to qualify as a medical graduate or licence holder can be taught homœopathy. What happens is that all legal qualifications to practise medicine in this country are obtained from the orthodox medical schools. What the student hears there of homœopathy, if that name should ever be mentioned, is in derision of the cult, and its denunciation as quackery. Therefore, anyone who, after qualification, desires to study homœopathy must do so by his own efforts. Here he has the initial difficulty that he has been taught to consider all patients to be suffering from some named disease from which he usually makes a start, and thus he is handicapped in the beginning. This is an entirely wrong way of going about the selection of the remedy. What Hahnemann recommends is to treat the *patient* and not the *disease*, and for this purpose he gives directions for taking note of all the symptoms of the *patient*, that is the totality of the symptoms.

We now proceed to consider the relative value of the various symptoms. Thus the general symptoms are of the highest value. General symptoms are made up of what the patient states or predicates of himself, *e.g.*, "I am cold," "I am frightened," "I was wakeful last night," or "I dreamed," "I am irritable or cross," "I am restless," "I feel worse or better in a warm room," also the character of pains, *e.g.*, stitching, burning, throbbing, &c. Thus general symptoms, or those that affect the whole body, are of very much higher rank than particulars which only relate to special organs, so much so that any number of particular symptoms can be overruled by one strong general symptom. In the highest rank must be placed all mental symptoms if at all well marked, and of these all symptoms of the will and affections, including desires and aversions, also irritability and sadness, are the most important. Of less importance are disorders of intelligence, while those of the memory rank lowest of all the mental symptoms. Among the general

symptoms are to be included those in connection with sleep, dreams, the menstrual state, also the effects of the weather, and sensitiveness of the patient to heat and cold. We frequently find on examining the particular organs that some symptom or modality runs strongly through them all and may be predicated of the patient himself, *e.g.*, when all the particular symptoms are aggravated by motion; so that here we have a general made up of particulars. The skin being the outermost part will yield the least important symptoms. A tumour or other pathological condition is no guide to the curative remedy, for in the first place it is not the disease itself but merely a result of the disordered vital force, and in the second place provings of remedies have not been carried so far as to produce pathological appearances of this type.

We are told by Hahnemann that we are to select the remedy by what he calls the totality of the symptoms. I here may call to your notice the analogy by which the botanist classifies a plant which comes under his observation. He examines the whole plant, "the totality of the plant"—the roots, the stem, the leaves, and their arrangement and venation, the sepals, the stamens, the pistil, and their relative positions, and the fruitification. After having considered all these particulars, he is able to refer the plant to the class to which it belongs, and to give it its specific name. In like manner the physician, after taking into consideration all the symptoms of a sick person, is enabled to compare it to a substance or remedy which has produced a like series of symptoms in its proving.

One of the principal causes of failure to get the proper remedy in a case of sickness is the insufficient care taken in collecting the symptoms of the case. We are all so apt, on account of our former medical teaching, to start off from the name of a disease, while, on the contrary, we ought to start off by taking down the general symptoms of the patient according to the instructions given by Hahnemann and paying little attention to the morbid anatomy and pathology, which are of little use in the selection of the remedy.

Here I may be allowed to refer to one subject of interest, *viz.*, "Diagnosis of Disease." The true Hahnemannian

makes a thorough examination of his patient by all modern methods. By this means he is able to name the disease according to the lists of diseases furnished by the Registrar-General, and in this he satisfies the requirements of the patient and friends, who are often delighted to have the name of the condition from which the patient suffers. But supposing there are no pathological or objective symptoms, the homœopath can still go ahead and proceed to cure the patient by the aid of consideration of the totality of the symptoms. The subjective symptoms are to the homœopath quite as important to investigate thoroughly as are the objective ones; in fact they are of greater importance from the point of view of the prescription. Still, when possible, the doctor must make a diagnosis for the patients and their friends, otherwise they are apt to consider that you do not understand their case. Moreover, the man who can go to a case and treat it successfully when subjective symptoms alone are present has prevented the appearance of pathological deposits, has prevented the appearance of the ultimates of disease in the body. His prescription has set the disordered vital force to go in the right direction and to get the disordered functions into order. In Dudgeon's 1880 translation of Hahnemann's "Materia Medica Pura," vol. i., p. 18, the master gives two illustrations of the method of selecting the remedy. A study of that article as well as of all others of his writings is most essential to the student who elects to practise homœopathy, and will well repay the study. The first volume of chronic diseases is most instructive and the "Organon" is the Bible of the homœopath, and these works contain his discovery of the miasms, psora, sycosis, and syphilis, and their treatment.

I have written out the workings of a few cases which have occurred in my experience for the consideration of the audience. In Case 1, M. H. is worked out in two ways: The first, beginning from particulars to generals—the wrong way, and leading to the selection of sulphur, the administration of which was not curative, and made the patient feel so much worse that she stopped taking the placebo, which followed the single dose of sulphur. The second way shows

the starting from generals and coming down to particulars, and not including the actual diseased condition complained of, but which nevertheless was cured by the remedy selected—viz., calc. c., 2 c., and calc. c. 1 m.

CASE 1.—PSORIASIS PALMARIS.

Contrast Results of working from Particulars to Generals and from Generals to Particulars.

M. H., aged 46, widow, multipara.
 Menopause ten months ago.
 Has psoriasis palmaris.
 Fissures and cracks in hands.
 Heat and itching of hands.
 Restless at night.
 Waking frequently.
 Irritability.
 Pressure on vertex.
 Coldness of thighs.
 Feet cold and hot.
 Distension of abdomen.
 Numbness of fingers and toes.

Workings from Pathological State (Particulars) to Generals (Wrong Method).

Psoriasis palmaris, 977.¹—Crot. h., kali. s., lyc., ntr. s., petr., phos., psor., selen., sulph.

Itching of Palms, 1004.—Petr., selen., sulph.

Heat of Palms, 992.—Petr., sulph.

Numbness of Fingers, 1018.—Sulph.

Heat of Vertex, 124.—Sulph.

Coldness of Thighs, 945.—Sulph.

Gave one dose of sulph. 50 m, and placebo.

A week after she said that the medicine made her so much worse that she stopped taking the powders (sac. lac.).

At the end of September I worked out the case again, [this time from generals to particulars, and gave calc. c., 2 c.

Calc. c., 1 m, was given a week after.

General improvement followed rapidly, and she is now well.

¹ The numbers refer to the pages in Kent's Repertory.

*Workings from Generals to Particulars (Correct Method).**Irritability*, 57. } Acon., aur., calc., camp., carbo. an.*Heat of Vertex*, 124. } Cham., chel., coc. c., corn., crot. h.,
daph., eupi., grap., grat., hep., hyper., lach., laur., med., mez.,
ntr. c., ntr. p., ntr. s., nux v., phos., tarent., sulph., thea.*Anxious Dreams*, 1202.—Acon., aur., calc., carb. an., cham.,
crot. h., eupi., grap., hep., hyper., lach., laur., mez., ntr. c., ntr. p.,
ntr. s., phos., sul.*Waking Frequent*, 1221.—Acon., aur., calc., carb. an., cham.,
grap., hep., lach., mez., ntr. c., ntr. p., phos., sul.*Numbness of Fingers*, 1018.—Acon., calc., carb. an., cham.,
grap., hep., lach., ntr. p., phos., sul.*Numbness of Toes*, 1022.—Acon., calc., phos.*Coldness of Thigh*, 945.—Calc., phos.*Itching Palms*, 1004.—Calc. c.

If the cure of psoriasis by this medicine were well verified by other cases it would enable calc. c. to be placed after the rubric psoriasis of the palm. In this manner symptoms which are not produced in the provings of medicines, because not pushed far enough, but which are cured by the similar remedy, are called clinical symptoms and become of value. When the case is progressing to cure, the disordered symptoms should disappear from within out from above downwards and in the reverse order to that in which they appeared, *i.e.*, that which appeared last should disappear first, and so on in this order. Among the many causes of failure in the treatment of patients I give a few. (1) Bad case-taking. This is the most frequent cause of failure with the neophyte in the practice of homœopathy and often arises from beginning with particulars instead of generals. With a practised hand a good keynote is often of great service with a man who is well up in his "Materia Medica," which knowledge enables him to be sure that all the generals can be included in the remedy selected. (2) Pathological prescribing, *i.e.*, starting from the ultimates, the results of the disease, instead of from the disordered vital force of the patient. (3) Giving the wrong potency. This is a difficult subject on which to lay down rules. In practice I find that the more sensitive the patient and the more carefully the

case is taken the more effective are the higher potencies. (4) Another very common cause of failure is the too frequent repetition when the correct remedy has been given; the patient's symptoms and the progress of the disease must be carefully watched and no more medicine given until the remedy has ceased to act, after which the patient's symptoms must again be carefully recorded, those which have disappeared struck out, and note made of what fresh ones may have shown themselves, and the indicated remedy administered, whether it be the same or a different one. In acute diseases it is comparatively easy to determine when the last dose has exhausted itself, by means of the general appearance and mental state of the patient and also by the pulse and temperature. In chronic cases much more care and more accurate observation is found to be required. (5) Alternation of medicines, which mixes up the symptoms confusingly and spoils the case. (6) The external treatment of diseases with local symptoms, unless they are the results of injuries, is always injurious (paragraphs 185 to 203, "Organon.") "The use of camphorated oil for lubrication is always injurious and most reprehensible, as camphor is an antidote to almost all medicines."

CASE 2.—BRACHIAL NEURALGIA.

Female, aged 47, September 18, 1892. Patient has suffered from severe burning pain of whole of left hand and forearm and tingling of the fingers of the left hand. Patient is a widow, dependent on her own exertions for a livelihood, and goes out by the day to do washing and housework. The pain is worse when she has had the hand in water and when washing, and at night is so severe that she cannot lie in bed but must get up and walk about, moving the arm to get a certain amount of relief. There is a sensation of pressure on shoulder like a heavy weight. She is always worse in wet weather.

Selection of Remedy.

Burning Pain.—Under this rubric Bœninghausen's Repertory gives the following remedies in the highest rank: ars., arum, bry., carb. v., caust., euphr., iris, merc., nat. m., phos., phos. ac., rat., rhus, stann., sulph., sep., sil.

Numbness of Forearm and Hand.—Bry., caust., euphr., merc., nat. m., phos., phos. ac., rhus, sep., sil.

Water (Washing) agg.—Bry., caust., merc., phos., rhus, sep., sil.

Motion of Affected Part amel.—Rhus, sep.

Of these two remedies of probable utility to which the list has by elimination been reduced, I was led to choose rhus, which appeared to me, from my knowledge of its characteristics, to be the similimum. Moreover, it had the further symptom, sensation of there being a heavy weight on the shoulder. There was also the very strong modality of amelioration from motion. I therefore gave one dose of rhus t., C.M.

September 21.—The patient feels much better, and has been able to sleep for the greater part of each night since the 18th. In about six weeks she was quite well and able to follow her occupation.

CASE 3.—SPINAL NEURALGIA—LACHESIS.

Female, aged 28, married, two children, aged 3 years and 1 year. This patient complains of having for three years suffered excruciating pain in the middle of the back, resembling, according to her idea, rheumatic pain, though she had never suffered from rheumatism.

The pain was more intense on movement and on waking. She cannot lie on the back, as that position aggravates the pain. She has been subject to "bilious sick headaches" for twelve months. This kind of headache is a pressing pain on the vertex, accompanied by dimness of sight. The headaches and the spinal pain alternate. She feels the clothing very tight round the neck.

Selection of the Remedy.

Rheumatic Pains in Back, agg. lying on back, 885 and 1333.—Acon., ars., bar. c., bell., bry., cham., dulc., lach., nux v., ran. b., rhus t., sulph.

On Waking agg., 1369.—Acon., ars., bar. c., bell., bry., cham., dulc., lach., nux v., rhus t., sulph.

Pressing Pain Vertex, 209.—Bry., lach., rhus t., sulph.

Heaviness or pressing pain in vertex felt on waking is one of the prominent and very characteristic symptoms of lachesis, as is also the feeling of constriction round the neck, so that the lachesis patient must unloose everything encircling the neck.

In this case I observed that the patient had undone the brooch fastening the neck band of her dress, which she had felt very tight.

As a result of these workings, and of my general knowledge of the genius of lachesis, I administered one dose of lach., C.M., and gave S.L. thrice daily.

When next seen, one week afterwards, she was free from all pain and discomfort, and felt that she had regained the youthful vigour which, though only 28 years of age, she had previously lost.

CASE 4.—RENAL CALCULUS—LYCOPodium.

June 7, 1907. F. C., aged 31, bookkeeper in mercantile house. Complains of having been unwell for a long time, during which he had been under much medical treatment, and he had been told that he was suffering from renal calculus for which he would have to be surgically operated upon. During [this attack he was kept continually under the influence of morphia hypodermically, "which, however, did me no good; indeed, quite the reverse, there being no easing of the intense pain, and then the morphia making me sick." His first outing was to see me, as he did not like the idea of being operated upon. On this date I have entered on my case book as follows:—

Dull, aching pain left hypochondrium for months.

Sharp, sticking pain from left loin down to pubis.

Last year he had a fall down a trap, and thinks he may have strained himself.

Urine frequently bloody.

Once had red sediment in his urine.

Alternate diarrhoea and constipation.

Desire to take deep breaths.

Dull ache for months down outer left thigh and leg.

Sensation of throbbing internally; conscious of heart beating.

Borborygmi.

Heat of back.

Right hypochondrium sore to touch.

Appetite easily satisfied.

Urine, intermittent flow.

Must wait a long time for urine to start. Retarded.

With these symptoms I at once turned to Kent's Repertory with the following result:—

The numbers indicate the page in Kent's Repertory, 2nd edition.

Pulsation Internally, 1353. } Acon., alum., aur., bor., bry., cact.
Desire to Breathe deep, 760. } Calc., calc. p., caps., carb. v.,
 caust., chin., crot. t., glon., ign., lyc., merc., mez., mosch., ntr.s.,
 nux. m., par., phos., ran. b., sang., seneg., sep., stann., strm., sulph.,
 verb.

Easy Satiety, Appetite, 478.—Bry., caust., chin., ign., lyc.,
 merc., phos., sulph.

Pain Right Hypochondrium, 563.—Bry., chin., ign., lyc., merc.,
 phos., sulph.

Urine Frequently Bloody, 679.—Chin., lyc., merc., sulph.

Heat of Back, 878.—Lyc., phos., sulph.

Urination Interrupted, 656.—Lyc., phos., sulph.

Urination Retarded, 658.—Lyc., sulph.

Here you see the probable remedies were reduced to two, lyc. and sulph., and without going on any further with the repertory I made use of what little knowledge of materia medica I possessed to decide on which of these two medicines I should give.

The first question I put decided the selection. I asked the patient if he observed any difference in the temperature of his feet. He at once replied in astonishment, "Yes, the right is colder than the left." "This," he continued, "I told the last three doctors I had, but as they only laughed at me for describing such a symptom, I was afraid to mention it to you, and now, wonderful! you have just asked me that question."

This confirmed the selection of lyc., of which I gave him lyc., 1 M., four doses in water to be taken night and morning.

July 2.—Much better in every respect; has no pain to speak of. But as this is not a report of treatment I briefly state that he continued to improve, with occasional repetitions of the medicine, till on November 5, while at the lavatory, the flow of urine suddenly stopped, and after a short time something passed with great pain, followed by free flow and continued immunity from pain.

CASE 5.—COUGH—COCCUS CACTI.

A girl, aged 7½, brought to me on account of troublesome cough, with which she (*and her parents*) were troubled, and with which she awoke every night before midnight.

There was nausea accompanying the cough. The patient was said by her attendant to be quite well, with the exception of the cough, and I could get no other symptoms.

Kent's Repertory, p. 773, I find the following remedies under :—

Waking from Cough at Night.—Am. m., bell., calc. c., caust., cocc., coc. c., coff., hyos., kali. c., kali. n., lach., mag. m., nit. ac., phos., puls., ruta, sang., sep., sil., squil., stront., sulph., zing.

Nausea during Cough, 508.—Calc. c., coc. c., kali. c., lach., nit. ac., puls., ruta, sep.

Cough 11.30 p.m., 774.—Coc. c.

One dose coc. c., C.M. cured.

In this short paper, and with the limited time at my disposal, I have necessarily just touched on many subjects of paramount importance, and I fear I have tried your patience with frequent repetitions. *Apropos* this aspect of the case, I quote a story that Dr. Z. T. Miller tells of a Methodist preacher who used to say that “unless salvation was preached twice on Sunday and prayed for on Wednesday people would forget all about it.” I fear that a similar remark may apply sometimes to Hahnemann’s teachings.

After the “*Organon*,” “*Chronic Diseases*,” and “*Materia Medica Pura*,” I have found most useful for my own instruction “*Kent’s Lectures on the ‘Materia Medica,’*” the dry bones of which he has clothed in most attractive raiment, and “*Kent’s Lectures on Homœopathic Philosophy.*” Both of these works are to be had in book form, and form interesting subjects of study. Also Miller’s (R. Gibson) “*Synopsis of Homœopathic Philosophy.*” Among periodicals I have derived most benefit from the *Medical Advance*, a monthly publication, which contains many capital articles by good Hahnemannians.

During the first half of the present year I had the pleasure and privilege of visiting this hospital, I was much impressed by the good work and self-denying energy exhibited by the medical staff, whose work shows good results as compared with the returns of the dominant allopathic school. Should the teaching of Hahnemann, as delineated in the “*Organon*,” be even more closely followed—should they be realized as accurately portraying the method of practice of a great truth in therapeutics, a method of practice full of possibilities only dreamt of at present—should all this be realized I venture to say that the results will be so much further favourably affected, and will afford an irresistible argument for the consummation devoutly to

be wished for—the foundation of a teaching and graduating school in London which may, I believe, become the chief centre of homœopathy in the world and the Mecca of all true homœopaths.

Dr. STONHAM (Vice-President, in the chair) accorded the thanks of the Society to the author for his instructive paper. He had reminded them once again of the old paths that Hahnemann suggested should be followed in the selection of the remedy for the treatment of cases. If they threw their minds back to the condition of medicine at Hahnemann's time, it must be acknowledged that Hahnemann struck out a vastly superior path to that which he found existing at the moment. At that time the humoral pathology was in vogue, and after that the theory which divided all medicines into stimulants or sedatives. Hahnemann must have taken an immense deal of pains with his patients as compared with the ordinary physician of his day. When one remembered that Hahnemann worked out his cases in the careful way the author had shown, the vast superiority of his results, and those of his disciples, were not surprising. Hahnemann considered, as all homœopaths had done since, that minute symptoms, however trivial and unimportant, might play a great part in the condition of the patient. No symptoms occurred without a cause; even such a comparatively trivial symptom as one foot being hot and the other cold must be due to some special state of the patient, and that single symptom might be sufficient to indicate a remedy. After the advent of the microscope and pathology came morbid anatomy, and patients were treated according to what the author had called the ultimates of the disease, and not according to their symptoms or their true pathology. He thought the profession was now getting to a truer view of pathology, and an attempt was being made to arrive at an understanding of the pathological state to which gross lesions were due. As time went on he had no doubt the various symptoms which homœopaths had used for many years would have their true pathological explanations.

Dr. WHEELER thanked the author for recording for the benefit of the Society several of the cases which he had treated by the method he had described. Although one could realize why Hahnemann himself recorded so few of his cases, and why those of his followers who adhered most closely to his methods

were a little chary of doing the same thing, nevertheless, it was the best way to bring the method home to those who, perhaps, had not carried it out so fully as the author had done. Hahnemann was particularly anxious that his followers should not fall into the mistake they were all apt to fall into—namely, of considering that because a remedy had benefited one case that it would therefore benefit another. It was for that reason he thought Hahnemann did not often record his cases. With regard to the difference between the general and particular symptoms, he admitted that, especially of later years, he had come to realize the great truth of the value of the general symptoms rather than the particular. The general symptoms were, in his opinion, those which showed the particular constitution and character of the patient. Homœopaths always maintained the importance of the constitution, and the profession at large was more and more coming to realize that. They were realizing that, behind morbid anatomy, there was still a disease process which had to be traced, and were attaching much greater importance to the condition of the actual soil upon which the disease grew—*i.e.*, the constitution of the patient. It was because of the clue that the general symptoms gave to that condition that they were of such value. With regard to pathology, he admitted that a subjective symptom that had been continually removed under a certain remedy, after a time might be allowed to rank as a symptom of that remedy, and they were entitled to consider certain pathological conditions as clinical symptoms. If it was continually found that a certain pathological condition that could be definitely traced by a method that was impossible to Hahnemann, owing to lack of instruments of precision, disappeared under the action of a remedy, they were entitled to regard that as a definite symptom of the remedy and give it its particular place in a consideration of the subject when that particular condition came under their notice in practice. If that could be admitted, it had a certain advantage, because very often the recognition of a definite morbid anatomical condition gave the clue to a number of symptoms which otherwise would have to be taken in detail. If they were able to cover a large number of the symptoms by a clear recognition of the morbid anatomical process that was going on, it would shorten the process of selecting the remedy, and also enable them to appraise the symptoms at their just value. The great difficulty with Dr. Ridpath's method was the enormous time it took. Fortunately the acuter and subacuter forms of disease responded very quickly to remedies.

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The fact that they were acute meant that the body possessed means of recovery, but for chronic disease he was more and more convinced that a process of the kind the author had described was required. He was particularly rejoiced to hear the remarks Dr. Ridpath and Dr. Weir made with regard to potency. He thought the time had come when it must be realized that not only were all the potencies of value, but that it was their business to define the sphere of each of them. Having made up their minds that all the potencies were valuable, it was necessary to decide which potencies were to be chosen for particular cases and particular classes of individuals. He believed that ultimately it would be found that the potency depended upon the kind of affection, the constitution of the patients, and very often the nature of the remedy. He had found in his own experience that he obtained no benefit from some remedies in low potencies, but that good results had followed from the use of high potencies. He thought it might possibly be a definite feature of certain remedies that they only acted in certain potencies. He had made a few experiments with regard to the action of one drug upon protoplasm, and they had given him a hint of extraordinary possibilities in the direction of the varying effect of different potencies. For instance, arsenic—the drug with which he experimented—had a definite stimulative effect upon the growth of yeast, if used in a dilution of 1 in 30,000 or 1 in 40,000. It would go on stimulating up to a certain extent, but when an infinitesimal point was reached, instead of stimulating, it began to depress; but if they went on past that, it would be found that it would begin to stimulate again. That up-and-down characteristic might be found to exist in more than one drug, and it might be a possible explanation of the fact that a drug was sometimes given in a particular potency without the slightest effect, and then the patient was subsequently cured by a fellow-practitioner with exactly the same drug, only in a different potency. He thought practitioners should rather change the potency than the remedy if they were sure they had the right one, and in that way they would be able to accumulate data for inferences which could ultimately be established.

Dr. EDWIN A. NEATBY said that it had already been pointed out that the method of the selection of the remedy, according to the "Hahnemannian" method advocated by the author was a very difficult one. All those who, in their younger days, had burnt midnight oil in working out symptom lists similar to those shown by the author would concur in this. It was difficult in part



because the drug-provings were not complete. The knowledge they possessed of the effects of drugs was not as great, deep, and wide as the knowledge they had of disease. That was one reason why all those who wished for the advancement of homœopathy were anxious to see the "Materia Medica" perfected. A very great deal could be done with the material at hand, but it was easy to see how much more could be done if they had better weapons—not, perhaps, extended symptomatology, for that was already overloaded, but a further knowledge of the action of the drugs in the way of what had been called pathological ultimates. He was very much gratified at the moderate tone of the paper and its extremely reasonable character. For instance, the author very wisely acknowledged that, although the patient's general health might be re-established, it was often found that the remedy was unable to remove what he had described as "the ultimates," whether it be a varicose vein, a fibroid uterus, or what not. The question arose whether it was fair to say under those circumstances that the patient was cured. In his opinion it depended upon the nature of the disease. If the author's case of renal calculus had been a little further advanced, he might possibly for a time have relieved all the symptoms and restored what had been called "the action of the vital force," thus making the patient comfortable for the time being; yet, if the calculus had been left where he (Dr. Neatby) thought, it was not justifiable to speak of the case as a cure. Happily for the patient the calculus was expelled; one might be quite ready to believe that its expulsion might have been facilitated by the use of the remedy. But supposing it had been a larger calculus, and had begun to ulcerate the pelvis of the kidney and produce septic absorption, the patient could not have been cured by a temporary medicinal improvement of the condition. It was the overlooking of such facts that had brought discredit on the so-called Hahnemannian method of prescribing on a purely symptomatic basis. He (Dr. Neatby) wished to harp upon this point, because he thought there was great danger of adopting a one-sided attitude on such matters, and especially in those who came with new enthusiasm to so fruitful a principle as homœopathy, and had not yet had all the experience of the difficulties which came to them as time went on. A case which came under his observation not very long ago illustrated the need of pathological investigations as well as careful symptomatological study. The case had been most carefully written out in detail; it contained a page and a half of pure, subjective symptoms, with the correct indications as to aggravation, amelioration, and

all the general "modalities." But only one line and a half was given in the record to the patient's general objective symptoms. The patient was suffering from a certain degree of anæmia, breathlessness, and urinary symptoms in the way of retention. It was not evident, however, from the record of the case whether the retention was due, as was often the case, to a spinal lesion, or to some local condition of the bladder, or some pelvic lesion. The drug was selected on the symptoms alone. He felt quite sure that if the patient had been examined earlier and an operation had been performed it would never have got into the hands of the physician, because the whole of the symptoms were due to an "ultimate"—to the pressure of a uterine tumour on the neck of the bladder, which caused the retention and loss of blood, the anæmia, and cardiac weakness. With regard to the question of dose, he thought to limit oneself to the highest potencies was a mistake. Great harm had been done to the cause of pure homœopathic prescribing by persistently recommending the use of the "C. M." potency, the definition of which had never been given. He had seen Skinner's apparatus and heard of Fincke's, but what they produced no man could possibly tell. If homœopaths contented themselves with such "crude" (!) potencies as the 30 and the 200, which could be made up by hand, they would trespass less on the credulity of their friends, and do more for the good of the cause than if they limited themselves to the other transcendental potencies. He need not remind those present that the very best case Hahneman ever recorded was cured by the mother tincture, and that Hahnemann's own pocket-case contained, up to the very last, mother tinctures, which he presumably used. He had been very much interested in the author's cases, and thanked him for bringing them before the Society. The fact that he had urged the importance of the "Materia Medica" would stimulate the members to learn up their drugs, even if they did not find time to work out every case in the strict way they would like to. He listened, however, very carefully to the reports the author read, and in two of the four cases, before the author stated the drug he eventually gave, he (Dr. Neatby) selected in his own mind the actual remedy which the author arrived at, namely, rhus and lycopodium, and in a third case he thought the author was going to use lachesis. So that by a general knowledge of the "Materia Medica" homœopathic practitioners could do a very great deal to help their patients, even without the difficult method the author had described.

Dr. ROBERSON DAY thought the author was exceedingly happy

in the comparison he had made of the analogy between the mode of selecting the remedy and the manner in which botanists classified an unknown plant. When a botanist found a new plant he examined carefully every part—the leaves, the flowers, or the seeds, as the case may be, and finally the roots; thus a conception of the whole plant was obtained; and if homœopaths took that as their text when prescribing for their patients it might often keep them from wandering off the right lines. Just as in the mind there are in the subjective and objective sides of experience, and it is important that the balance should be accurately preserved lest one side obtains the predominance, so homœopaths should weigh the symptoms and thus avoid the traps into which they may fall if one predominating symptom of a case is taken and the totality disregarded. At a first interview, no matter how long the practitioner spent on the case, it was often impossible to thoroughly appreciate the mass of clinical material before him, and he had endless difficulties in classifying the symptoms. It was well known that the most careful methods had to be adopted in elucidating symptoms lest, in the legal phrase, they put the “leading question.” There was very little to criticise in the paper, and he thanked the author very heartily for bringing them back to the old story which they were too apt, he was afraid, to wander from. Dr. Ridpath had said, however, that there was at present no medical school of homœopathy. There was such a medical school, and there were present two of the able lecturers who were conducting the second Honyman-Gillespie course of lectures on the theory and practice of homœopathy. Some valuable scholarships also existed, which enabled enquirers to follow the lectures with considerable benefit. He thought this should be as widely known as possible.

Mr. KNOX SHAW said it might seem a strange thing for a surgeon to take part in such a discussion, but he felt that an open confession was occasionally good. He had great difficulty in following the pure Hahnemann method of prescribing, because he could not believe that all the symptoms recorded in the huge volumes of repertories were actually symptoms produced by the drug. When practitioners prescribed remedies upon symptoms alone, he felt they were not prescribing scientifically. Many years ago he proved a drug. He was not an introspective man; he led a healthy life, and did not trouble himself about his symptoms. But he thought that if he intended to prove a drug he ought to know what symptoms he had before commencing. Therefore for a month he introspected himself, and he was

perfectly astonished to find when he came to look at himself from the inside what an extraordinary number of symptoms he had. He took no drug at all, yet he had many symptoms. After taking a complete record of them every day for a month, he began to take the drug he intended to prove in various dilutions, beginning with a small dose and gradually working up to a larger one. Yet after a month he had very few different symptoms to record than he possessed in the previous month when he did not take the drug. That might have been because the medicine was practically inert to him, but what he felt was that, supposing he had started to prove that medicine without knowing his own symptoms to begin with, he would have put down the queer pains that he had, the sensation at the back of the head, stiffness and so on, to the drug he was then taking. The more they dealt with human beings the more they knew the extraordinary symptoms some people described, and if they were provers of medicine they would possibly have the same weird symptoms which were recorded in the repertories. He therefore felt he was not prescribing on a safe basis when he prescribed entirely on the symptoms. He had sometimes, to the best of his ability, set to work to prescribe on the lines indicated by the author, but he felt all the time he was doing it that he was not adopting a scientific principle, and that he was a bit of an empiric. He wished to reiterate to his younger colleagues what Dr. Neatby had said. He sometimes said to the young men when they came to the hospital that because they had become homœopaths he hoped they would not abolish their common-sense. It seemed to him that, if a man became enamoured of symptom prescribing, he was very liable to lose a great deal of whatever common-sense he was born with. So fascinating, interesting, and absorbing was the hunt for the drug that one not infrequently missed the most important things in the vital interests of the patients. He was very strongly of opinion that if Hahnemann were alive at the present time he would further emphasize what he so ably emphasized in his "Organon," that the practitioner was to look out for the mechanical hindrances to the cure. In many cases the symptoms could be relieved, as the author had shown, but the mechanical hindrances to the permanent cure remained. In the patient with the renal calculus, it was fortunate for the patient that the stone was small enough to pass. If the stone had not been small enough to pass, no amount of accurate homœopathic prescribing would ever have cured the case. A practitioner must not let a patient go about with a stone in his kidney, destroying the kidney

structure, while he was hunting for the remedy. The specimen on the table came from a patient which illustrated the point. It was thought by a practitioner of the old school that the woman had an abdominal growth. She placed herself under Dr. Margaret Tyler, who, prescribing according to the symptoms, selected arsenicum as the remedy which seemed to be indicated. One dose of arsenicum 200 was given, with very marked relief to the symptoms, the patient becoming much better. Dr. Tyler observed, however, that in spite of the betterment the patient still had a mass in her right hypochondrium, and so she very wisely, he thought, sent her to the surgeon with the view to seeing what could be done. It was well known that adenocarcinomas of the intestine were not particularly malignant, and were very amenable to surgical treatment, but he did not believe that any remedy would have removed the condition. The patient would ultimately have developed intestinal obstruction, and it would then have been impossible to operate on her with a reasonable prospect of success.

Dr. G. F. GOLDSBROUGH thought one point of view which ought to be emphasized was that, in the interests of the development of homœopathic principles, they should be extremely careful in forming judgments on single or particular cases which were brought forward as illustrations of cure. Single cases were interesting in themselves, and the fact could not be denied that recovery had taken place in the cases the author had brought forward; but it seemed to him that to generalize or to form an opinion as to the value of remedies on such a basis would lead to failure in the end. If they were led to think that the standard of prescribing advocated by the author, which was the ideal standard of homœopathic prescribing, could be carried from a single case to all cases of a similar kind, he thought it was extremely fallacious, and that failure would result. The author referred to homœopathy as an infallible system. If homœopathic practitioners got that idea into their minds it seemed to him (Dr. Goldsbrough) it would commit them to a very great deal which they could not substantiate. Homœopathy was undoubtedly based on a law of life, and there was no abrogation of that law. In that sense homœopathy was infallible. It was uniform in its application; but that was very far from its being infallible as a system of treatment—*i.e.*, that cures could be promised in cases which hitherto had been known to be incurable. In face of the many cases which they knew perfectly well had been hitherto incurable, it was impossible

to hide from their minds the fact that as yet no medicines had been found to meet these cases. He therefore thought it was inadvisable to suggest that the system was infallible as a system of treatment. In the out-patients' department of the hospital that afternoon he had seen fifty cases of nervous trouble, which were extremely unamenable to medicine, and in each case the patient wanted to know whether anything could be done! Could he say, from the point of view of homœopathy, that he was perfectly sure something could be done? He never could say that; in fact, he always refrained from stating anything of the kind. He simply said that everything should be done that could be done as far as he or anyone else knew it. From the point of view of selecting the remedy, he would like the author to state how many cases of the kind he had suggested he could consider in a day, and whether medical men should be prepared to undertake the position of physicians in charge of the out-patients, where something like thirty or forty cases had to be treated in an afternoon, and on what basis he would then be able to select a remedy. They were not choosers of the state of things that existed at the hospital. They were planted there by force of public opinion and custom to deal with such things. It was a problem which had to be faced in the development of homœopathy as to how a condition of things of that kind was to be faced. Dr. Goldsbrough did not regard the author's analogy to botany as particularly apt, because in the end he likened the patient's disease not to the disease produced by the remedy, but to the remedy itself. It appeared that the author referred the analogy back from the patient to the drug, and there was no analogy there. What homœopaths had to consider was the analogy between what the drug could do and what was found in the patient. With regard to the question of external treatment, he could not follow the author's suggestion that skin symptoms were unimportant. It seemed to him that if external treatment was prejudicial, then skin symptoms must be important, otherwise external treatment would not do any harm. The skin covered the whole surface of the body and was an active organ, and anything affecting the skin it seemed to him must be of importance as a general symptom affecting the patient. It seemed to him a stage had been reached in the development of homœopathic principles when a correct view of the relation of Hahnemann's work to general medicine at the present time was a matter of extreme importance, and that the following of any line of thought or inference which could not be substantiated

would be fraught with disaster to the development of their principles in the future. This danger was more prevalent, perhaps, than homœopaths were accustomed to regard it. At the present day, when methods from the outside were being developed so fully, they must be on the alert and ready to show, both from the point of view of symptoms and pathology, what relationship homœopathic principle had to those developments.

Mr. EADIE was surprised no one had called attention to the confusion existing between the expressions that had been used of pathology and symptomatology. It seemed to him that Hahnemann had included pathology as far as he knew it under symptomatology. For instance, with potassium iodide a coryza and an eruption were obtained. Both these conditions Hahnemann put under symptomatology, whereas practitioners nowadays regarded them as pathological. He thought if Hahnemann had lived at the present time he would have put such things as the presence of a fibroid and various other things that medical men regarded as pathological, as symptoms. The case had been referred to of a practitioner who treated a patient with a remedy because he had cold feet. With all due deference to that practitioner, he thought he was a bad homœopathist, because he had not taken into account the totality of the symptoms. He left out of account the temperature and the fact that the man had a bruit and a rapid pulse, the reasons that brought the patient to seek advice.

Dr. HEY said a good deal had been said about choosing a remedy from the totality of the symptoms; but, if he might criticise the author's cases, it seemed to him that either the patients had very few symptoms, or he did not go into the totality of them; he rather took the principal or more peculiar ones and prescribed on those. With regard to what Mr. Shaw had said about want of confidence in the symptoms produced by the drugs mentioned in the repertories, he (Dr. Hey) had always understood that none of the symptoms given under the heading of various drugs in the *materia medica pura* had been inserted without being verified from more than one prover. Had Mr. Knox Shaw taken the various symptoms apparently produced by the drug in half a dozen people as well as himself, and only chosen those that were common to the seven, he thought he would have arrived at a different conclusion. The symptoms in the repertories had, he thought, been corroborated, and gave a very sound basis upon which to work from the symptomalogical point of view. In dealing with the question of the too frequent repetition of the remedy, the author had suggested that they should wait to see the effect of the

one dose. Dr. Hey desired to ask what the author did in acute cases. Did he give one dose and wait until he called the next day to see the effect of it, or did he leave so many doses for the patient to go on with ; because, if he did the latter, he did not see how the repetition of dose could be checked ? There was another point he wished to raise with regard to prescribing on symptoms alone. A patient was admitted to the Hospital a little over a year ago, the only symptom complained of being a little pain in the vicinity of the umbilicus. On palpating the abdomen a small lump about the size of a walnut was felt. Mr. Knox Shaw, who saw the case with him, thought it was a tumour in the abdominal wall. The patient was given an anæsthetic, in order that a more thorough examination might be made, and a tumour as large as a man's fist was then easily palpable, and on opening the abdomen it was found that every one of the abdominal viscera, as well as the abdominal wall, was infected with carcinoma, and that there was one tumour almost the size of a child's head ; yet the only symptom of any note, of which the patient complained, was the pain in the vicinity of the umbilicus. If such a case had been treated on the symptoms alone, the practitioner would have been hopelessly at sea. The patient died a few months afterwards from generalized carcinosis.

Dr. T. MILLER NEATBY said that he was interested in the question how far they were justified in saying that cases were curable or not curable. At a certain stage even the most enthusiastic homœopath admitted that certain cases became incurable. For instance, the child referred to by Dr. Hare as admitted to the hospital in a moribund condition was bound to die. He was not sure that he had met cases of generalized miliary tuberculosis that had been cured, and the old school frankly said that such cases were incurable, and possibly they were right. In a paper he read a month ago he suggested that if homœopathic treatment were given in time to those who manifested tubercle in any way or were suspected of the tuberculous diathesis, a state of generalized tuberculosis would be prevented from developing. That might possibly be an explanation of such cases as Dr. Moir had referred to of infective or malignant endocarditis. It was possible that such people if they had been homœopathically treated would never have developed malignant endocarditis, and the same applied to cancer. He remembered being told, when quite a small boy, that, although allopaths said that cancer was incurable, if a child from the outset were treated homœopathically he would never develop

cancer. He thought that was possibly quite true, although it was impossible to prove it. There was good evidence that certain kinds of cancer had been cured simply by the use of homœopathic remedies, but it was also possible that many forms of cancer represented an incurable stage of disease.

Dr. H. F. Woods said the point raised by Dr. Hey agreed with Kent's remark that when a case showed very few symptoms, or none at all, it was incurable. The more symptoms a patient had, the more chance there was of his being cured. He understood Dr. Ridpath to say that pathological states were of no value on which to base a prescription, and it seemed to him to follow from that that all symptoms dependent on pathological states were also of no value. In his opinion, the majority of the symptoms on which prescriptions were based could be referred to pathological states, such as a sharp pain in inspiration in pleurisy, due to inflammation of the pleura, or pain in the stomach after eating, due to inflammation of the mucous membrane. He would like to know what limits the author put upon this kind of symptom. Dr. Neatby had raised an interesting point with regard to potency, suggesting that it would be well that practitioners should limit themselves to potencies of 200 and downwards. He had found in his brief experience that in chronic cases, after a certain point, the lower potencies refused to work, and that it was necessary to go up to the highest potencies before the patient was cured.

The CHAIRMAN said the discussion had been a very full one, more speakers having taken part in it than on any previous paper read recently. The upshot of the discussion seemed to be that the homœopathic method was infallible within limits—*i.e.*, as long as the vital forces could react the homœopathic remedy would do its curative work. When, however, portions of tissue were dead or destroyed, or growths had taken place which were outside the ordinary vital economy, then it could not be expected that homœopathic treatment would have any effect. Those results of disease nearly always of themselves set up symptoms, and though sometimes a homœopathic remedy might be able to relieve them, it could not take away the cause, and other measures, therefore, had to be resorted to. As far as drugs could do anything, he thought all the good that was possible could be found within the homœopathic range. The cases cited by Dr. Moir were not amenable to any drugs. The patient was not worse for having had the homœopathic drugs given. The misfortune was that the cases were not diagnosed properly; but, as far as treatment was

concerned, the homœopathic was as good as any other, even in those bad cases. Mr. Wright had very effectively ridiculed the suggestion that it was possible to speak of a disordered vital force. The body economy was really a balance of forces, and it was a disordered balance of forces, and not a disordered force, that had to be dealt with.

Dr. RIDPATH, in reply, said he felt quite unable, in the time at his disposal, to reply to all the topics which had been alluded to. Reference had been made to the great difficulty in selecting the remedy. That was a difficulty which had to be overcome by hard work. The means by which he was trying to do it was by becoming as conversant as possible with the "Materia Medica." He read up one drug, say, every day, remembering what he could of it, trying to get at the characteristics of the drug, and in the meanwhile did as well as he could with what knowledge he had of the "Materia Medica," in dealing with ordinary daily patients. Of course, he could not carry large repertories with him in dealing with acute cases, but in his consulting room he always referred to the symptoms in his repertories. At first the remark used to be made that he did not know much about his subject when he did that, but the results he had obtained by repertorizing gained him a reputation afterwards which was worth all the painstaking. It was possible to deal with acute cases with the practitioner's own knowledge of "Materia Medica," and possibly a small repertory, such as Bœnninghausen's "Pocket Book," which consisted almost entirely of the general characteristics. In some cases, after noting the peculiarities of the patient, he had given a placebo of spirits of wine—two or three drops, to be taken every half-hour—while he had gone into another room and looked up some of the leading characteristics. He carried a pocket-case with him which contained a good many globuled potencies; and, going back into the room again, he gave a dose of the drug which seemed most indicated, to the patient. That led up to the question of the repetition of the dose. In chronic cases that could easily be considered, but he had been asked what he did in acute cases under the circumstances. The medicines could be repeated much more frequently there: why, he did not know; but this conclusion was the result of reading and experience. The results very often could be observed immediately by the rise and fall of the pulse, the temperature, and the general appearance of the patient. He would refer to the term "disordered vital force," as treated in paragraphs 9, 10, 11, 12, and 13 of the "Organon," on which he founded the statements made in his paper. The disordered vital

force was merely a name for the patient who was out of a state of normal health. He thought some confusion had arisen with regard to what he had said of the pathological and anatomical condition. One or two of the speakers had implied by that, that he meant the diagnosis of the disease. That was taken into consideration first: all pathological appearances could be looked at afterwards. In the case of psoriasis which he mentioned—where he argued from the particular morbid condition, to the state of the palm, the local condition—he found that the medicine he selected produced disorder and did not improve matters; so he went on the other system, and brought it down from the general state to the psoriasis, and he remarked that if a cure were frequently made of psoriasis palmaris by calcarea carb., with properly verified cases, that drug could be added to the list of medicines curing the disease. The latter was what would be called a clinical symptom, but such cases require great care in verification before acceptance. The potency question was a most difficult one. He found that the more carefully the cases were taken and as much as possible recorded, the greater the sensitiveness of the patient, the higher the potency he found it advisable to use, and which was almost invariably effective. He merely gauged the sensitiveness of the patient for a single dose from his own knowledge; he could not lay down any rule for it. There was no doubt it was difficult to repertorize, but that was met to a certain extent by attaining a knowledge of the “Materia Medica,” through which the genius of the different remedies was known, and in that way very often it was possible to make use of a keynote. With regard to Mr. Knox Shaw’s remarks, full directions were given in the “Organon” for the taking of provings; the remark being made that the person on whom the drug was to be proved must be in perfect health beforehand. In reply to Dr. Goldsbrough, it should be borne in mind that it was not the diseased condition which had to be treated, but the patient. He would probably never meet another case of renal calculus having the same symptoms, and in the next case probably some other drug would be called for, which would be selected according to the patient’s symptoms. In cases such as pneumonia, where there were ultimates, as a rule the condition was known, but he found it most useful to base his selection of the remedy on the various subjective symptoms of the patient that he had noted; and after giving the remedy it was possible to observe the clearing up of the pathological conditions as the effect of the drug.

MINUTES OF THE SOCIETY MEETINGS.

THE FIRST MEETING of the British Homœopathic Society for the Session 1909-10 was held at the London Homœopathic Hospital on October 7, 1909, at 8 p.m., Dr. T. G. Stonham, Vice-President, in the chair. There were also present Dr. Spencer Cox, Mr. James Eadie, Dr. Washington Epps, Dr. McCandlish, Dr. Byres Moir, Dr. Powell, Dr. Purdom, Mr. Frank Shaw, Mr. Knox Shaw and Dr. Neatby (Hon. Secretary).

ABSENCE OF THE PRESIDENT.

Dr. Stonham announced from the chair that Dr. David Macnish, the President of the Society, had in consequence of serious illness been prevented from returning from abroad in time for the first meeting of the Society. The usual Inaugural Presidential Address was therefore postponed.

Apologies for absence were also sent from Dr. Dyce Brown, Dr. Burford, Dr. Roberson Day and Dr. Goldsbrough. Dr. Ramsbotham and Dr. Weir were announced as visitors.

SECTION OF MATERIA MEDICA AND THERAPEUTICS.

Under the auspices of the Materia Medica Section, Dr. Stonham, Vice-President, presented a paper on Phosphorus, which was followed by a discussion. During the reading of the paper the chair was occupied by Dr. Byres Moir. The paper, with the discussion, appear on pp. 1-29 of this issue of the Journal.

The SECOND MEETING of the Session 1909-10 was held at the London Homœopathic Hospital on Thursday, November 4, at 8 p.m., Dr. Stonham, Vice-President, in the chair. The following Fellows and Members were also present: Dr. Blackley, Mr. James Eadie, Dr. Goldsbrough, Dr. Vincent Green, Mr. Granville Hey, Dr. Jagielski, Dr. Kennedy, Dr. McCandlish, Dr. Byres Moir, Dr. E. A. Neatby, Dr. Miller Neatby, Dr. Neild, Dr. Ord, and Mr. Wilkinson.

Regrets for absence were sent by Dr. Speirs Alexander and Dr. Roberson Day.

NEW MEMBER.

Charles Samuel Spencer, L.S.A.Lond., L.M.S.S.A.Lond., of 226, Stamford Street, Ashton-under-Lyne, was elected a member of the Society.

SECTION OF GENERAL MEDICINE AND PATHOLOGY.

A paper was read by Dr. Miller Neatby entitled "General Tuberculosis in Adults based on an Analysis of 110 Cases," which, with a discussion which followed, appears on pp. 35-73 of this issue of the Journal.

The THIRD MEETING of the Session 1909-10 was held at the London Homœopathic Hospital on December 2, 1909, at 8 p.m., Dr. Stonham, Vice-President, in the chair. There were present also Dr. Bennett, Dr. Blackley, Dr. Cooper, Dr. Roberson Day, Mr. Eadie, Mr. Ellwood, Dr. Goldsbrough, Mr. Granville Hey, Dr. Jagielski, Dr. McCandlish, Dr. Byres Moir, Dr. E. A. Neatby, Dr. Miller Neatby, Dr. Pincott, Dr. Pullar, Dr. Roche, Dr. Searson, Mr. Knox Shaw, Dr. Thomas, Dr. Wheeler, and Mr. Dudley Wright.

Dr. Washington Epps sent an apology for absence.

NEW MEMBER.

John Weir, M.B., Ch.B.Glas., of London, was elected a member of the Society.

VISITORS.

Dr. Ridpath, of Sunderland, was introduced by Dr. R. M. Le H. Cooper and contributed the paper of the evening. Dr. Fergie Woods, Dr. Hare and Dr. F. Wheeler were also present as visitors.

SECTION OF MATERIA AND THERAPEUTICS.

Dr. Ridpath's paper was entitled "The Selection of the Remedy," and the reading of it was followed by a discussion which, with the paper, appear on pp. 85-98 of this issue of the Journal.

THE FUTURE OF HOMŒOPATHIC JOURNALISM.

Owing to an early discontinuance on the part of the British Homœopathic Association of the publication of the *British Homœopathic Review*, of which they had been officially informed, the Council of the British Homœopathic Society have had under

consideration the advisability of altering the character of the Journal of the Society and incorporating in it the publication of original articles from outside sources, cases from hospital practice, &c., &c., or, as an alternative, a transfer of the publication of the Society's proceedings to a new journal, should such be started independently. A memorandum of possible alternative schemes for a future journal has been sent to all Fellows and Members of the Society asking for their opinions, and also what support, literary or financial, they would be willing to afford to any particular scheme. It has been thought that there is room for one high-class homœopathic professional journal in Great Britain, but possibly not for more than one. An immediate reply to the circular sent by the Honorary Secretary is requested.

PROCEEDINGS OF THE LIVERPOOL BRANCH.

The FIRST MEETING of the Session 1909-10 of the Liverpool Branch of the British Homœopathic Society was held at the Hahnemann Hospital, Liverpool, on October 14, 1909, Dr. John D. Hayward, the President, being in the chair. The following members were also present : Drs. Ellis, Gordon, Green, A. E. Hawkes, J. Hawkes, Hayward, sen., Charles Hayward, Proctor, Gordon Smith, Watson and Bryan (Hon. Secretary).

PRESIDENTIAL ADDRESS.

The President gave an introductory address, his subject being "A Historical and Practical Examination of the Methods Employed for the Disposal of the Dead Body," an abstract of which is as follows :—

GENTLEMEN,—It is many years since the kindness of this Branch of the British Homœopathic Society honoured me with the position to which you again elected me last autumn. As you know that I am now, to some extent, removed from daily touch with the practice of our profession, you will hardly expect from me practical experiences in the treatment of disease according to our more excellent method ; most of you are rather able to impart such information than to receive it from me. I venture, further, to believe that questions of ethics and medical politics are sufficiently discussed amongst us, without further contributions from me. I have occupied your attention in both these respects on many previous occasions and, during the session now opening, which I trust will be a successful and instructive one, we shall have opportunities for the consideration of these and similar matters of medical and surgical importance. I ask your permission to-night, for the short time that etiquette amongst us dictates shall be engaged by the presidential address, to present a short historical consideration of the methods employed by mankind for the disposal of the dead, and some practical suggestions of the means advisable for employment to-day. This is a subject that has long interested me and I have conducted some literary research in the matter, as well as made some photographic illustrations, a few of which latter I shall present before you.

If I treat the subject, occasionally, in not quite the severely scientific spirit you may consider your due as members of a learned and serious profession, I bespeak your leniency.

The lantern slides I shall exhibit are mostly my own, prepared from negatives taken by me, or which have been lent to me. The paper is not one that lends itself to much pictorial illustration and some of my views may seem a little irrelevant thereto, but they will at least serve to enlighten a grave subject.

Dr. J. D. Hayward then went on to describe the methods employed for disposal of the dead in past times. He traced the survival and analogues in present-day practices of customs followed many ages ago. The lecture was illustrated with lantern slides and concluded as follows:—

In England every baptised person, not a suicide, excommunicate, or a murderer, is entitled to be buried in the churchyard of his parish, by a Church of England clergyman, without fee. It is not my intention to dilate upon the advantages of cremation, or of earth-to-earth burial, this has been ably done by Sir Henry Thompson and others.

The massive oak coffin with its enclosed shells, of which one consists of lead, is a barbarous and insanitary method, especially if the body has not been previously specially prepared and embalmed. The mind refuses to contemplate what bodies must resemble in such receptacles at various periods after death, or to compare the orderly beauty of a churchyard with the scenes in the graves and vaults below. For those whose prejudices revolt at cremation, basket, or earth-to-earth burial should be the only alternative; the tragedy of decomposition is at least shortened by such devices. Unfortunately, we have no legal property in our dead bodies and we may think that what shall be done with our dead bodies is no concern of ours—after the deluge! But at least medical men should be intelligent and altruistic enough to advocate cremation and to leave on record a wish for such to be carried out in their own cases, leaving their relations, or heirs, to disregard such wishes on their own responsibility. With most of us there are traces of the old superstition that, somewhere and somehow, our old bodies will be of use to us again. Cremation and urn burial form the ideal method of disposing of a corpse; the only possible objections are the slight legal ones. The funeral ceremony can be carried out much as at present, if so desired, and even the appearance of our graveyards need not necessarily be altered. If the practice became common the cost could be reduced to 30s. The time occupied in reducing an average body to about 5 lb. weight of ashes is about an hour and a half, and there is nothing whatever revolting in the process. Those who like myself have examined the appliances, and the results in this

country and abroad, more especially in Italy, must feel that cremation is the speediest, sanest, safest plan, and altogether the most sanitary and satisfactory method for the disposal of the dead.

Being sanitarians as well as healers, it is our duty to instruct and to lead the public in a course which will render resolution of the corpse as innocuous as possible to those who survive. I hope that ere long law and public opinion may dictate that, in our crowded communities, the only alternative to cremation shall be the earth-to-earth, or basket, burial. Only in exceptional circumstances, or in cases likely to lead to judicial enquiry, should methods of preservation or embalming be allowed. Where our present popular, but disgusting, method is allowed this should be carried out "far from the madding crowd."

In St. Giles' Church, Shrewsbury, on the grave of a member of our profession, one John Whitfield, surgeon, is carved, wittily, the familiar prescription direction which, no doubt, the deceased had written hundreds of times upon his recipes:—

"Composita solvantur."

Such resolution is the inexorable fate of every man, let it be performed *tuto, cito et jucunde*.

A hearty vote of thanks to Dr. Hayward for his very interesting address was proposed by Dr. Green and seconded by Dr. Proctor, and carried.

The President then invited all present to accompany him in taxi-cabs to Leyfield Priory, West Derby, where a most enjoyable evening was brought to a successful conclusion.

The SECOND MEETING of the Session 1909-10 was held in the Hahnemann Hospital, Liverpool, on November 11, 1909, Dr. John D. Hayward, the President, in the chair. The following members were also present: Drs. Ellis, Gordon, A. E. Hawkes, Chas. Hayward, Douglas Moir, Proctor, Cash Reed, Watson and Bryan.

SPECIMEN EXHIBITED.

Dr. Chas. Hayward exhibited a specimen of Paget's disease of the breast with a chain of enlarged glands running to the axilla which he had removed earlier in the day.

REMINISCENCES OF FORTY-FOUR YEARS OF PRIVATE PRACTICE.

A paper bearing the above title was read by Dr. Douglas Moir, of which the following is an abstract.

Dr. Moir commenced by thanking the Society for the honour of being elected Vice-President, and in an interesting address reviewed several cases of various diseases which he had met with, especially mentioning two very grave cases of appendicitis which he had successfully cured by injections of fresh ox-gall.

In comparing present-day practice with that of forty years ago Dr. Moir found that everything had completely altered. He mentioned the rarity of appendicitis in the early days compared with the number of cases met with at the present time and thought the increase in the number of cases was a real one and to be accounted for by something other than more accurate diagnosis. Comparing the attitude of the public towards the medical profession to-day with formerly, he was of the opinion that the people at large had not the same faith in any system of medicine or any particular doctor as they used to have. The lower classes preferred to go to the different special hospitals and as soon as anything serious turned up the better classes preferred to obtain the best man they could for their special complaint.

All the members present took part in the subsequent discussion. Dr. Proctor drew attention to the simultaneous increase of influenza and appendicitis compared with many years ago, and suggested that there might be some relationship between the two.

A hearty vote of thanks was accorded Dr. Moir for his interesting address.

Dr. Moir briefly replied, and the meeting terminated.

The THIRD MEETING of the Session 1909-10 was held at the Hahnemann Hospital, Liverpool, on Thursday, December 9, at 7.30 p.m., Dr. John D. Hayward, President, in the chair. The following members were also present: Drs. A. E. Hawkes, J. Hawkes, Chas. Hayward, Proctor, Watson and Bryan.

A paper was read by Dr. James Watson, entitled "A Study of Clinical and Pathogenetic Symptomatology," which was discussed by the members present and they thanked Dr. Watson for his extremely interesting paper. The proceedings then terminated.

Dr. Watson's paper will appear in the April number of the Journal.

SUMMARY OF PHARMACODYNAMICS AND
THERAPEUTICS.

*Extracted from Exchange and other Journals by the Editor in
collaboration with J. Galley Blackley, M.B.*

Aconite. *The Mental Sphere.*—Dr. J. Cresswell Lewis contributes an interesting article on the “Mental Sphere of Aconitum Napellus.” Such influence depends on the power of the drug to depress the sensory spheres of the nervous system mainly, but also the motor and reflex. The most prominent mental symptom of aconite is fear, following which secretiveness, and desire to be alone as consequences, lead up to a plaintive fear of death. Restlessness is the second characteristic symptom, especially in thoughts. Next comes anxiety, accompanied by forebodings and vagrant fancies. Procrastination, clairvoyance, and dreaming fill up the picture. The effects of anxious dreams, nightmare in the overworked, worn-out, or abnormally psychically developed are met by aconite. (*Pacific Coast Journal of Homœopathy*, October, 1909, p. 561.)—ED.

Aragellus Lamberti. *Loco Weed Provings.*—Because of its effects on the stock-raising prospects of the West the loco weed, or rattle-weed of the plains, has been under investigation by the Agricultural Department of the States Government. For this reason the plant has been selected for proving by the Bureau of Materia Medica of the American Institute of Homœopathy, a full report of which will appear in the *Journal* of the Institute later. Separate provings have been conducted at different places, the rules adopted being those of the O. O. and L. Society. There have been eight provings from Iowa City, six from New York, three from Philadelphia, and two from Kansas City. The activity of the drug is exerted chiefly on the nervous system, the following being the chief symptoms produced: Mental confusion, bewilderment, inefficiency, defective expression in writing, crossness and irritability, mental and physical unrest, mental symptoms associated with stomach symptoms. One prover did not care to eat;

when eating, did not know when he had had enough, and his food distressed him. Restlessness and aimless wandering. Diplopia. "Wanted to touch a certain spot but could not, as it moved." Another prover felt he must concentrate his mind on walking, or he would get off the side-walk; all kinds of sensations in the head and ears. Throat symptoms very marked, soreness, grating, choking. Pharynx dark, swollen, glazed, or pale and anæmic. Face looks bloated and besotted. Pain, pressure and constriction in the left chest in the region of the nipple. Examination of heart revealed nothing. Before the proving, Dr. J. B. G. Custin, of Washington, had given loco weed to a patient suffering from symptoms resembling locomotor ataxia with much benefit. He used potencies from the 6th and the 200th. He suggests the activity of the drug may be due to the barium present in it. (*Journal of the American Institute of Homœopathy*, October, 1909, p. 449.)—ED.

Arnica.—An interesting case illustrating the value of arnica when other remedies failed is reported by Dr. D. E. Coleman, of the Flower Hospital (?). It was that of a male, aged 17, who had had his first, second, and third toes of the left foot crushed in a press, necessitating an amputation. The operation was performed and the wound dressed with bichloride of mercury 1 in 10,000, but the flaps were too short, and no healing resulted. Ulceration ensued and the wound required continual dressing for a period of three months. Various local applications and internal medicines were used, the patient being ill and sleepless. During this period the only thing which gave relief was arnica 30, and after this he slept one whole night. No reason is given why this remedy was not adopted further, but at the end of three months a higher operation was decided on and the patient prepared for it. But owing to failure in anæsthæsia the operation was not performed, and that night, the symptoms again calling for it, arnica 30 every two hours was prescribed and arnica 1 in 100 applied locally. The patient slept all night and complained of no pain the next day. This treatment was continued and the wound soon took on healthy granulations. In four weeks the last ulcer had healed. (*The Chironian*, October, 1909, p. 117.)—ED.

Bismuth Subnitrate. Poisoning.—A woman, aged 42, admitted into hospital with severe gastro-intestinal symptoms, was submitted to a radioscopic examination after the ingestion of

50 grm. of subnitrate of bismuth suspended in bread and milk. After the examination she returned immediately to the ward, and nothing abnormal was noted in her condition. Four hours later, however, she was suddenly seized with vertigo and nausea, then with profound *malaise* with sensation of cold and violent abdominal pains. She was immediately put to bed and was found to be suffering from a severe rigor with trismus and her tint was very strongly cyanotic. In spite of energetic friction and the ingestion of hot liquids the shivering persisted for about two hours. Respiration was rapid, the extremities very cold, the pulse small and much accelerated. This alarming condition persisted until after the passing of several abundant blackish stools. Little by little the rigors ceased, the respiration became more regular and calm, and the pulse recovered its normal rhythm. The cyanosis of the lips and hands persisted longer, and it was only by the next day that the patient had returned to her normal condition. She never had any vomiting, and, in spite of the gravity of the symptoms at times, she never lost consciousness or had any convulsions. (Lesieur et Rome, *L'Art Médical*, September, 1909, p. 181.)—J. G. B.

Diphtheria. *Treatment.*—Dr. E. S. Abbott, of Bridgton, Maine, has contributed an important paper to the Maine Homœopathic Medical Society on the subject of "Diphtheria." The statements and conclusions are based on personal collective investigation, on excerpts from literature, and on published statistics. Circulars were sent to fifty-four physicians, of whom thirty-six replied, but only nineteen of them gave information relative to the treatment of diphtheria. Only two reported a total of nine cases, with no death, in which antitoxin had not been used along with local treatment and homœopathic remedies. For local treatment peroxide of hydrogen 1 in 2 was preferred by most, second coming alcohol, and third permanganate of potash. Dobell's solution, listerine, and persulphate of iron were also mentioned. As an internal remedy one physician reported that he had had good results from a 5 per cent. solution of carbolic acid in 9 parts of glycerine. A few drops of this are mixed in a half wine glass of water, and two dessertspoonfuls given every two hours. Two physicians recommended the use of calomel in 1 gr. doses. Of homœopathic remedies, merc. cy., merc. protiod, and merc. biniod. were most in favour, but besides these there were also used ars. alb., apis, arum, lac. can., kali bichrom., phytolacca, lachesis, and diphtherinum. With regard to statistics,

Dr. Abbott finds that there had been a general decline in the occurrence of the disease in the State of Maine, but the death-rate varies in different years. With regard to different modes of treatment, homœopathic with and without antitoxin, there was proved a slight advantage in favour of what the author terms straight homœopathic treatment. (*New England Medical Gazette*, October, 1909, p. 447.)—ED.

Graphites in Erysipelas.—Dr. Walter Sands Mills contributes a short paper on "Graphites," and cites some cases of erysipelas in which this medicine appeared to effect a cure. So marked was the effect that Dr. Mills states that unless the indications for some other remedy are overwhelming, he now always uses graphites in the above malady, although in what doses he does not state. (*North American Journal of Homœopathy*, December, 1909, p. 837.)—ED.

Mercurius and Mucous Membranes.—Attention should be directed to a paper by Dr. W. A. Seibart, entitled, "The Mercurius Mucous Membranes and Comparisons," which illustrates very brilliantly one mode of studying the *Materia Medica*. By a process of exclusion one nosological variety of mucous membrane disease is selected, namely, dysentery, and the symptoms of merc. sol. and merc. viv. as relating to this are given in a tabular form by a comparison with twenty-six other remedies, and they are grouped under the headings of (a) sensations, altered function and locality; (b) condition or modalities; (c) concomitants; (d) memoranda and differential hints. For instance, in merc. s. and merc. v. we have under (a) stools slimy, bloody, green, tenesmus in rectum, "cannot finish" sensation, burning in anus, prolapsus ani; bad taste, foul breath, salivation; tongue large, flabby, and shows imprint of teeth. Under (b) we have < during and after stool, not > by stool, < night, heat of bed and during perspiration. Under (c) we have constant desire to urinate but little passed; profuse perspiration that does not relieve; offensive sweat, chilliness after stool, weakness after stool, trembling, rheumatic pains in limbs. Under (d) is given "the more blood the better indicated," sporadic dysentery rather than malignant; intensity rather than quality differentiates this remedy from others. (*Hahnemannian Monthly*, November, 1909, p. 848.)—ED.

Notes on Provings.—The veteran, Dr. Cushing, of Springfield, contributes a few "Notes on Provings" he has made from

time to time, with some suggestions as to use of the remedies.

Glonoine.—A small quantity of the second decimal dilution ran down the outside of a vial, Dr. Cushing and a fellow-student touched their tongues with it. Within two minutes both were suffering from such severe headaches that they dare not repeat their experiment. A middle-aged lady was suffering from such a severe headache that she had been unable to leave her bed for several hours. One dose of glonoine 200 cleared away the pain in less than fifteen minutes. *Artemesia abrotanum* in Dr. Cushing's hands produced symptoms of paralysis of the extremities, and he has seen it do surprising work as a remedy of certain states of the kind. *Dioscorea*.—Referring to his provings of this drug recorded in Allen's "Materia Medica," although the doses were considerable no one apparently dangerous or serious symptom was produced. *Ratanhia* produced such an itching of the rectum that the test had to be quickly abandoned. *Verbascum* produced involuntary and sometimes unconscious urination, and has often cured inveterate cases of the same kind. *Phaseolus nana*, given as an infusion, rapidly relieved a lady suffering from dropsy, with malignant disease. In another case this remedy, given for the same condition, produced severe headache, which soon disappeared on ceasing the medicine. Dr. Cushing proved this on himself and got no urinary symptoms and no headache, but in a few days he was nearly pulseless. He was frightened to continue the proving. In a case of puerperal albuminuria and dropsy with failing heart, the child having been delivered in a convulsion of the mother, one dose of the ninth attenuation of phaseolus rallied the pulse and the patient made a good recovery. *Homarus*.—Dr. Cushing thinks that the gastric juice of the lobster will prove one of the most valuable remedies in the Materia Medica. In a proving of this substance two striking symptoms were produced, a sore-throat like diphtheria and a heavy, dull pain in the stomach that nothing relieved. Dr. Cushing believes homarus deserves investigation in cases of severe dyspepsia and malignant disease. (*Homœopathic Recorder*, November, 1909, p. 497.)—ED.

Pyrogen. *Characteristics.*—In an interesting paper on pyrogens Dr. Julia C. Loos gives the characteristics calling for the use of this remedy, and reports briefly the details of twenty-three cases in which it had been given. Compared with other remedies called for in febrile states tending to suppuration, Dr. Loos regards as the chief characteristic of pyrogen a variation of

the usual ratio between the temperature and the pulse, whether high temperature with low pulse-rate or the reverse. The following are the chief morbid states in which this remedy may be called for : (1) Septic conditions without characteristic symptoms and where other remedies have failed ; (2) acute zymotic fevers ; (3) conditions in which localized suppurative process occurs, aroused by traumatism or without traumatism ; (4) inflammatory conditions favouring or tending towards suppuration. The doses employed varied from the 10x to the C.M. (*Journal of the American Institute of Homœopathy*, November, 1909, p. 516.)
—Ed.

Tetanus (?) following a Cat - bite. *Nux Vomica*. —Dr. Walter Wesselhœft reports a rare and interesting case in which a severe tetanic condition followed three weeks after the bite of a cat, and in which the administration of nux vomica undoubtedly contributed very markedly to recovery. The patient was a man, aged 47, a printer, of a highly neurotic temperament, who had suffered previously from what was believed to be acute rheumatism. He was bitten by a cat while engaged in gardening and had been handling fresh moist earth. The cat was normal and remained so. No change of health occurred until three weeks afterwards ; the wound, which was in the right index finger, although painful and sore, had healed fairly well. The first symptom was a great increase in the patient's nervousness and irritability, extreme irascibility, and great sleeplessness. A few days afterwards there was an uncontrollable burst of anger, followed by a stiffening of the right side of his face, spreading to the left, with inability to open the jaws and the stiffness extending to the neck. The mouth was drawn to the left, and the right eyelid could not be raised or properly closed. In twenty-four hours the muscular rigidity gradually affected all the muscles of the neck and extended down the back, with frequent spasms of the muscles of the pharynx, twitchings of the face, and backward motions of the head. After another day attacks of opisthotonus occurred at intervals of from four to five minutes. The spasms were without actual pain, but extremely distressing. By the end of a week all the muscles of the back had become affected, also those of the chest, abdomen, and the diaphragm. The latter seemed to contract as the muscles of the back relaxed. Only naps of three or four minutes at a time were obtainable, and there was excessive sensitiveness to all external impressions, which would bring on the spasms. There was partial retention of urine, great desire

for stool with no power to expel fæces. There appeared loss of power in the legs. Swallowing was difficult, but now and then he could drink freely. The mind remained clear. Speech occasionally possible, although articulation difficult. The whole aspect of the case when Dr. Wesselhœft saw him pointed to nux vomica as the remedy, which was given in the 3x dilution, fifteen drops in water, as often as it could be administered. The first night after this there were longer naps although still spasms, but the latter gradually lessened in severity and frequency. At the end of a fortnight an abscess developed in the perineum, which discharged about a gill of offensive pus. No other remedy was given except one dose of cicuta, which did not help. In from five to nine weeks health was restored. (*New England Medical Gazette*, December, 1909, p. 556.)—ED.

Thiosinamine. *A Remedy in Tabes Dorsalis.*—About five years ago Dr. G. J. Müller, of Berlin, in order to facilitate the dilatation of a very tight stricture of the urethra occurring in one of his tabetic patients used injections of thiosinamine. Under the influence of the drug Müller found not only that the stricture became dilatable, but that there was decided amelioration of the vesical crises, as well as complete disappearance of the lightning pains in the lower extremities. Since this time Müller has used thiosinamine systematically in eleven cases of tabes, injecting every other day, or, in a few cases, every day, 1 c.c. of the following solution :—

Thiosinamine				
Glycerine	āā	10·0 grammes.
Sodium salicylate		20·0 „
Distilled water	...	ad.	100·0	„

The injections, when made into the body of the gluteal muscles, are practically painless, and produce neither abscesses nor toxic symptoms. Judging by Müller's experience, thiosinamine undoubtedly has power over certain manifestations of tabes. In five out of the eleven patients it caused complete disappearance of the lightning pains, and the other six, who are still under treatment, have already recovered their natural sleep. In one case there has been disappearance of strongly marked gastric crises, in another the drug has had a like effect upon the rectal and vesical crises, whilst in a third there has been a notable amelioration of laryngeal crises. Ischuria speedily disappeared in six of the patients, and in all the cases micturition became easier. The

general condition of all the patients showed considerable improvement which may have been probably due to the disappearance of the pains and re-establishment of sleep. The ataxy of the lower extremities appeared to be but little influenced by the drug, which also remained completely inert with regard to other objective symptoms pathognomonic of tabes. (*Semaine Médicale*, May 26, 1909.)—J. G. B.

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**“A STUDY OF CLINICAL AND PATHOGENETIC
SYMPTOMATOLOGY.”¹**

BY JAMES WATSON, M.B., C.M.EDIN.

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THE title of my paper is “A Study of Clinical and Pathogenetic Symptomatology.” Clinical symptomatology includes all evidences of disease, wherever found, however caused, and it would in and by itself furnish material for many papers more elaborate than the one I propose to bring before you to-night. I intend to confine myself to a general survey of disease manifestations such as will, I hope, prove interesting, and afford us some little help in our dealings with cases in everyday practice. The other component part of my title, “Pathogenetic Symptomatology,” is an equal, if not more extensive subject, but I purpose dealing with it after a somewhat similar manner. I hope to review its genesis, and discuss some of the points in which its constitution is faulty, or in which it might be improved, and also to summarize its merits, and

¹ Presented to the Liverpool Branch, December 9, 1909.

to illustrate those by reference to clinical cases such as we meet with in daily practice. You will, therefore, see that my paper, roughly speaking, will consist of two sections, of which the first will deal with symptoms as aids to diagnosis, and the second with symptoms as aids to treatment.

Before entering on the first part of my paper, I wish to acknowledge my indebtedness in the preparation of this section to a book entitled "Symptoms and their Interpretation," recently written by Dr. James Mackenzie, late of Burnley, and now Hon. Physician to the West End Hospital for Nervous Diseases, London. In treating of symptoms as aids to diagnosis I have followed the lines adopted by Dr. Mackenzie in that book, and have extracted therefrom certain passages in which he propounds some new theories regarding the utility of the reflex phenomena of diseases in the diagnosis of disease.

Clinical Symptomatology.

This embraces, as I have already remarked, all the phenomena of diseases, and is divisible into two constituent sections, composed on the one hand of subjective, on the other hand of objective, symptoms.

The subjective symptoms of disease are regarded clinically as of comparatively little value in the diagnosis of disease. But I venture to think that they do possess importance of a certain degree even in the anamnesis of the case, and that they cannot, therefore, be altogether overlooked.

They may be defined as expressions of the sensations of the patient, and they are discernible only by him. As a consequence they vary both in number and in degree according to the sensibilities of the patient. This explains, no doubt, the general attitude of reserve and scepticism which characterizes the attitude of mind from which they are regarded. Their estimation calls for the exercise of considerable judgment on the part of the physician. They may be general or local, the latter being met with in connection with any or all the systems of the body,

including the special senses. I propose to omit the consideration of all general subjective symptoms, and of local ones I shall deal only with that of pain. This symptom illustrates very forcibly the influence which the individuality of the patient has upon subjective symptoms, and, in consequence, we find that a proper appreciation of its value as a symptom is frequently not an easy matter. What would in the case of a highly neurotic, excitable patient be described as an acute pain or agony would, or might, in the case of one duller and more obtuse in his faculties very probably be spoken of as a sensation of discomfort, or at most of slight pain. This inequality of sensation caused by equal stimuli lends all the greater significance to what may be termed the objective indications of pain. These latter are met with in various localities, and are manifested in divers ways. Facial expression, bodily posture, or divers movements on the part of the patient may all bear witness to the presence and to the degree of suffering involved. Familiar illustrations of these evidences of pain are seen in cases of meningitis with retracted head and wrinkled brows, in cases of renal or biliary colic with restlessness and bodily contortions, and in hip-joint disease in the comparative immobility and flexion of the limb.

But pain as a symptom of disease, and as an aid to diagnosis, should be studied from some other standpoints. As Musser, in his work on clinical diagnosis, points out, much information of diagnostic value is to be got from the consideration of pain—as regards its character, its times and modes of incidence, and lastly, and most important, by the modifications which it undergoes under the influence of pressure, rest, movement, temperature, or mental diversion. The investigation of pain along these lines not infrequently throws considerable light upon the morbid process present, and should always be carried out.

Objective symptomatology comprises all those evidences and manifestations of diseased conditions which are discernible by the physician. The methods by which they are to be discerned are familiar to you all—they are inspection,

palpation, percussion, auscultation, together with chemical, microscopical and bacteriological examination of the tissues and fluids of the body. It is evident from this summary that all the faculties of the physician find scope for fullest exercise in the detection and recognition of the objective symptoms of disease. The scope of this paper does not permit of the consideration even in the most general way of the technique of the clinical investigation of disease. What does concern us here is rather the interpretation which is to be made of the objective phenomena of disease discovered—in other words, the physician has not only to discover the objective symptoms of disease, but he must also be able to analyse them and to discover the probable relationship subsisting between them. To illustrate—a patient presents herself with gastric symptoms of localized pain, fulness, vomiting, and it may be anorexia, and along with these symptoms we find well-marked evidences of anæmia—pallor of skin and mucosæ, general lassitude, headaches, and breathlessness. The problem, from the diagnostic standpoint, which the symptoms of such a case presents is this: which of the two series of phenomena is to be looked upon as causal in character—are the gastric symptoms dependent on the anæmia, or is the anæmia the resultant of the starvation and inanition produced by the presence of stomach disorder?

Or to take another example—a patient presenting symptoms of impaired kidney function, puffiness of eyelids, swelling of ankles, scanty and albuminous renal secretion of high specific gravity is found, on further examination, to have mitral disease of the heart with evidence of backward pressure in both pulmonary and systemic circulations. Such a patient, if only partially examined, might quite easily be erroneously diagnosed as suffering from a primary kidney lesion, whereas the fuller investigation of his symptoms shows that the real causal factor in the case is the heart disease. This latter example illustrates also the paramount necessity, for purposes of diagnosis, of a thorough examination of the entire patient in order to arrive at a satisfactory explanation of the phenomena presented. This desideratum is one which we are all more

or less apt to neglect. This happened, I regret to say, only recently in a case of my own, in which a patient whom I had for nearly a week been treating as a case of typhoid, was found by a colleague to be suffering from an osteomyelitis with pus retention. The general features of the case were not at all incompatible with the diagnosis of typhoid, but there were present local manifestations which, had they been seriously considered and reasoned out, would have shown that that diagnosis was untenable. Suchlike unfortunate accidents happen, I do not doubt, to most practitioners at one time or another, but it is specially incumbent upon homœopaths whose practice is based upon the proper appreciation of the diseased image to guard against such errors. But leaving aside all considerations of a therapeutic nature, the thorough examination of the patient is a matter of supreme importance in regard to the prognosis of the case, with which element we have much to do.

Before leaving the consideration of clinical symptomatology I wish to refer to Dr. Mackenzie's classification of it. He divides the symptoms of diseases into three classes : (1) Reflex symptoms ; (2) functional symptoms ; (3) structural symptoms as revealed by physical signs.

Of these three classes by far the greatest is the first, that of reflex symptoms. So great is this preponderance, in Dr. Mackenzie's estimation, that he considers that the reflex phenomena of diseases afford a basis on which to found a rational principle of diagnosis. He elaborates this hypothesis in the book to which I have referred, which is largely concerned with the reflex phenomena of disease, and the case which he makes out in support of it is so strong, and is so well supported by clinical data, that I feel warranted in bringing the main points of it before your notice.

It is in the first place necessary to recount some of the elementary points regarding the anatomy and the special functions of the nervous system in order to properly gauge the number and variety of reflex symptoms obtainable. "The nervous system consists of two great divisions

which are distinctly separated in their functions, viz., the cerebro-spinal and the autonomic. The former of these divisions occupies the brain and spinal cord, and the peripheral nerves (of it) are distributed to the external body-wall, and subserve the functions of sensation and muscular contraction. Incorporated with the cerebro-spinal system is the other division, the autonomic nervous system, which includes the origin of such nerves as the vagus and the sympathetic. This system presides over the functions peculiar to the different organs." It has efferent fibres passing from the centres (ganglionic and others) to the various organs, and much experimental work has been done in connection with these. According to Mackenzie, this system has also afferent fibres passing from the various organs to the ganglia or central nervous system, and in the normal processes of life a stream of energy is continually passing by the afferent nerves to the spinal cord, and continuously playing upon the efferent nerves that run to the muscles, blood-vessels, and so forth, maintaining what we call "tone" in the muscles and blood-vessels. These processes are conducted so that they give rise to no appreciable sensation. If, however, a morbid process in a viscus gives rise to an increased stimulus of the nerves passing to the spinal cord, this increased stimulation affects neighbouring centres, and so stimulates sensory, motor, and other nerves that issue from that part of cord. Such stimulation of a sensory nerve will result in the production of pain referred to the peripheral distribution of the nerve whose spinal origin is stimulated, so that visceral pain is really a viscerosensory reflex. If the incurred stimulus affects a motor centre, then a contraction of a skeletal muscle results, and thus is produced the visceromotor reflex.

Experimental evidence in support of this theory of Mackenzie's has recently been given by Professor Sherrington. He has been carrying out an investigation into the effects produced in the abdominal muscles by stimulating the sympathetic nerves. He dissected out and divided a branch of the solar plexus going to the bowel, and stimulated the *central* end. There was an immediate response in the broad

muscles of the abdomen, which contracted over an extensive area. By dividing one after another the posterior roots of those spinal nerves that supply this extensive area the extent of the contraction became greatly limited until when there was but one posterior nerve root left intact, the contraction became limited to a few fibres of the muscle.

The following clinical case which Mackenzie records as evidence in support of his hypothesis is worth quoting :—

A patient aged 36. For a couple of years the patient had suffered from violent attacks of abdominal pain. I never saw her during an attack, but the following was the condition found after a severe attack. The abdominal wall over the right iliac fossa was hard and rigid, due to the contraction of the flat muscles. When the skin was lightly punctured there was no increased tenderness, but pressure on the rigid muscle was very painful. The right thigh was slightly bent on abdomen, and could be extended only with difficulty, due to a tonic contraction of the psoas. When the erector spinæ muscles on both sides were lightly grasped those of the right side were found painful. There were frequent calls to micturition, the quantity passed each time being small and containing no abnormal constituent.

Mr. Caird operated. When the abdominal cavity was opened nothing abnormal could be seen at first. The parietal peritoneum was perfectly healthy, and only healthy coils of intestine were exposed to view. On separating these coils the appendix was found red and inflamed, adherent by soft, red bands to the cæcum and separated from the bladder by coils of uninflamed intestine. The appendix was removed, and the patient made a good recovery.

Another excellent illustration of reflex pain is seen in cases where the lesion is on the tissues supplied by the phrenic nerve. This nerve passes out of the spinal cord with the fourth cervical nerve, receiving occasionally small branches from the third and fifth cervical nerves, and it is distributed to the diaphragm, liver and gall-ducts. The sensory nerves leaving the cord at the same level—*i.e.*, with the fourth and fifth cervical nerves—are distributed to the skin over the top of the shoulder and down the outside of the arm. Hence arises the well-known association of top of the shoulder pain with diaphragmatic pleurisy and in

gall-stone disease. Another illustration in which the visceromotor reflex was mainly concerned is worth quoting. In a case of pyloric stenosis in which gastro-enterostomy had been performed, much pain and tenderness persisted in the left rectus muscle. As the patient experienced no relief she again consulted the surgeon who had performed the operation. He detected a small tumour in the abdomen and insisted on an operation for its removal. Dr. Mackenzie thought the tumour was a contraction of a portion of the fibres of the left rectus muscle. The abdomen was opened. No tumour was detected, but there were numerous adhesions attached to the parietal peritoneum, stomach and bowel. It was manifest the apparent tumour had been entirely muscular, this contraction being in the nature of a reflex, for there was no extension of the inflammation from the adhesions to the muscles.

These illustrations will suffice to show the way in which Mackenzie, from practical clinical cases, seeks to substantiate the claim of reflex symptoms as affording a basis for which to found a rational principle of diagnosis. For the successful carrying out of this hypothesis in practice, it is naturally essential and of the highest importance to know the nerve supply of the part in which the pain is felt and the relation of the nerves to others in the central nervous system. The manner in which the pain spreads and the appearance of other phenomena due to central stimulation provide this clue, or, as Mackenzie puts it in another part of his work, phenomena appearing at a distance from the causative lesion give the best clue to the seat of the disease.

We pass now from the consideration of the symptoms of natural diseases to the study of the symptoms of artificial drug diseases. This constitutes our pathogenetic symptomatology, and is the product of experiments which have, from the time of Hahnemann downwards, been made with drugs upon the healthy human body. This method of ascertaining the pure effect of a drug has its limitations and weak points. It is for the most part only capable of partial fulfilment. Except in cases of poisoning we cannot by this means determine to the full the drug's action. Further,

as compared with experiments upon animals, this method affords much less scope for scientific examination into the organic and the tissue changes brought about in the experiment. The method labours under these additional disadvantages: that the personal equation of the prover is always more or less an unknown quantity, that a certain degree of morbid introspection on the part of the prover is almost invariably present, and lastly, that not a little ambiguity of language, or it may be even inaccurate statements on the part of the prover, which it may be difficult to detect, must be allowed for. These must all be reckoned with as sources of possible error. But, even allowing these defects, to my mind, there still remains a credit balance in favour of this method as compared with experiments upon animals or *abusu in morbis*. I need not labour this point, as I think you will all agree that Hahnemann was correct in saying that the drugs act as such, and are only efficient in so far as they are capable of altering the health of the otherwise healthy body. There are several considerations regarding our pathogenetic symptomatology as a whole which I would briefly refer to. In the first place, exception has frequently (*vide* "Dudgeon's Lectures") been taken to the mould in which it has been cast. Hahnemann adopted, as you are aware, the schema form in which all the symptoms of all the subjects were collated and arranged in bulk under various anatomical headings and systems. The result has been an aggregation of an extremely heterogeneous mob of symptoms, many of which seem mutually contradictory. Again, it has been objected that no chronological order of events has been observed, so that we have little knowledge of the sequence of the events recorded, and lastly that little or no attempt has been made to verify the symptoms produced by an investigation of the objective phenomena which one would suppose must have been associated with them. In regard to these criticisms, I would remark that considering the number of subjects engaged in the experiments, some such simple arrangement as the schema was the only feasible one—that any arrangement necessitating on the part of the provers any, even the most elementary,

knowledge of the physiology of their time would, even though successfully carried through, have resulted in a symptomatology which would soon have become antiquated and out of date, whereas the records of the provings as they now stand, being statements of plain facts, remain good, and will continue to hold good whatever advances the collateral sciences may make. This is a point on which Dunham, in his "Science of Therapeutics," lays great stress, and rightly so, I think. The deficiency in the chronological element appears to me to be a matter of but little importance. The contrary opinion arose probably owing to the theory which many men have advanced, that drugs have alternate, and for the most part contrary effects, which they designate as primary and secondary. The familiar illustration quoted in support of this theory is that of aconite, in which the symptoms of the chilly stage are taken to represent the primary effect of the drug, whilst the later symptoms of the heat stage are representative of the secondary effect. This arbitrary subdivision of the pathogenetic effects of aconite would almost seem to have been previsited by Hahnemann, when he says in his introduction to the proving of it—"Aconite is one of a few drugs whose primary action consists in several alternating conditions of chill or coldness and of heat." As Dunham says in relation to this point: "The process of inflammation consists of several successive steps, and it is true that the earlier steps are prior to the later, but they are equally successive and necessary steps in a uniform and definite process, and nothing justifies the drawing of a line anywhere in the process, and affirming that all that lies behind the line belongs to a different and opposite series to that which lies in front of it."

Our pathogenetic symptomatology, taken as it stands, affords us what is, to all intents and purposes, a series of clinical pictures indicative of the scope and character of the effects of our drugs. Here, as formerly, in the case of clinical symptomatology, the symptoms are divisible into two great classes, subjective and objective. As has already been hinted at, the subjective symptoms have, in the case of

provings, met with almost more recognition than have the objective ones. Of the subjective symptoms, those of the mind and of the morals have been elevated to what I consider their fit and proper place. They rank first and foremost. They are frequently so pronounced that they colour, as it were, the whole picture. In the case of arsenic the anxious restlessness of mind finds a fitting expression in the bodily uneasiness, whilst with hellebore the mental lethargy is accompanied by a corresponding bodily depression and languor.

In dealing with the clinical symptomatology of disease I referred to the modalities of pain met with in pathogenetic symptomatology. This affords us the greatest possible scope for investigating the variations, not only of pain, but also of very many other important symptoms, under numerous extenuating circumstances and conditions. This is one of the most illuminating and characteristic features of homœopathic pathogenesis, and is of great service in practical operation.

Lastly, as a result of the very numerous experiments which have been made from time to time, various drugs have come to be associated with certain constitutions for which they seem to have a special affinity. This is shown by the very ready response which those constitutions make in provings. The practical outcome of this is, in some instances, so marked that we can very often foretell by the merest cursory survey of the patient what his or her medicine is to be. The calc. carb. patient, the pulsatilla patient, the nux vomica patient, are all familiar examples and have been evolved through the study of our pathogenetic symptomatology.

We come now to the consideration of the relative values of the symptoms of drug provings. I have already referred to the place of honour which symptoms of the mind and of morals holds. But from the standpoint of relative values of symptoms, a classification of the symptoms, into what are known as (1) general and (2) particular, is worth noting and exemplifying.

(1) General symptoms are those which apply to the patient

as a whole, and include, besides general sensations of heat, cold, &c., general aggravations and ameliorations.

These general symptoms of our pathogenesis are of the greatest importance, and are the most reliable ones on which to base a prescription. Our reason for this is, as was pointed out in a recent number of the *Medical Advance*, that drug generals have appeared in so many of the provers, and in so many different localities of the provers, that they are evidently an essential expression of them. One advantage which these drug generals have over the other symptoms is that they can be utilized in connection with the organs and tissues of the body, even though in the records of the provings they may not have been elicited therein.

(2) Particular symptoms are those appertaining to a single part or function of the organism. They vary much in value, generally speaking, according to the part or function of the part affected. Many of the particular symptoms of the mental sphere are of importance—*e.g.*, sadness, suicidal tendencies, anxiety, and restlessness; whereas particular symptoms appertaining to, say, a secretion of a gland or an emunctory are, for the most part, of comparatively little value.

There are other modes in which symptoms of our pathogenesis can be classified—*e.g.*, into common or peculiar, the latter affording the basis of what is known as keynote prescribing (see the BRITISH HOMŒOPATHIC REVIEW, December, 1909). I have not, however, sufficient time at my disposal in which to elaborate this part of my subject.

I promised, at the outset of my paper, to illustrate, by reference to actual clinical cases, the uses to which our pathogenetic symptomatology can be put. Such illustrations will serve to show what forms the basis of my prescriptions, which is a point of very great importance, and has, I believe, great influence upon the outcome of treatment.

The following case came under observation twenty-four hours ago, and, therefore, the result of the treatment adopted remains yet a thing unknown—and an interesting topic for speculation.

T. A., aged 34. For eight years, 14 to 22, employed in chemical works ; for subsequent ten years casual labourer, and for last two years chronic invalid.

Family History.—Father had two operations for cancer of lip ; recovered from both, and ultimately died of some other trouble, exact nature unknown ; mother died, aged 54, from cancer of womb.

Personal History.—Has no knowledge of ever ailing a thing until three years ago, with the exception that he once had an eruption of pimples and spots on his back which caused considerable discomfort, and was treated locally. Three years ago had his first attack of gastric pain, with vomiting. This has occurred at intervals ever since, but during the past two years the intervals have become gradually less and less. Two years ago he was an in-patient in the Hahnemann Hospital ; later on he was on two occasions in the Royal Infirmary, and finally, in June of this year, he went into the Royal Southern Hospital, when in view of the entire failure of medical treatment he underwent the operation of gastro-enterostomy. The patient's account of the condition as found at the operation is, as is usual with this class, very indefinite, but his wife was given to understand by the nursing sister that the condition was a cancerous one, and that nothing further than making a false passage for the food from the stomach to the bowels had been possible. The pain is located by the patient in the epigastric region, with, since the operation, an extension to the region below and to the left of the umbilicus. One feature of the earlier months of his illness was that in between the attacks of pain he had a most ravenous appetite, and could eat and apparently digest almost anything. But such clear intervals were always followed by very severe attacks of pain, and very heavy though difficult emesis, the vomited matter being nasty, slimy, semi-solid, followed by copious yellow-greenish fluid. There is a history of passage of blood in stool before operation. Constipation has been a prominent feature throughout illness.

Present Condition and Physical Examination.—Pain in epigastric and umbilical regions of a gnawing character, almost constant ; has marked aggravation after anything taken, either solid or fluid, except in the case of cold water, which relieves for a time ; suffers greatly from flatulence upwards, but escape of it affords little or no relief. Weight which when in health was known to average 12 st. 4 lb., has greatly gone down, and is now estimated to be about 10 st. Weak and debilitated to an

extreme degree, yet says if the pain was to go away he could get up from his bed, and get about quite well. He is of a dark, swarthy complexion, and I noticed during the interview that he was very cross and irritable, being specially intolerant in his behaviour towards his wife. Milk and eggs, but especially milk, cause greater aggravation of his pain than anything else does. There was no history to be got of any special desires or aversions in diet in the pre-illness days. Was practically a non-smoker and a very moderate drinker. Apart from the amelioration through sipping cold water, the only relief was from lying over on his right side.

Physical examination showed extremely bad teeth, a common condition amongst workers in chemical factories, and said by them to be due to the gases they encounter; tongue large, flabby, sparsely coated white, abdomen presents the usual gastro-enterostomy scar. Cutaneous hyperalgesia was found to be present only in two limited areas, close to margin of left costal arch, and below and to left of umbilicus; tenderness on pressure was found extending over entire epigastrium, but this was most marked over left rectus muscle—viscero-motor reflex of Mackenzie.

Query—What was the treatment to be? The points upon which I based my prescription—which was sepia 200, one dose—were: (1) The mental symptoms of crossness and snappiness; (2) the aggravation from milk; (3) the relief from lying on right side; (4) the attacks of ravenous feelings, which I interpreted to mean an inward craving and emptiness. I could elaborate these points, but await your criticism with interest. With the recital of another interesting but very brief case I will close my paper.

C. D., a single lady, aged 33; of a markedly neurotic temperament and disposition. I was called to see her for the first time on December 2, 1909. I found her suffering extremely from dysmenorrhœa. The trouble was of many years' standing, and had been treated by numerous doctors. She was practically beside herself with pain, and the mother had tried all their usual remedies without effect. When I could calm her sufficiently to get indications, I found that the pain originated in the left inguinal region, that it came in paroxysms, and was of a colic-like character, slowly gathering in force until unbearable. This was varied at times with sharp pains flying across to right abdomen. Immediately I heard that I put my hand on ribs

below left breast, with the result that the patient rebelled, as I had struck a spot which was already painful enough. Personal general history showed bad attacks of chorea, and also indications of rheumatism. On these points a dose of *actæa racemosa* 200 was given dry on the tongue, with s. v. r. in water to follow.

I had a few minutes' conversation with the mother downstairs afterwards. When I called the following day I found the patient up and about, complaining only of surface-bruised feeling, and I learned that the mother, on returning to the room after my departure, had found the patient asleep, and that there had been no return thereafter. One curious point remains to be noted in this case: the period had set in nearly sixteen hours before the pain, which in a case of rheumatic or spastic dysmenorrhœa is, I think, unusual.

A SHORT DEMONSTRATION OF SOME POINTS IN TECHNIQUE ACCESSORY TO OPERATION, AS RECENTLY OBSERVED IN VIENNA SUR- GICAL CLINICS.¹

BY GEORGE BURFORD, M.B., C.M.ABERD., M.R.I.

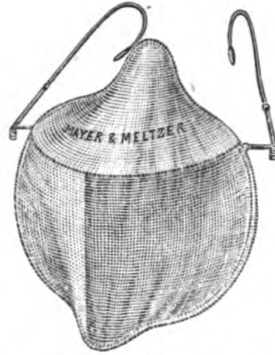
Senior Physician for Diseases of Women to the London Homœopathic Hospital.

MR. MATTHEW ARNOLD tells us that culture is the "striving after perfection"; and surgical culture, therefore, is the striving after surgical perfection. It was the spirit of surgical culture—the striving after perfection—that took me to Vienna during this autumn, and here I renewed those enthusiasms which inspire all who make Vienna their post-graduate Alma Mater—after an interval of twenty years. Then, Billroth was giving his splendid lead in stomach operations, ushering in the dawn of that work on the alimentary tract which is now surgical use and wont. A smart, bright assistant he had then, the Freiherr von Eiselsberg. To-day von Eiselsberg sits in the seat of his master, and conducts the first surgical clinic. How they work in Vienna may be inferred from the fact that operative procedure frequently begins in this clinic at 8 a.m., and in summer, I am told, at 7.30.

¹ Presented to the Section of Surgery and Gynæcology, January 6, 1910.

The first thing I noticed in this clinic was the use by all operators and assistants and anæsthetists of some form of face-piece. For rank-and-file operations it was the wire-frame mask. This is simplicity itself, is easily replenished, will boil like any instrument, and is cheap and lasting. I have worn this myself in an operation lasting two hours, and found it quite pleasant to bear for that time. Why is it necessary? Mr. Lockwood tells that even with quiet talking and quiet breathing bacteria may be emitted from the air-passages. Hence the oro-nasal mask.¹

But for abdominal operations the more elaborate head-piece, with a face-veil like an Egyptian yashmak, is utilized. And this again is cheap, easily cleansed by boiling, and



Protective Mask for Mouth and Nose (as used in Vienna).

effective. It is quite comfortable; I have worn it during an abdominal operation lasting one and a half hours, and am gratified with the procedure. The advantage of the wire-gauze mask exists *in excelsis* in the face-veil.²

So much for head-dress; now for hand covering. All having part or lot in an operation wear gloves—of the usual india-rubber type. I have nothing to add to the glove controversy; I merely remark that here gloves are *de rigueur*, as part of the surgical equipment.

Every stranger admitted had to take off his coat and put on a sterilized gown.

¹ This has been supplied for the London Homœopathic Hospital by Messrs. Mayer and Meltzer.

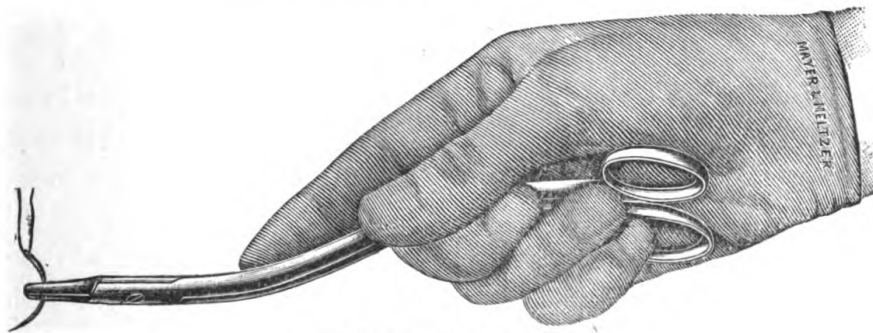
² Also supplied by Messrs. Mayer and Meltzer.

Of needle-holders there is no end; and when I was formerly in Vienna the pattern I saw used was what is called the Russian variety. But now the form used practically at all the important clinics is a German one. I



Complete Head and Face Veil for Operation (as used in Vienna).

have used it myself; it is to my mind much superior to Doyen's or Hagedorn's, or any other form of needle-holder I have seen or used. It includes in its range of usefulness three aptitudes, according to the method of holding:



New Needle-holder.

(1) For light work—intestine, &c.; (2) for medium work—breast, &c.; (3) for heavy work—where the resistance is great. I cordially commend this needle-holder to the critical notice of all my colleagues.¹

¹ This has been supplied for the London Homœopathic Hospital by Messrs. Mayer and Meltzer.

Naturally, my interest was greatest and my time most spent in the vast gynæcological clinic — new buildings, away from the old site, which, on their size and importance the city of Vienna justly prides itself. They are as large as the whole buildings of some of our principal medical schools; and well they may be, for in the obstetric clinic on the average 3,400 births take place annually.

These buildings, only recently completed, are supposed to represent the last achievement in the struggle after perfection in obstetric and gynæcological operating and nursing.

(1) Operator and assistants alike wear the head-cap and veil, as well as operation costume.

(2) All wear gloves, but the operator and assistants two pairs—the ordinary rubber, and over it a very thin, white thread glove, said to give “bite” to the rubber glove.

(3) Rubber high overshoes—nurses, operators, and all wear them—for the quantity of water used is great and the floor wet. But their primary use is to sterilize the walking and standing equipment.

(4) The nail-brush for cleansing the patient's skin is disestablished. I always had my doubts about it, and here it is banished. In its place is used a handful of absorbent fibre, such as wood or tow. These are sluiced with fluid soft soap, and then the scrubbing is done and the handful of fibre thrown away. Next, another handful is taken, soaked with mercury solution, and rubbed on the skin or vulva in the same way, and then sacrificed. And just before the operation is begun, the skin incision area is rubbed with a strong solution of iodine.

Artificial sponges are used out of the sterilizer direct, and are not washed or used again, but flung on one side and counted after operation. As each is rejected it is hung on a kind of framework for easy count when all is over. I enumerated in one operation as many as seventy-five thus strung up.

Now, all these details—(1) the accoutrements of the operator, assistants, and nurses; (2) the antiseptic preparation of the patient, no cake soap nor nail-brush being used; (3) the complete sterilization of instruments, the ex-

travagance in sponges, the free use of silk for nearly every suture and ligature—all these make the operative technique here as nearly perfect as possible. They conform to the rigid aseptic rule, that nothing is brought in contact with the patient that is not capable of being boiled beforehand.

Still, like Opie's paints, antiseptic details have to be mixed with brains. Here patients do not die of sepsis, but the mortality bill, I am told, is unnecessarily high from post-operative pneumonia, and this is attributed by the *habitués* of these clinics to the unlimited drenching with sterilized water. The patients lie in wet packs, so to speak, during operation time; and while the surgeon is fully satisfied, the physician is not.

So much for the great gynæcologic clinics.

There remains—in importance like the lady's postscript—what I chiefly went to see, the operative procedure in the women's department of a smaller suburban hospital, where Wertheim does that operative work on cancer of the uterus which has, in a few years, given him world-wide fame.

And here, as his chief assistant, Dr. Werner, assured me, the operated patients may die of necrosis of the ureters, but of sepsis, *never!*

Here I saw a little thing which well illustrates the capacity of the German mind to include trifles. We plug our wash-basins with a stationary rubber plug; often it has a chain permanently attached, and may be the rift within the aseptic lute.

But in Wertheim's clinic a solid ball, encased in rubber, is used to plug; and can be taken out and boiled as many times as you please.

Trifles make perfection! I venture to show you a suitable ball which, I believe, resembles in size an item used in the ancient and royal game. Do not imagine that modern-made golf balls will do—these perversely float—but I am informed the older varieties do not float, and if you can get hold of these so much the better. This specimen came from the Hospital Contracts Association, and has had to be loaded to cause it to sink.

The aseptic ritual at Wertheim's differs in no material

point from that at the greater gynæcological clinics. The abdominal and vulvar skin is scrubbed with liquid soap, then with cotton-wool soaked with alcohol, and finally with ether, in the same way. Other minor points call for no special notice.

In Wertheim's museum, over which I had the honour to be personally conducted by the Professor himself, are ranged 500 specimens of uterine cancer removed *per abdomen* by his special method during ten years. Half of these are placed along one wall; they are those where no recurrence has been traced in the after-history. Approximately half are ranged along the opposite wall; these are those where recurrence has taken place. Still, I submit it is a great record to present, out of 500 cases, 250 which, during this ten years' work, have remained free up to the present from the reappearance of this dire malady.

The after-histories are looked up from time to time with a zeal and a method that are characteristically German, I mention this pathological arrangement in order to show to what clinical use museum collections can be kept and turned. Here they are not merely dead organs kept in an imposing array of jars. By their arrangement they constitute an important clinical control on the conduct of the operation, and give a warrant for the operative procedure as regards its several details, for the weakest points in any case can be at once determined by comparison of each specimen with the after-history of each patient.

A portion of each growth is removed for microscopic investigation; the portion is cut into microscopic sections in series, amounting to scores in each instance: each of these sections is stained, mounted, and examined, in every case.

Here, again, is a striving after perfection: it is this constant striving that marks surgical culture. Trifles make perfection, but perfection is no trifle!

Dr. EADIE, in opening the discussion, thought that English surgeons were not far behind the Germans in the respects to which the author had called attention, because at least two years ago he saw almost the same appliances as those shown

by Dr. Burford in use at Mr. Barker's clinic at University College Hospital. In fact, if anything, the technique used in that hospital was superior to that of Vienna. He saw Mr. Barker perform an appendectomy about eighteen months ago in which he did not touch the patient with his hands at all, but only with the instruments. Instead of using a headdress like that shown by Dr. Burford, Mr. Barker merely put a piece of gauze over the nose and fixed it behind his head. It acted in exactly the same way, and was not so warm. Mr. Barker also wore a cap which came down over the forehead, so that the whole of the face with the exception of the eyes, was covered. He also wore sea-boots which came up to the knee.

Dr. HEY in referring to the method of sterilizing the field of operation adopted at Vienna, said that the amount of biniodide of mercury and rectified spirit that was deliberately wasted on each individual case in Wertheim's clinic was astonishing. A patient was stripped naked and after being washed with soap and water a bottle holding about a quart of biniodide was poured over her and rectified spirit in a like proportion was rubbed into the skin. If rectified spirit cost as much in Vienna as in London, it was a very dear process to sterilize one patient, and he was certain that it was not necessary to waste such a large amount of spirit lotion. He thought the large amount of post-operative bronchitis in Vienna was not entirely due to the fact that the patients lay to a certain extent in a wet pack, because the last two applications made to the patient were rectified spirit and ether, so that the patient was pretty well dry before the operation commenced. He blamed the existence of post-operative bronchitis more than anything else to the absurd manner in which the anæsthetic was given. The idea was prevalent in Vienna that the gutter round Schimmelbusch's mask, used in many hospitals for chloroform, was intended to catch the excess of chloroform. It was not intended for that purpose. The Germans, however, carried the idea to such an extent that at the end of the mask they made a spout to carry away the excess of anæsthetic poured on to the mask; and whilst the patient was being anæsthetized it was a common thing to see the anæsthetic run out of the spout on to the patient. The anæsthetic was given in a most careless manner; in fact he had never yet seen a decently anæsthetized case in Vienna. Viennese technique might be elaborate and perfect, but the method of anæsthetizing was very opprobrious.

Dr. E. A. NEATBY enquired whether the needle-holder exhibited by Dr. Burford was capable of receiving the Hagedorn needle.

Dr. BURFORD replied in the negative.

Dr. NEATBY said he had been particularly interested in what Dr. Burford had said about the abandonment of the scrubbing-brush in Vienna, because Sir Almroth Wright had been teaching the same doctrine in this country. Wright had shown that the micro-organisms multiplied very rapidly in skin that was much stimulated by compressing and scrubbing. Personally, he often thought that the amount of scrubbing which used to be done at the Homœopathic Hospital was a little defeating its own object by wounding the skin, and latterly he had done very much less in that direction. He was not at all convinced that the compress over night was the best form of rendering the skin less septic than it was at the beginning, because of the multiplication of germs which ensued. Wright had proved that at the end of a long operation the hands of the operator were usually extremely infectious, even if they were not at the beginning, by reason of the multiplication of germs in the soft, moist skin. While some of the features that Dr. Burford had brought forward were of great importance, it was not necessary, as Dr. Eadie had said, to go as far as Vienna to find them, because they had been seen for a long time past no further away than in the operating theatre of the Homœopathic Hospital.

Dr. SPEIRS ALEXANDER thought it would be of interest if the question of pneumonia to which Dr. Burford had referred could be further elucidated. Was it the case that a special grade of pneumococcus existed in Vienna, or was the trouble due to the water used in the course of the operations? He did not quite follow Dr. Hey's suggestion that it might be due to the manner of giving the anæsthetic. Slipshod as the method might be in Vienna, it was perhaps superior to that sometimes employed in Berlin, where he had seen a sponge put in the bottom of a bag made of jaconette, saturated with the anæsthetic and put over the patient's face, the anæsthetic being administered by the porter. With regard to the use of the scrubbing-brush, he had recently seen a paper by Dr. Freeman Fergus, the well-known oculist of Glasgow, who endeavoured to sterilize the conjunctival sac with perchloride of mercury and nitrate of silver, without success. At the end of the sterilization, so-called, Dr. Fergus found that the microbes were just as numerous as ever, which he attributed to the fact that the antiseptics impaired the integrity of the epithelium, so that the microbes took a firmer hold than ever on the structures. When, however, a copious douching with normal saline was carried out they were entirely eliminated, which Dr. Fergus attributed to

the mechanical washing away of the microbes. Perhaps the same principle could be applied even to abdominal operations. If the abdominal wall were well doused with normal saline, the opprobrious microbes might be got rid of.

Mr. KNOX SHAW said that the operative results obtained in England were not behind those obtained in Vienna. All English surgeons did not carry the technique to quite such an elaborate extent, but without such elaboration results were obtained in the London Homœopathic Hospital of which they were not in the least ashamed. A septic case was a comparative rarity. In all operation cases the personality of the operator or his assistants played an important part. Very often it was owing to some peculiarity in the personality of the operator that sepsis seemed to dog his footsteps, however careful he might be. Frequently the sepsis was in the surgeon and not in the patient. It might be necessary for one surgeon to take infinitely more care than another, because he was septic. It was necessary to exercise greater care when a surgeon was constantly changing his assistants and his surroundings. If it were possible to ensure that the same assistants always worked with the same surgeon, perhaps such rigid precautions were not so necessary as when an unknown element was introduced into the case.

Mr. DUDLEY WRIGHT did not think it was desirable to compare results obtained in a small hospital with those obtained in a large hospital. In watching operators in a big hospital he had often been struck with the fact that they had a very great deal to contend with. In an operation at the Homœopathic Hospital there were present the operator, the house surgeon, the anæsthetist, three nurses, and occasionally two or three students, the latter of whom were never allowed to touch the instruments. But in a large hospital many factors came into play which were liable to introduce sepsis, especially in a medical school. There were usually several students who were dressers, all of whom were to a certain extent allowed to participate in the operation, not so much in handling the instruments, but in giving such minor assistance as might be required. He therefore thought it wise of the operators in large hospitals to take every precaution they possibly could to prevent sepsis. He did not believe that in small hospitals like their own such precautions were so necessary. Personally he had never used a mask, and only occasionally had he used gloves, and nevertheless, like Mr. Shaw and others, his results had been extremely good. It was also his experience that operators in their early operating days were much more liable to

get their cases septic than later on. He supposed that was due to the fact that the operator in time became more accustomed to the technique of the operation, and obtained more knowledge of how sepsis was prevented. The results of a house surgeon or a man just appointed as assistant surgeon to a hospital were seldom as good as those of a man who had been operating for some years, and who had learnt by sad experience the risks run. In the first two years of his operating career he had more septic cases than he had seen for many years past. Another very important feature was the ligature. In private work he was very careful to keep the ligatures in absolute alcohol, and he found in that way the risk of sepsis intervening through the use of the ligatures was entirely obviated.

Dr. E. A. NEATBY said that since he had used gloves for all abdominal operations, a matter of three or four years, and had insisted upon the assistants and nurses wearing gloves, he had been very gratified at the better results obtained. Not only was general sepsis practically excluded, but the annoying trouble of stitch abscesses had been practically banished. He had come to the conclusion that the handling of the stitches by the surgeon during sewing, and the threading of the needle by the sister or nurses, were a very prolific source of infection; but since gloves had been used, and the little pair of forceps which Mr. Shaw had introduced for taking hold of the stitches and keeping them taut, much better results had followed. With reference to the question of the head-mask, quite a long time ago he was led to the use of a cap from the remark made to him by a house surgeon who was assisting him at an operation that a piece of scurf had fallen into the open abdomen. He had noticed in watching others operate that very often the "fringe" of the operator's hair rubbed against that of his assistant, and it was not the operator's "fault" if dust or scurf from the hair did not drop into the abdominal wound; so that he felt he was justified in adopting what was at that time a peculiarity in the hospital, namely, the wearing of caps, and he was satisfied that that was a good plan.

Dr. BURFORD, in reply, said he fully agreed with the remark Mr. Knox Shaw made with regard to the importance of the personality of the operator. It was really that fact which underlay the whole of the elaborate equipment of the Vienna Hospital. The idea of the Vienna surgeons in insisting upon such aseptic ritual was to eliminate personality. Everybody had to do the same thing in the same way. The whole equipment was as far as possible ideal, and the Vienna surgeons then knew

that it was not necessary to take into account the mental vagaries or personal equations of any kind on the part of the operator and his assistants. When the peculiarities of personality were eliminated, a great deal had been done to ensure the safety of every patient who came under the operating hand. With regard to post-operative pneumonia, he could not say why the post-operative complication should be pneumonia instead of bronchitis. He did not make that observation himself, it was the opinion of some American house surgeons who had been at Vienna for a long time, and who noticed that an appreciable number of patients died with the clinical symptoms of pneumonia and the pathological appearances of pneumonia. He had no doubt, as Dr. Johnston had suggested, that since the buildings were erected in 1880 a special variety of pneumococcus had increased in virulence within the walls, and the conditions existing during the course of the operation made the place a happy hunting-ground for a pneumococcus to live and thrive. A post-operative mortality after major operations existed in Vienna from medical complications; and the Viennese surgeons did not seem to have risen to the situation and ascertained the cause. There came times and seasons in an operator's career when he had to trust to something else beside aseptic measures. A good many of the people who went to the Vienna Hospital were dirty, country people, many of whom were imbued with the idea that water was chiefly drunk and soap eaten. Something more than asepsis was necessary for such cases. It would be remembered that Lawson Tait openly despised antiseptics of every kind in his wonderful work in the early days in his abdominal operations, and kicked a visitor down the stairs because he would not believe what he said. He wished also to say a word with regard to the perfection of Dr. Neatby's operative ritual. He had watched it again and again, and had been filled with appreciation of the extraordinary care his colleague had taken to limit the personal equations of his assistants. He remembered that in one case he (Dr. Burford) got half-way through an abdominal operation before he discovered that one of the nurses who was washing the sponges had a purulent discharge from her nose. If everyone present at the operation wore a mask such risks would be minimized. Dr. Eadie had said that it was not necessary to go to Germany for the latest information in surgical technique, and that this country led the way. There were two points, however, in the particular hospital to which he referred in which the Germans led the way. He saw one patient who, after having the anæsthetic administered to her, collapsed

on the table. Personally that was the first death he had seen from anæsthetics for many years, and he thought the Germans could be yielded the palm in that respect. He also attended the chief clinic of the chief surgeon in a great Austrian town. The surgeon had been away for a holiday, and the assistant had prepared for him a series of major operations on his return. The first operation was a case of supposed appendicitis. The professor made an enormously long incision, about a foot long. He made a search after the appendix, and eventually drew it out, but with absolutely nothing the matter with it. Nevertheless, he cut off the appendix; no examination, however, was made of the gall-bladder or the state of the pelvic organs. The patient's long incision was stitched up, and she was returned to bed. She had risked her life in a serious operation; she had an organ removed that had nothing the matter with it, and she ran all the risks of post-operative hernial trouble. On such a point the London Homœopathic Hospital would yield the Vienna Hospital the palm. All the questions to which he had called attention were manifestations of the striving after perfection manifested in Vienna. It was not to be supposed that they would ever stand still. It was the striving after perfection which the surgical side, following at a distance their friends on the medical side, always endeavoured to keep before them, and from that point of view it would be impossible to read a better article than Dr. Neatby's interesting contribution to the current number of the *Homœopathic Review*. Dr. Burford referred to a case of a medical colleague who had his prostate removed by Mr. Freyer, and who stated that he attributed a considerable part of his recovery to the size of the tube used. On the other hand, there was lying in the room next to the patient another medical man who was operated on by the perineal route by Mr. —, and who was dragging out a long and painful convalescence. The perineal wound did not heal, and the patient heartily wished he had not had the perineal operation performed upon him, but had been operated on by Mr. Freyer.

THE PRESENT POSITION OF PROSTATECTOMY.¹

BY C. KNOX SHAW.

Senior Surgeon to the London Homœopathic Hospital.

It is an unfortunate weakness in our profession that having got hold of a good thing we are inclined to run it to death; and this applies equally to medicine as to surgery—to drugs and to operations. We read in our journals, and hear at our meetings, the value of certain operations: we have, as a rule, the best side enthusiastically presented to us, and we are too apt to think that every case of the particular disease under discussion will be benefited by this, the latest and most up-to-date operation. An era of indiscriminate operating ensues, and as a number of unsuitable cases are submitted to operation, discredit is brought upon what is really a sound method of treatment if properly applied. The last ten years has been fruitful of such experiences, and it is with the hope of trying to place the prevalent operation of prostatectomy, and to initiate a discussion upon the most suitable cases for operation, that I am asking your kind attention for a few minutes this evening. Though operative surgery is spreading among the general body of the profession, the operators are still in the minority, and the general practitioners in the majority. Now I have not unfrequently found that it is the general practitioner who will promise the patient splendid results from an operation which the operating surgeon fails to confirm or fulfil, and it is with the desire of assisting those who have the early care of prostatic cases to arrive at a wise decision that I am reading this short paper.

We all know the usual symptoms that draw our attention to prostatic obstruction, but we must never forget that in a middle-aged patient urinary difficulty with incapacity to completely empty his bladder is not always dependent upon an enlarged prostate, but may be due to simple stricture; or

¹ Presented to the Section of Surgery and Gynæcology, January 6, 1910.

to loss of bladder reflex from locomotor ataxia, of which I have seen several cases; or even to a simple neurosis, of which I have had experience. Any operation on the prostate in such cases as these is, of course, quite out of the question.

I am strongly of opinion that the catheter, carefully and scientifically used, still has a valuable place in the management of prostatic cases, and should not be lightly thrown aside for what, after all, is a serious operation. For an operation with a mortality varying from 7 to 16 per cent. requires careful consideration before being recommended. Nor should we, when we are first called to deal with a patient presenting the symptoms of prostatic obstruction or prostatic retention, think at once of offering an operation upon his prostate. Let us take the first class of case—prostatic obstruction—first: a man between sixty and seventy has found an increasing difficulty in the act of micturition, the force of his stream has abated, he micturates more frequently than normal, he is not feeling as well as usual, has some indigestion, his appetite has failed, he is thirsty, and he has possibly lost weight. His urine is probably of low specific gravity, and either has no albumin or a mere trace. He has no idea himself that he does not empty his bladder, but on examining him that organ will often be found distended, even as high as the umbilicus. An examination *per rectum* should now be instituted, which may or may not disclose an enlarged prostate. If it be a large adenoma, the finger, *per rectum*, will be of great value, and if the bladder is empty, a bimanual examination will add confirmation to the diagnosis, but if the enlargement is confined principally to the median lobe the finger may not be of much service. We must then come to the catheter. Here is a man standing on the brink of a precipice. His general condition is not good, he probably has commencing secondary renal degeneration owing to his vesical incompetence. Submit him to an operation, or even an unwise catheterism, and the chances of a surgical disaster are great. These cases need most careful handling. Personally I am a little faddy about using a catheter for the

first time in my consulting room, especially in this class of case. I think the best interests of the patient are considered if we advise this part of the diagnosis to be done at the patient's home. With a coudé catheter one realizes at once when one reaches the prostate and gains a good idea of the length of the prostatic urethra by noting how much of the catheter is passed after reaching the prostate before urine escapes. Treat, then, this patient with the catheter, render his urine antiseptic with some such drug as urotropin; relieve the condition exciting changes in his kidney; restore, by having the bladder empty at least once a day, some of the lost bladder tone, and then, if necessary, deal with the prostate surgically. This step may be contemplated if the patient become entirely dependent upon the catheter. If by means of the cystoscope and the other methods previously referred to, the prostate be found to be large, both intra and extraventrically, and the patient's general condition be satisfactory, a good prognosis may be given: but if the prostate is very small and hard it may still be wise to continue the catheter.

Now take the second class of case—cases of retention. As the result of a chill or some indiscretion in diet our patient has sudden and complete retention of urine, which is found to be due to prostatic enlargement. Should we at once perform a prostatectomy? I would say most emphatically, No. If catheterism is impossible we should resort to repeated aspirations of the bladder (after which a catheter can often be passed) or even to suprapubic drainage of the bladder. In acute retention there is great engorgement of the prostatic veins and free hæmorrhage and septic absorption is likely to follow any attempt at removal of the prostate: besides, the patient is not in a fit condition to bear a severe operation.

We meet with yet a third class of case. Here the unfortunate patient is unable to urinate except by means of the catheter, but in addition to this, probably owing to some lack of vigilance, his bladder has become infected and there is chronic cystitis with all its attendant misery:

catheterism is both frequent and painful. These patients are sincerely to be pitied, and if an operation will offer them any prospect of relief they will willingly run any reasonable risk. In such cases, if it is at all possible, we should offer operation without delay, for delay only means infection of the pelvis of the kidney, thus adding an enormous risk to any operation. It is in these cases that a preliminary cystotomy to drain the bladder is so valuable.

Since so many prostates have been removed an interesting discovery has been made—namely, the frequency of carcinoma of the prostate. We may get some inkling of this condition when, on making a rectal examination, we find one lobe to be very dense and hard and of quite a different feel from the other. Mr. Hurry Fenwick says it feels “like a buried nut with an ill-defined border.”

Carcinoma is stated to be found in from 9 to 15 per cent. of all prostates removed. It is often not suspected until operation, when the capsule is found to be hardened and adherent: but the existence of the disease is sometimes not revealed until a microscopic examination of the removed organ is made. These cases will often be operated on, and in the early stage, when the infiltration is slight, with every prospect of success: but should the case present evidence of considerable extension of the disease no operation should be undertaken, as it must of necessity be incomplete.

Here in England, owing to the recent advocacy of Mr. Freyer, the suprapubic method of operation is principally in vogue, but in America the perineal route is ably championed by Dr. Young and practised by many surgeons. I am unable to offer any opinion of any value on the latter method, as I have never done it, and though it is admittedly more difficult of performance, it has a distinct place in the treatment of prostatic enlargement, but all the world over most surgeons prefer the suprapubic route.

The cases most suitable for operation are those who have undergone some catheter education, whose bladders and urethras have been rendered immune to instrumental handling, and where the prostates are of the large adenomatous variety, and where cystitis has not produced secondary

changes in the kidney. Cases in which a rectal examination in the knee-elbow position, and bimanually do not reveal much enlargement, are probably cases where there is the so-called "middle-lobe" obstruction, and total enucleation will be difficult. As soon as a chronic cystitis develops we should seriously consider an enucleation, and in weakly patients a preliminary suprapubic cystotomy is likely to be of great value. This preliminary cystotomy will often enable an operation on the prostate to be undertaken on an otherwise inoperable case: it gives rest to the patient, and allows the bladder to be treated and rendered less septic. A fortnight's interval might well elapse between the two stages.

I would suggest the consideration of a preliminary cystotomy in old and feeble patients, in severe cystitis cases, and in emergency cases, such as cases of retention where catheterism is impossible.

In a successful case we can promise the patient freedom from the use of the catheter, and in most, but not in all, cases, cure of cystitis. We have at this moment in Bayes Ward a man whose prostate has been removed elsewhere, but who needed a secondary operation for a calculus formed since the prostatectomy. He also had a ventral hernia form in the site of the suprapubic incision, a condition I had not met before.

In conclusion, I should like to mention a few points concerned with the operation itself which experience has taught us. When I first began operating on these cases I strictly followed the lines laid down by Mr. Freyer, but since reading a paper by Mr. Moynihan in the *Practitioner* I have somewhat altered my technique, with great advantage to the patient. Now, immediately I open the bladder I introduce my finger and then pass a silkworm gut suture through the skin and bladder wall on either side and tie it fairly firmly: this holds the bladder up. This suture is removed in three days. I have also dispensed with the use of the large drainage tube; this only caused sloughing of the edges of the wound and delay in healing. In the last case I did the patient was dry on the twelfth day. The sister in Bayes Ward says the comfort to the patient

and the ease in nursing is most marked since we gave up the tube. We gently syringe out the bladder through the suprapubic wound for five days and then pass a soft catheter *per urethram* and wash out the bladder daily until the wound closes. I have found a dressing called "cellulose" most valuable in keeping the patient dry.

Mr. DUDLEY WRIGHT, in opening the discussion, thought that every surgeon nowadays felt somewhat relieved, in dealing with a case of prostatic obstruction, to know that he had one more method at his command by which he could give his patient relief, and the writer of the paper had well indicated those cases in which relief could be given by the new method of operating. With regard to the question of the passing a catheter on the patient in one's own consulting room, personally, he did not usually hesitate about doing so, because he thought it was quite possible by careful asepsis to prevent almost entirely any complications or accidents arising therefrom. He first of all carefully sterilized the penis and the meatus with some spirit lotion, and then used a previously boiled Jacque's catheter; and after the withdrawal of the urine contained in the bladder he introduced into the bladder some 3 per cent. argyrol solution. As a matter of fact, he did not think prostatic cases were nearly so liable to complications after catheterization as stricture cases. He remembered a stricture case being sent to him from the country which had been allowed to go on to almost complete obstruction. He passed a catheter in his consulting room; the patient went home, developed a high temperature, and eventually died. He made the mistake of allowing the patient to go home some distance by train, but he sent him to the doctor who had originally sent him, and personally thought that doctor was very much to blame for never having attempted to pass a catheter on the patient. After having drawn off the water from the bladder, he thought the bimanual examination (the patient lying on his back) was by far the best examination to adopt. By pressing very deeply above the pubes, with the other examining finger in the rectum, the prostate could be felt between the two hands, and it was possible to gauge the size of the obstruction and all the other particulars with regard to the enlarged organ. He thought it was important that before operating for prostatic enlargement the bladder should be examined with the cystoscope. It could be done during the time the patient was on the table under the anæsthetic. He was of the opinion that the

size of the prostate as felt bimanually or in any other way was not a sufficient guide to the need or otherwise of operation. The two best and also the hardest cases of the kind he operated on were those in which the prostate was extremely small. There was a small adenomatous projection which acted as a ball valve and blocked up the opening of the urethra, so that both patients were absolutely dependent on the use of the catheter. Both cases healed up extremely rapidly, and both were able to urinate naturally afterwards. When the prostate was removed it was hardly worth looking at, and yet both cases were absolutely relieved. With regard to the question of the suprapubic *versus* the perineal route, his experience of the latter, like that of the writer of the paper, had been *nil*. He had just now under his care, however, a patient who had been operated on elsewhere by the perineal route, and the result in that case did not encourage him to try it. The patient, who had no stricture of the urethra, had both a perineal and urethro-rectal fistula which would not close up, and there was incontinence of urine. Evidently the sphincter of the bladder had been so injured that the patient could not retain his urine. It was also possible to get a certain amount of incontinence after using the suprapubic method. He had performed several suprapubic operations, and there were one or two subsequent complications connected with them which he would like to refer to, because it was as well to own up to mishaps and mistakes as well as to tell of one's successes. In his experience it was necessary to be extremely careful to see that no suppuration occurred in the cavity that was left after the removal of the prostate. He had experienced that trouble in one case, and it was very difficult to treat afterwards, as it was difficult to get into the pocket to wash it out properly. In the case to which he referred it was undoubtedly due to a septic instrument or some septic method being introduced by an instrument when the pocket was being washed out afterwards; and the patient was now in an uncomfortable position as a result several months after the operation. Another of his patients died three months after the operation from suppuration in the epididymis. The patient was an elderly man who had two stones as well as his prostate removed. A small abscess developed in the perineum some two weeks after the operation. The suprapubic wound healed. Some septic matter got into the scrotum; then his testicle suppurred, and two or three months after the operation he died at the seaside. In elderly patients one had to be exceedingly careful about suppuration afterwards. He had performed twelve such



operations, and in two of them the patients had died. In the second case the patient died on the third day after operation, apparently from shock. There was a great deal of hæmorrhage. Although an examination of the prostate was not made afterwards, he believed there was malignant disease of the prostate. Like the writer, he had given up the use of the tube, and in the last patient on whom he operated the wound healed in twelve days. The cellulose dressing was extremely useful; it held much more water than the other dressings, and it saved a great deal of trouble in the after-treatment.

Dr. EADIE enquired whether the author could suggest how a practitioner was to diagnose the condition of the kidney prevalent in such cases. Personally, he had never heard of anyone being able to diagnose it definitely. In his opinion the disorganized state of the kidneys was probably the cause of the high mortality of the disease. He also desired to ask whether in such cases the author had heard of pain referred to the tip of the last rib, the upper part of the sacrum, and the soles of the feet. It was Dr. Head's opinion that the prostate was supplied by the lower three dorsal and the upper three sacral nerves, and often in prostatic inflammation the pain was referred to those regions. He recently saw a case of enlarged prostate where the patient referred the discomfort to those regions. He supported Mr. Wright's suggestion that the bimanual examination should be adopted, it being an excellent method. With regard to the question of catheterization *versus* prostatectomy, he thought the general opinion amongst surgeons was that when a patient required to use a catheter he ought to be operated on. Three kinds of operations could be performed. The author had referred to two of them, but he did not mention the combined method of the perineal and suprapubic route. He had seen two or three cases operated on in that way, and had noticed that the suprapubic usually healed up, and the patient drained by the perineal route. He saw a case of enlarged prostate about three months ago, in which the patient did not mention any other trouble, and it was decided to perform a prostatectomy, but fortunately the patient's daughter told him that her father had a growth the size of a child's head in his armpit. That immediately convinced him that the patient had carcinoma of the prostate with secondary disease. It was well known nowadays that a very small malignant growth of the prostate might give rise to a very large secondary growth, especially in the bone. The occurrence of epididymitis after prostatectomy was recognized as a very common complication.

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Dr. HEY stated that in September, 1907, a patient who had previously been under the care of their late colleague, Dr. Lambert, came to see him. He had been advised eighteen months previously to lead a catheter life, but had refused. Examining the patient, he found his bladder was distended up to the umbilicus, but the patient again refused to be catheterized without his wife's consent. After obtaining his wife's permission, the patient was very carefully catheterized, upwards of 80 oz. of urine being drawn off. Dr. Hey admitted it was a mistake to have drawn off so much at once. He gave the patient detailed instructions of the routine he was to adopt following the catheterization; but he subsequently heard, while on his holidays, that the patient was very ill. He also received a letter from the wife of the patient saying the local medical man condemned his (Dr. Hey's) behaviour, and stated that the patient ought never to have been catheterized. Since then Dr. Hey had never seen the patient, although he was still alive. Dr. Hey admitted that in that case he was to blame, firstly for drawing off such a large quantity at once, and secondly for catheterizing the patient in his consulting room instead of at home in bed. With reference to the subject of urine and renal degeneration, he believed Mr. Hurry Fenwick held that an elderly patient whose urinary specific gravity was persistently under 1010 should never be catheterized. If he was catheterized, the patient would die within ten days. Two friends who had told Dr. Hey of that had seen actual cases where it had occurred. The case to which Mr. Wright referred was that of an elderly man who came to the hospital on a Sunday morning last summer, suffering from great distension. The smallest catheter could not be got into his bladder, owing to the fact that he had been through the hands of two local surgeons, who had riddled him with false passages. It was found necessary to aspirate through the abdominal wall and empty his bladder in that way. A hot bath was advised, in the hope that congestion would be removed, but by evening the bladder had again filled. As it was impossible to get an instrument of any kind in, it was decided to operate, and not only was the prostate removed, but forty-two phosphate of lime calculi as well. A large amount of cystitis and phosphaturia supervened, the latter being so excessive that the phosphates deposited on the sides of the wound and prevented it healing for a long time. It did, however, heal subsequently, and the patient is now quite well. With reference to the perineal method, in the case to which the author referred, the patient had been operated on suprapubically at one of the large London hospitals. When Dr. Hey first saw him there was

a tremendous amount of scarring in the region of the incision, and there was a large ventral hernia. The patient complained of incontinence which he had suffered from ever since his operation, but under medical treatment he recovered control of his urine. A radical operation for the hernia was performed. A little time ago the patient appeared again in the out-patient department and was obviously suffering great pain. The urine was loaded with pus, and as he knew the patient had two old strictures, he passed an instrument to give him a little freer passage, and it was in using the solid instrument that he felt the calculus, which was obviously a soft one. It was impossible to dilate the cicatrized neck of the bladder sufficiently to get in the smallest lithotrite, and Mr. Shaw suggested that it would be better to do a lateral lithotomy; this was done, and since the operation the patient had done very well. The case demonstrated the advantage of doing away with the tube. The tube was kept in for three or four days, and the patient was extremely uncomfortable. One day the tube slipped out, and the house surgeon did not put it back again; since then the man had passed urine naturally, and the wound had healed up rapidly. Although the patient had not yet regained control of his urine, he (Dr. Hey) was hopeful that it would be controlled by means of medical treatment. He was impressed in that case by the immense amount of cicatricial tissue which formed at the neck of the bladder, as a result of the prostatectomy; it was like cutting through cartilage when the operation was performed.

Dr. STONHAM said there were cases of enlarged prostate in which retention suddenly occurred where drugs were sometimes of benefit. Mr. Wright would recollect a case, in which he was called in as consultant, of an old gentleman about 77, who had had complete retention for about ten days, and whose urine could only be drawn off by means of the catheter night and morning, Mr. Wright thought the patient was not a good subject for operation; his general health was not good, and he was a feeble man. It was therefore thought better to treat him a little longer with the catheter. He gave the patient cantharis, mother tincture, one drop about every three or four hours, and in a few days he was able to pass urine, and retention had not recurred. Eventually the patient died of senile dementia, but without any return of retention. That was a case in which operation would have been dangerous, but in which a drug was useful in enabling the patient to get over his trouble. Another drug, *sabal serrulata*, would often relieve retention, due to an enlarged prostate suddenly becoming congested. If the congestion could be relieved the

retention passed off, and *sabal serrulata* was a useful drug for that purpose.

Dr. SANDBERG said that if a patient came to him suffering from an overflow of urine or a distended bladder he would not feel inclined to wait a few days before relieving him by passing a catheter. If he did so the patient would go to his next door neighbour and have the urine drawn off. Dr. Stonham had forestalled him in mentioning the benefit derived from the use of *sabal serrulata* in such cases, a drug on which their late colleague, Dr. Madden, once read a very interesting paper. He had used that drug with very great benefit in cases of enlarged prostate. He remembered one case where the patient was compelled to use a catheter almost every hour, but after being treated with *sabal serrulata* for two or three days was able to go for five or six hours without any difficulty.

Dr. SPEIRS ALEXANDER said that on several occasions he had noticed that rigor and a rise of temperature up to perhaps 103° F. occurred after the passage of a catheter ; but if aconite was given no evil effects resulted. The temperature would go down, and the symptoms of shock pass away in a few hours.

Mr. KNOX SHAW, in reply, said that everybody who had used the catheter must have had a similar experience to that described by Mr. Wright. Personally, he had had laid to his door the death of more than one patient from having passed a catheter, but it was a risk that would happen to every professional man in the course of his life. The risk was minimized a good deal, however, if great care was taken, and if the patient was warned of what was likely to happen. As an illustration of that point, some years ago he was asked to see rather an important man in consultation, and he was extremely anxious that everything should pass off well. The patient came to his house, and wished him to ascertain whether he had an enlarged prostate and whether there was residual urine, but he (Mr. Shaw) declined to do so in his own consulting room, and said that the examination must take place at the patient's own house. He accordingly went to the house, and he took every precaution that could possibly be adopted, but in spite of all he did, the patient had a most severe rigor, and was very ill for a few days after the simple passing of a catheter and the drawing off of a certain amount of residual urine. It was not always the fact that the trouble was due to want of care and sepsis ; but Mr. Shaw, nevertheless, wished to impress upon his colleagues the fact that the passing of a catheter should not be looked upon as a light thing. He had a little quarrel with the general practitioner on

that score. Very often a medical man wrote to him and said that he was sending up a particular patient, with the request that a cystoscopic examination should be made and the result of it communicated to him. But a cystoscopic examination could not be done in the consulting room, and one of the objects of writing the paper was to draw attention to that fact.

Dr. EADIE enquired whether the patient to whom reference had been made was given any medicine.

Mr. KNOX SHAW, in reply, said that he generally left a certain amount of antiseptic lotion, such as boro-glyceride in the bladder, and the patient was given a dose of aconite, first decimal, to be taken every few hours afterwards; and yet in spite of those precautions trouble sometimes ensued. If, however, a patient came to him and said that he had used a catheter several times, he did not hesitate to pass a catheter in his consulting room; the remarks he made only applied to cases where the catheter was passed for the first time. It was his usual practice when he saw a new operation advocated to collect all the available evidence of published cases. He had read a good deal about the perineal operation, especially that advocated by Dr. Young, of Philadelphia, but at present it did not appeal to him as being likely to supersede the suprapubic route. He had also noticed in the various American publications that the sequelæ of the perineal route were much more likely to be troublesome than the suprapubic. Perineal incontinence of urine was more troublesome than suprapubic incontinence. With suprapubic incontinence the patient could wear a tube; but if there was a fistula in the perineum the patient was in a state of the utmost misery. He had not met with any abscess in the prostatic pouch. After he removed the prostate, and before finally closing up the case he always tried with his finger to pack down to the base of the bladder, the mucous membrane reflected from the prostate. The London Homœopathic Hospital had recently had the honour of a visit from a distinguished professor of surgery in America, and on going round the wards and seeing a patient on whom prostatectomy had been performed seven days previously in which a tube had not been used, the American professor said he had not seen a case in which the tube had not been used in America, and that the patient looked as well as tube cases did at the end of three weeks. Mr. Eadie asked the very important question of how the dangerous cases were to be recognized, and Mr. Hey had referred to the low specific gravity. He was unaware of Mr. Hurry Fenwick's statement to which Mr. Hey referred, but he knew he laid great

stress upon the point that a man who had prostatic obstruction and had low specific gravity urine, and a thirst not for alcohol but for water had renal incompetency; and that operation and even catheterization would spell disaster. In the case of an old gentleman aged 82, the patient had consulted one or two other specialists, who also advised him not to have an operation performed. The patient was condemned to a catheter life, and made the remark to him (Mr. Knox Shaw) that his life at that time was not worth living, and that he was perfectly prepared to risk it if he were obliged to continue to live as he did. He, therefore, insisted upon having the operation performed, and it was completely successful. He thought it was also of interest to state that he circumcized the patient when he was 81 years of age, because he could not pass catheter owing to an adherent and tight phimosis.

THE ALTERNATION OF REMEDIES IN THE THE PRACTICE OF HOMŒOPATHY.¹

BY J. MURRAY MOORE, M.D., F.R.G.S.

THIS year of grace, A.D. 1910, is the centenary of the publication of our earliest text-book of Homœopathy, Hahnemann's "ORGANUM OF THE RATIONAL SYSTEM OF MEDICINE."

It is useful at certain stages of our progress as practitioners of the art and professors of the science of homœopathy, which has now more than completed its first century, to consider how far, to what extent, and in what directions, we of the twentieth century A.D., have advanced or developed the grand system of therapeutics handed down to us by three generations of earnest, industrious, and self-sacrificing medical men.

In my Presidential Address to the Congress of 1908, I pointed out some of the vast improvements in surgery, hygienics, anæsthetics, anti-toxin and anti-malaria agents, mechanical inventions, radio-active remedies, &c., and I

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warmly advocated the use of all these, as applied to the cure or alleviation of disease ; but that address did not comprise any comments upon the actual homœopathic practice of the present day. Responding at very short notice to the urgent appeal of the Secretary of this section for a paper to fill the gap caused by the regrettable illness of Dr. Hervey Bodman, I propose to-night to examine into the origin and *rationale* of a practice which has grown up amongst us of giving medicines in pairs, instead of singly, commonly called "alternations."

A discussion upon this subject will not unsuitably follow Dr. David Ridpath's excellent paper upon "The Selection of the Remedy."

I would preface my criticism of "alternation" by stating my conviction that uniformity in the practice of all the followers of Hahnemann, and their homœopathic consistency, is greater than that of the practice of the so-called "orthodox" school, who do not embarrass themselves by adopting any *principle*. Our cohesion, therefore, on even debated subjects is greater than that of the dominant majority.

Assuming as an axiom that each homœopathic practitioner tries to select the *similimum* remedy for each case brought before him, most of us will admit that in the rush of dispensary work, and the hurry of a widely scattered private practice, it is not always possible to achieve this. And forty-four years' experience has taught me that searching a repertory in presence of the patient is not tactful. Patients usually assume that all the homœopathic remedies for all sorts of diseases are in one's mind, ready at call, and do not, as a rule, give one credit for careful and conscientious searching after the *similimum*. It is only the steady lay adherent of homœopathy, intelligent beyond the average—one who has tested and proved its efficacy—who appreciates the doctor's labour. As a sort of "*Apologia pro vitâ meâ homœopaticâ*," I should like to explain in the first place how I commenced this habit of "alternations."

Late in 1866, having become quite dissatisfied with my experience of allopathy, I succeeded Dr. Herbert Nankivell as House Surgeon of the Liverpool Homœopathic Dispen-

sary. At once, with no preliminary training whatever (for my fair-minded father had expressly refrained from biasing my views while a student at Edinburgh, and had even advised my practising the old system, and taking my own course in life as to adopting the new system), I plunged into the task of prescribing for a crowd of patients at the rate of forty to fifty per hour, and of visiting others in the Liverpool slums, to the number of twenty-five to thirty per day.

With Hull's "Jahr," Hughes' "Pharmaco-dynamics," Thompson and Capper's "Sixteen Principal Remedies," and the kindly help of my honorary staff, I managed to work into the new therapeutics. Not having time to search out the simile for each case, I prescribed on a pathological basis of diagnosis, and gave remedies in alternation, because I could not always decide which of two or three remedies was the *similimum*. And I succeeded in curing or relieving a large proportion of cases. In fact, I found that the worst, most slipshod, inaccurate homœopathic treatment was better than the best allopathic medication of *that day*, for nearly all our dispensary patients had visited the ordinary hospitals and dispensaries without relief, before resorting to our institution. Our percentage of recoveries far exceeded that of the best hospital in Liverpool.

My younger colleagues, the stipendiary medical officers, Drs. O'Neill and Simmons, helped me much in prescribing; but they, too, more often used pairs than single remedies. Still, I gradually improved in the art of selection, and I find in a clinical note-book started in 1867, that between 1867 and 1871, out of 140 cases cured, 112 were treated by single remedies, given one at a time, and only 28 by alternating medicines. Two of those 28 were treated by different dilutions of the same medicine, given alternately. They were: (1) calc. carb. 6 and 12 in a case of marasmus from tuberculosis of the mesenteric glands; and (2) thuja 3 and 6, which in a short time completely removed sycotic warts on the anus of an old man.

My chief instructor in the practice of homœopathy in those early days was, naturally, my worthy father, and he

was an habitual alternator. His patients always had two glasses ready for him, and I remember that, sometimes, when acting as his *locum tenens*, some of them would be quite disappointed when I decided upon *one* remedy, instead of two. Dr. Hayward, sen., used pairs of medicines less often than my father, and Dr. Drysdale very seldom indeed. As far as I could trace results, all three eminent practitioners were equally successful in curing their patients.

The commonest and most successful alternations that I have used during my forty-four years of practice are the following :—

(1) In simple sore-throat, whether ulcerated or not, bell. and mercurius sol.

(2) In tonsillitis, with fever and great soreness of the pharyngeal mucous membrane, bell. and baryta carbonica.

(3) In real diphtheria, bell. and mercurius biniod. (freshly made trituration, if obtainable). I reported a good case in the *Homœopathic World* for 1875, p. 346, where this pair of remedies in forty-eight hours completely removed the exudation from the whole of the left tonsil and part of the right, lowered the pulse-rate from 114 to 80, and made the patient feel well in himself. Bell. 3 cent. and mercurius bin. 3x trit., were the dilutions used. What better result could have been obtained by anti-toxin?

(4) Apis mel. and mercurius biniod. in diphtheria.

(5) Cantharis 3 and mercurius biniod. 3x in diphtheria, with albuminous urine.

(6) Bell. and kali bichromicum in diphtheria of an ordinary, non-phagedænic character.

(7) Aconite and phosphorus in simple acute pneumonia.

(8) Aconite and bryonia in pleurisy, in acute rheumatism, and in peritonitis (idiopathic).

(9) Mercurius corrosivus and colocynth in dysentery, where the colic pains are a prominent feature.

(10) Aconite and pulsatilla in measles.

(11) Cannabis sativa and mercurius corrosivus in gonorrhœa, with a hard chancre; if with a soft (non-infectious) chancre, cannabis and mercurius sol.

(12) *Nux vom.* and *carbo vegetabilis* in some forms of chronic dyspepsia.

(13) *Nux vom.* and sulphur, the former usually given in the morning, and the latter at night, for chronic constipation.

(14) *Arsenicum* and *veratrum album* in some cases of diarrhœa, characterized by frequent watery stools, severe griping, relief after stool, and considerable debility.

(15) Iodine 1 cent. and *veratrum viride* 1x, given alternately every two hours in infantile acute meningitis (one case) I found effect a rapid and permanent cure.

(16) *Ferrum metall.* 1 or 3x, and *pulsatilla* 1 or 3x, in anæmic girls, with scanty and irregular menstruation.

I have always lengthened the intervals between the doses as soon as improvement began, and have ordered a single remedy (*not necessarily* one of the first pair) to finish off the cure.

I might mention here that our colleague, Dr. Samuel Philip Alexander, of Southsea, wrote an interesting article in the monthly *Homœopathic Review* for September, 1891, in which he alludes, though with apologies, to his own successful alternations of remedies. Of my No. 13 he says, "The stock treatment of piles with *nux* and sulphur . . . certainly seems to do more good than the employment of either of these drugs singly."

He goes on to quote three other successful alternations in his practice: "I have seen a case of acute rheumatism promptly cured—*mirabile dictu*—with *bryonia* and *rhus tox.* given alternately! . . . That two such antagonistic drugs, thrown into the system together, should effect a cure is only to be explained on the principle of the 'survival of the fittest'; the disease selects its own *similimum*, and discards everything else. . . . I can recall at least two cures in my own practice, following upon the alternation of drugs. . . . One was a case of chronic gastro-enteritis, the principal symptoms being vomiting and diarrhœa after food, with burning pain in the stomach, and severe colic. . . . *Arsenicum* and *colocynth* were given in alternation, and the man *who had suffered for months* was well in a few days.

“The second case was somewhat similar, in a lady . . . but recent, and typhoid in character, and attended with liver symptoms. *Baptisia* doing no good, I hesitated between *merc. sol.* and *veratrum album*, but finally gave the two in alternation, with immediate and complete success.”

Now, I am pleased to be able to quote the evidence of this excellent clinician, the brother of an ex-President of our Society, in support of alternation—though, for brevity, I have omitted his deprecatory remarks thereupon. For I *know* alternation to be successful in ordinary, everyday practice, even while I admit that is unscientific. Although I began as early as the year 1868 to report cases cured (in the *Homœopathic World*), I have refrained all my life from reporting in print cases cured by alternating medicines, because colleagues could not derive any *definite* information from them, as an assistance in the treatment of other similar cases. Hence scores of cases that I considered “good homœopathic cures” have not been published. No doubt this feeling is shared by many colleagues.

Now it becomes us to enquire whether the practice of alternation is justified, excused, or condemned in the “*Organon*,” which Dr. David Ridpath has truly styled “The Bible of Homœopathy.” Guided by more mature experience, I can now endorse Dr. Ridpath’s statement: “A knowledge of the principles contained in the ‘*Organum*’ is necessary to the successful practice of homœopathy.” Yet in my homœopathic student days the “*Organon*” was not studied by any of us, except two, perhaps three, who became high-dilutionists.

The *general teaching* of the “*Organon*” is plainly as much opposed to alternation of medicines as it is to unnecessarily frequent repetition of doses of the one selected remedy.

Section 169 (p. 139 of “*Dudgeon’s Trans.*”) runs thus: “If, on the first examination of a disease, and the first selection of a medicine, we should find that the totality of the symptoms of a disease would not be sufficiently covered by the disease—elements of a single medicine—

owing to the insufficient number of known medicines, but that two medicines contend for the preference in point of appropriateness, one of which is more homœopathically suitable for one part, the other for another part of the symptoms of the disease, it is not advisable, after the employment of the more suitable of the two to administer the other without fresh examination. For the medicine that seemed to be the next best might not, under the change of circumstances that has in the meantime taken place, be suitable for the rest of the symptoms that then remain; in which case, consequently, a more appropriate homœopathic remedy must be selected in place of the second medicine, for the set of symptoms as they appear on a new inspection."

In a note to section 272 (p. 187), which runs: "In no case is it requisite to administer more than one single, simple medicinal substance at one time," Hahnemann writes: "Some homœopaths have made the experiment in cases where they deemed one remedy homœopathically suitable for one portion of the symptoms of a case of disease, and a second for another portion, of administering both remedies at the same or almost at the same time; but I earnestly deprecate such a hazardous experiment, which can never be necessary, though it may sometimes seem to be of use."

At this period homœopathy was still in the experimental stage as regards new remedies, and both Lutze and Ægidi had proposed to mix two apparently suitable medicines and give the combination, a sad relapse to the polypharmacy of the old school from which they had emancipated themselves.

In section 270 of the *first three editions* of the "Organon," however, we find the following sanction for occasional alternation: "When, therefore, a thoroughly suitable specific (homœopathic) remedy cannot at once be found, on account of the deficiency of medicines whose pure effects have been ascertained, there will usually be one or two next best medicines for the characteristic original symptoms of the disease, one or other of which—according to the

morbid state in each case—may be useful as an inter-current remedy, so that its administration in alternation with the chief medicine promotes the recovery much more palpably than giving only the chief medicine two or three times in succession.” (The italics are my own.)

This section, perhaps because it afforded an excuse for the practice of alternation, condemned by Hahnemann's note to section 272 above quoted, was omitted in the fourth and fifth editions of the “Organon.”

According to Dr. Croserio, of Paris, an intimate colleague of Hahnemann, the Master “never prescribed two different remedies to be taken alternately, or one after another. He would always first learn the effects of one remedy before he gave another, even in patients who were treated by him at two hundred leagues distance.” (Letter to Dr. von Bönninghausen, 4th American edition of “Organon,” in note to section 272.)

Notwithstanding this statement by Croserio, Hahnemann advised alternations in certain diseases, characterized by alternating morbid states, and “became an *a priori* prescriber of successions,” as Hughes terms it.

In purpura miliaris, he advises the alternation of aconite and coffea, one or other being given, according to the indications, every twelve, sixteen, or twenty-four hours. Of cholera he writes: “The best homœopathic practitioners have found *cuprum* indispensable in the second change of the fully developed disease, alternated, if the symptoms indicate this, with *veratrum album*. I have also advised the alternation of these two substances from week to week as a preventive against the disease.” He says, further, that *bryonia*, alternately with rhus tox., proves of eminent service in post-choleraic fever.

In treating croup, Hahnemann tells us always to precede spongia by aconite, and to follow it up sometimes by hepar sulphuris. Von Bönninghausen, “who,” said the Master (note to section 235) “has rendered more services to our beneficent system of medicine than any other of my disciples,” built upon this therapeutic suggestion a system of giving to all cases of croup five powders in succession—

aconite, spongia, hepar, spongia, hepar, and no more medicine afterwards.

In complicated chronic diseases, the second edition of the "Organon" advises mercury and sulphur when syphilis and psora coincide, and the third edition recommends mercury, assisted by thuja or nitric acid, when sycosis is also present.

Among Hahnemann's foremost disciples who alternated remedies were Gross, Rummel, Hartmann, Hirsch, and Hering. Occasional alternation has been ably defended by our own Drysdale and Russell, and by Drs. Martiny and Bernard, of Belgium, while it was as ably attacked by Carroll Dunham.

It was shrewdly pointed out by Jahr, in his "Therapeutic Guide" (1870), that alternation "renders all rigidly correct observations impossible." I remind the reader of Dr. Kallenbach's observation, who gave his diphtheria patients at The Hague at first *apis* and *lachesis* in alternation, but afterwards, when he wished to find out which of these two remedies really effected the cure, saw those to whom he gave *apis* alone recover in *three* days instead of in *five* under the alternation, whereas those who received *lachesis* alone did not improve at all."

I do not suppose that any of us, with the greater knowledge of drug action, and perhaps better acquaintance with pathological processes than existed thirty years ago, would countenance the absurd recommendation by Constantine Hering in an article in the *North American Journal of Homœopathy* for August, 1879, to give colocynth alternately with strong coffee in some forms of colic. Nor would his other eccentric advice, in the same article, be followed at the present day—namely, that in any case where great pain is present we may administer opiates in alternation with the specific homœopathic remedy.

The main arguments in favour of alternating remedies are these:—

(1) The practical advantage of saving time to the busy man, and the promptitude of relief to the patient in acute diseases.

(2) Assuming that the two remedies chosen are *not*

homœopathic *antidotes*—and this condition of alternation must be absolute—the second remedy may revive the susceptibility of the tissue, organ, or bioplasm, which would otherwise tend to be exhausted (Drysdale). Dr. Drysdale illustrates this by the laws of the reaction of the retina to certain colours.

(3) As even specific morbid processes, such as typhus fever and variola, may, though rarely, concur in the same individual, much disease is complex in character and needs more than one remedy, with its destructive processes (R. Russell). As it is against all homœopathic rules to give more than one medicine at a time, we give a pair by turns, at rational intervals, and enhance our healing power.

(4) The medicines alternated act as useful auxiliaries, assisting each other; or as correctives of each other; or by drawing out in various ways the reactions of the organism to make them converge to a cure (Martiny, Bernard).

(5) In definite diseases the presence of urgent complications is better met by alternations than by change of remedy (Richard Hughes).

(6) As certain drugs specifically effect certain tissues, it is a decided advantage to use two remedies, each of which act directly upon the morbid process in each different tissue.

For example, it is rational to suppose that when we give bell. and merc. sol. alternately in a case of ulcerated sore-throat (cynanche tonsillaris), belladonna reduces the swelling of the congested capillaries of the mucous and submucous membranes, while mercurius “alters”—to use an allopathic phrase—the ulcerated surface towards normal condition.

Similarly, the rapid cures I have often witnessed of quinsy, even when far advanced, are explicable by the action of belladonna, as aforesaid; and of the baryta carbonica specifically upon the glandular substance of the tonsil itself.

Also I can explain to my own satisfaction, though perhaps not to that of my colleagues, that in the nux and sulphur treatment of piles, constipation and cold feet, nuxvomica stimulates the vermicular movement of the intes-

tines through the *par vagum* and the sympathetic, while sulphur promotes the activity of the languid venous capillary circulation, and of the hæmorrhoidal veins.

In the treatment of chronic diseases, of which the major part of my practice in Leamington consists, I have almost given up alternation, because the diseases are of a definite fixed type; and, if complicated, then I take up each complication separately, matching it by a well-thought-out remedy, and following Hahnemann's direction to treat the latest symptom first.

My own conclusions upon alternation are these:—

(1) Alternation is not scientific homœopathy.

(2) Alternation is often very effective, and is legitimate to a homœopath.

(3) A case successfully treated by alternate remedies and reported in paper or journal affords no instruction to the colleagues of the writer.

I hope that this hastily written paper gives some material for a discussion, though I can hardly hope for such a full and interesting one as was reported on the subject of "The Selection of the Remedy."

Dr. STONHAM thought the question of alternation was one which had come before every homœopath in his practice, and probably every practitioner had alternated, at any rate, on some occasions. Dr. Moore had given what the members would not have found out themselves, namely, the history of the subject and the opinions of various eminent homœopaths on the question. He himself had no idea that the point had been discussed so profusely. Though the practice of alternation was said to be unscientific, yet good results were obtained from it, and the question arose, could a practice which had good results be really unscientific? The reason of the good results of alternating remedies was not known. He thought probably that diseases were not entities, at any rate in many cases, and that the body might get diseased in two different manners at the same time. If it did there was no reason that he could see why two different remedies should not be used at the same time. Of course, practitioners had to be very careful that the two remedies used were not antagonistic remedies. For instance, one would not use

causticum and phosphorus at the same time, and, with regard to the instance given by the author of the paper, one would hardly give apis and lachesis together; they were direct antidotes, and it was not surprising, in the case mentioned by the author, that when one of those remedies was discontinued the case got cured much more quickly. If any practitioner could say why alternation was successful he was sure the Society would be greatly indebted to him.

Dr. WHEELER said he thought it was true that the better one knew his *Materia Medica* the less need one had of alternation. It was quite conceivable, however, that two unrelated diseased processes might be present in the same body at the same time, and therefore it was not impossible that two remedies with different spheres of action were able to act upon the body simultaneously. With regard to the question as to why alternating remedies succeeded, when only one disease process was present—and observations would have to be accumulated continuously before any definite law was arrived at—his own personal feeling about it was that the explanation probably lay in the undoubted enhanced power of one remedy when it was following another. He would certainly require a great deal of evidence to convince him that the action of *nux vomica* was not a better one when it followed sulphur than when it was given by itself. For instance, if he thought a case was one for *nux* he often gave a few doses of sulphur first, and he found many instances of remedies being related somewhat in that manner. He preferred not to alternate remedies, but to give the one which went the deeper first, preparing as it were the way for the other, although the one that he gave first might not be the best indicated by the actual symptoms. It was very interesting to notice in homœopathic practice that men practising without any particular communication with one another tended to use certain pairs of remedies as the result of experience. The combination of *belladonna* and *mercurius*, for instance, had become almost traditional, and, undoubtedly, it depended upon a real relation between those two drugs. Homœopaths had to wait to find out what that relation was, but that there was a relation he firmly believed. He did not go so far as the author in saying that no case cured by alternating remedies was worth publishing. On the contrary, he thought it would stimulate research, and if a great many cases were accumulated some of the laws which undoubtedly governed the drugs' action would be discovered.

Dr. EADIE confessed he had been guilty of alternating, but he

did not defend the practice; he thought it was a sin, the sin of ignorance. He himself was perfectly convinced that if one discovered the one remedy which would cure a case it was much better than any two. The practice of alternating, he thought, was unscientific. He did not think the arguments which Dr. Stonham had brought forward, as to its being scientific, were tenable. He (Dr. Eadie) thought to a great extent a good deal depended on what view one took of disease. Disease was not an entity. What we had to deal with was diseased bodies—one could not separate them and say "Here is the disease, there is the body"—although it was convenient to talk of them as if they were separate entities. To treat a patient, say, with typhoid fever, pneumonia, and whitlow with different drugs for these different conditions was to overlook one of the fundamental points of homœopathy—the totality of the symptoms.

Dr. MILLER NEATBY thought alternating was very largely a matter of tradition and that one practitioner had copied it from another. For instance, those who were brought up in homœopathic hospitals fell into the ways that obtained amongst their seniors. Thus, in the hospital in which they were gathered that evening appendicitis used to be regularly treated at the outset with an alternation of belladonna and mercurius cor., and acute rheumatism with aconite and bryonia; one got into the way of adopting these formulæ which one derived from tradition from one's elders. He thought really that was the history to a large extent of alternation and the mere fact that good results were obtained from it did not prove it to be strictly a scientific method. Alternation, however, was undoubtedly often useful, and most homœopaths would agree with the author when he said that even crude homœopathy of that kind—the alternation of remedies—produced better results than anything under the old school. But he (Dr. Miller Neatby) did not look upon the process of the alternation of remedies as a scientific one; the truly scientific method would surely be the one that gave the best results, and not the second best results. From his own experience he could very heartily endorse what Dr. Wheeler had said, that certain remedies given in succession, that is, one remedy given after some other particular remedy, might produce a very much better effect than if the indicated remedy was first given. But that was not alternation; it was an entirely different thing. In a case of piles, where nux was indicated, the nux would often do much better if sulphur were given first. A few weeks ago he saw a case of rheumatoid arthritis which seemed to require rhus, but as it was the first time he had seen the case

he hesitated and decided eventually to give sulphur to begin with. When the patient returned the first time, there did not appear to be very much difference, but he then gave the the patient the rhus, and the next time the patient came back—that very afternoon as it happened—he was very much better indeed. He was rather interested in the case, because in one or two previous cases he found that rhus when apparently well indicated had not acted when given alone. He thought the reason why two remedies given in alternation would often produce good results must surely be that they were remedies which produced very similar symptoms. He felt, however, from his limited experience, that the policy of giving the single remedy and seeing what effect it produced was a better method than that of alternating.

Dr. PULLAR thought the Society was extremely obliged to the author for bringing such a practical subject before them, and he (Dr. Pullar) thought the observations confirmed the experience of most practitioners. Of course the ideal to be aimed at was that of Hahnemann—to give full study to a case and give one remedy. But in this workaday world a practitioner had to some extent to yield to considerations of time, and very often, as a matter of everyday experience, it was found that excellent results were obtained from alternation, although, personally, he resorted to such lines with a feeling that he was hardly thus attaining the perfect way. He himself sometimes alternated remedies day by day instead of by doses; for instance, in sore throat, if one remedy was indicated by the tissue conditions, such as baryta carb. for the infiltration of the tonsils, he gave that medicine and belladonna (for the congestion) on alternate days. The pathological examination, of course, existed only in our own minds, remedies being prescribed more on symptomology than on theories concerning the structure that was being acted upon by them. As a matter of experience, he had found that the method of prescribing two different remedies on alternate days seemed to answer better than alternation of doses. He thought with the last speaker that there was perhaps a good deal of tradition in the matter of alternation of remedies; but this may have risen from the experience that the action of one remedy emphasized that of the other when given alternately with it. Whatever the explanation was, there could be no doubt that the results of alternation were such as to render the practice by no means indefensible. Of course, we must look upon Hahnemann's instruction as, in some respects, a counsel of perfection, and in the ordinary round of work it was, indeed, almost impracticable because it involved

so much time. When all was said and done, too, the standard of therapeutic efficiency attained in the average practice of our method was a very much higher one than that of the old school. If a practitioner was going to work on the precise lines of Hahnemann he might do brilliant things, but every case had to be thoroughly individualized, and this meant a deal of time. There, however, we had a special development of knowledge, an ideal phase of medicinal treatment, which was of the utmost value in chronic disease: it was definite and far-reaching in its results, and if a practitioner carried out the method accurately, results were achieved such as no other therapeutic system could show.

Dr. ROBERSON DAY remarked that until the last two speakers had given their views the members had been listening to speeches of gentlemen apologizing for what all knew to be a very useful method of prescribing. It was called "unscientific," and not "pure homœopathy;" but how could it be proved that such a practice was not scientific? And if it was not homœopathic, what was it? At any rate they knew it was for the good of the patient, and practitioners must ever keep before them the interests of the patient as being paramount, and whilst they had that end in view he was sure they would always employ the alternation of remedies. A method of alternating which he adopted and with which he was very satisfied, was prescribing for a *constitutional* state by an occasional remedy, at the same time treating the *acute condition* by some other remedy which was indicated. He might instance the working of tuberculinum, which acted so well as a constitutional remedy, whilst treating the more active disease by its appropriate remedy, in the same way syphilinum, psorinum, and the well-known cessation of treatment for a course of sulphur. All that treatment was a form of alternation, and if he did not adopt it he was afraid he should not have the successes which he did have.

Dr. COOPER said that no greater objection could be raised to the alternation of remedies than that such a practice necessarily rendered all accurate observation of the actions of the remedies employed impossible. Every homœopath had the opportunity of making observations on drug-action in the course of daily practice, when he prescribed one remedy at a time, and the knowledge so gained was of the greatest value for future use, not only to himself, but to others. In this way it was often possible to find new indications for the employment of a remedy. He did not consider Dr. Day's remarks on the giving of constitutional nosodal remedies, in conjunction with other drugs, as coming under the

head of alternation of remedies dealt with by Dr. Murray Moore. Such a practice was, in every way, justifiable, for he had himself often found a well-indicated drug fail to act till some constitutional remedy, such as tuberculinum or syphilinum, was given. This latter had the power of clearing the ground and removing the obstruction which previously interfered with the action of the original drug. He thought, as years went on, the practice of alternation would gradually die out, and homœopaths would rely more on the action of one remedy given at a time, and that the tendency would be towards allowing more time for each individual dose to act than had otherwise been the prevailing practice.

Dr. E. A. NEATBY remarked there was one line of possible explanation of the action of alternating remedies which had not been referred to and which he would like to remark on, mentioning an analogy and suggesting that on similar lines some explanation might possibly be found. In modern bacterial treatment it was quite well known that the resisting power of a patient to more micro-organisms than one at the same time might be low, and that in order to improve the patient's condition a vaccine must be used, prepared from both organisms, such for instance as the streptococcus or the staphylococcus. He did not see why if that was true, drugs, if they were given in alternation more or less deliberate, should rouse different tissues or cells in the body, and act in the same way as they knew a bacterial vaccine would act. With regard to one instance that the author quoted as being a successful instance of practical alternation, namely, the celebrated Bœninghausen powders, years ago he (Dr. Neatby) used those powders very frequently with great success. He used them usually in fairly high dilutions, 12 or 30. Those five magical powders did wonders in simple laryngitis and spasmodic croup, sometimes very trying cases in children.

Dr. WEIR, referring to the question of the single remedy *versus* alternating, mentioned a case of sore throat in the hospital for which the physicians had suggested belladonna and mercurius cor. He asked to be allowed to treat the case, and he prescribed lycopodium 1,000, one dose, and in twenty-four hours the patient was cured. What homœopaths wanted to do was to improve their knowledge of the *Materia Medica*. It was his opinion that if one studied the *Materia Medica* it would be found that the single remedy would give much better results than alternating.

Dr. MURRAY MOORE, in reply, said that homœopaths of the present day ought to remember, in justice to themselves, that the growth of their *Materia Medica* had been enormous, the

reason being that there was a principle by which they could utilize the poisonous effects of any substance—animal, vegetable, or mineral. As illustrating the enlargement of our *Materia Medica* continually going on, he quoted a case of poisoning by *Primula obconica*, which is now the homœopathic remedy. The patient, a gardener, had been to three doctors of the highest eminence in Leamington, and none of them could detect the origin of the eczema. He (Dr. Moore) discovered it by having learnt the poisonous properties of the plant from an article in the *Homœopathic World* for 1906. He obtained the antidote (he thought it was anacardium), and as soon as ever the patient came under homœopathy he began to improve. No local application whatever was used. The man recovered in five weeks. This gardener had never had the slightest disease of any kind before his duties compelled him to tend about thirteen of these plants, thus slowly imbibing a quantity of the injurious effluvia of the leaves and blooms. He (Dr. Moore) drew attention to the fact that the latest edition of Dr. Boericke's *Materia Medica* contained 1,070 remedies, as compared with the twenty-three that Hahnemann published in his first volume. That was what their science had grown up to. Homœopaths aimed at perfection in their practice, but life was too short to attain it. He was obliged to Dr. Burford for mentioning the fact that Professor Henderson had introduced alternation into this country, because he had seen in an old number of the *British Journal of Homœopathy* that very expression—"Professor Henderson's Alternations"—showing that that gentleman was the originator, or one of the originators, of the practice. All the foremost men of our school, in the days when he (Dr. Moore) was learning homœopathy, used alternation at times. Professor Henderson was remarkably successful with alternations. When a student, he (Dr. Moore) caught diphtheria from a patient in the Edinburgh Infirmary, and was very ill with it. His father had advised him to call in Professor Henderson if there was anything the matter; he did so, and Professor Henderson cured him in a few days. Of course he was curious to know what the Professor had used, and it turned out to be belladonna and mercurius biniodatus in alternation. The practice of alternation, as Dr. Burford had truly said, was dying out; it was not as much used now as it was twenty or thirty years ago; and it was a very good thing, too, because homœopaths did not learn anything definite from it. He did not agree with the speaker who advised that cases treated by alternating remedies should be reported because something could be learnt from them. Another

thing which he had learnt in his old age was the value of the infrequent dose. He did not say that only unit doses should be used in acute cases of a destructive character, and in cases attended with great pain ; but in cases where there was plenty of time—say, in cases of stiff rheumatic joints—he thought if a practitioner gave a dose and allowed it to act for a week he would obtain better results than by giving the dose three times a day. There was no doubt that one of Hahnemann's great discoveries was that a dose of a drug would act for some time after it was given—in some cases thirty-six days. He thought that in these days of precisionized homœopathy it was every homœopath's duty to study the effect of unit doses. He had learnt very much from Dr. Cooper's father in that way. No doubt that gentleman used unproved remedies (for who had ever proved *agruphis*, *arbutus*, or *lemna minor*?), but by his remarkable intuition in selecting the right remedy the late Dr. Cooper had been successful both in curing patients quickly and in enlarging our resources. He thanked the members for discussing the paper in the full and frank way they had, and he felt it a compliment to be asked to come from Leamington—a hundred miles from town—to read a paper.

CASES ILLUSTRATING THE HOMŒOPATHIC PHILOSOPHY.¹

BY JOHN WEIR, M.B., CH.B. GLASG.

Assistant Physician to the London Homœopathic Hospital.

THIS case is brought forward by kind permission of Dr. Goldsbrough, under whose care he was admitted to the hospital. Dr. Goldsbrough asked me to prescribe, after having selected drug by use of repertory.

E. P., aged 67, had been a painter since 14 years of age ; is moderate in alcohol, now non-smoker. Small-pox at 18. Had ague at 24, no recurrence. Contracted syphilis at 20 ; treated twelve months by a local doctor (allopath). No secondary manifestations. Lead colic when 40 ; no paralysis. Attending National Hospital Dispensary for a long time for tabes, no improvement.

Present Condition, April 23, 1909.—*Face* : Thin, pale, very anxious, worried expression, almost fear.

Chief complaints were : (1) Dull aching pain left side of body

¹ Presented to the Section of Materia Medica and Therapeutics, February 3, 1910.

to hip, and also down left arm; (2) shooting pains on left side—sudden onset and gradually going away, down left arm and from left hip to left foot. < when cold, or if exposed at night, so that he had to wear long gloves; > hot application. (3) Excessive tenderness left wrist; < touch, yet > hard pressure. *Mental*: Very irritable, impatient, obstinate, passionate, which < pains; extremely restless, never seemed able to settle. *Head*: Occipital pain, < pressure. *Eyes*: Arcus senilis present, vision fairly good, pupils do not respond to either light or accommodation, diplopia at distance, no nystagmus. *Hearing, taste, and smell* all good. *Sensory*: Hyperæsthesia from chest down to both legs, left side more marked; pain exaggerated, no delay to sensation. *Temperature*; response to cold quicker than heat, heat delayed outside both legs; burning sensation both shoulders, left side chest and left arm; no girdle sensation. *Motor*: Walk jerky, slightly ataxic, Römberg's sign somewhat present; fair power in limbs. *Reflexes*: Superficial present, deep, lost entirely at ankle and knee. *Sphincters*: Good control. *Digestive*: Appetite good; good deal flatulence; bowels very constipated, has had lead colic, stool small, hard balls with mucus at times. *Urine*: Perfect control, but no force. *Generals*: < change weather; winter, cold, wet weather; is very chilly (own words were, "Would be comfortable if had clothes up to neck and my head out of window"); least exertion, > open air; gentle motion; warm room, yet desired fresh air; restlessness.

Selection of Remedy.

Chilly	Kent, p.	
(Lack vital heat) ...	1328	63 drugs.
< Cold wet weather ...	1312	30 drugs in previous list.
Desire open air ...	1306	ant. c., ars., bar. c., carb. s., CARB. V., graph., lach., LYC. SULPH.
> Warm room ...		ARS.

Here in four generals by exclusion we come to ars.
Suppose we take third list and work particulars into this.

Restlessness ...	72	ARS. CARB. S. graph. lach. SULPH.
Irritability ..	57	ars. CARB. S. GRAPH. lach. SULPH.
< Uncovering ...	1368	ARS. — graph. lach. —
Burning pain ...	1339	ARS. CARB. S. graph. lach. SULPH.
Shooting (stitching) pain, thigh ...	1118	ARS. carb. s. graph. lach. sulph.
< Cold ...	1023	ARS.
> Warmth...	1025	ARS. — graph. — sulph.
> Press. ...	1024	ars.
Sensitive to pain ...	1358	ars. — graph. LACH. sulph.

We see here the particulars all markedly fitting to the generals.

Subsequent Progress.—April 28. Ars. alb. 1,000, one dose ; sac. lac., nocte.

May 1. Marked < burning and shooting pains shoulders and left leg ; slept better ; bowels moved own accord ; constipated stool.

May 2. Burning pain entirely gone. The shooting pains have only been at ankles and left wrist ; sleep good ; bowels even acting three times a day, but still constipated stool. Hyperaesthesia of body disappeared, except at left wrist.

May 4. Little shooting pain left arm ; sleep well ; eating better ; flatulence gone.

May 7. No burning or shooting pains for two days ; complains only little aching left arm ; occipital headache, once prominent, has gone ; admits feeling greatly improved in every way—which is admission for him, as he always looks on pessimistic side of everything. Bowels acting daily, though still constipated.

May 8 to 21. Much same condition ; walking better, feeling stronger ; only slight twinges of pain some days.

May 22. Discharged to-day. Given arsenic 1,000, one dose and sac. lac.

May 25. Reported himself at out-patients' department ; had some return of the burning pain at left wrist.

The interest in this case is the selection of the remedy by considering the "generals" of the patient alone. The patient must be first, the disease second. This is especially, and almost essentially so in chronic cases, and often thus you get your case down to two or three remedies, or possibly one, as in this case. If there be but one remedy that has the numerous generals, covering them absolutely, in degree as well as frequency, that remedy will cure the case. There may appear a few particulars to contraindicate, but no particular can throw out even one well-marked general. For instance, a case may present many particulars which look like arsenic, yet if "the patient" be aggravated by heat it can never cure.

Usually, however, you have only sufficient generals to bring you to, say six remedies, and here the particular and peculiar symptoms, again indicating the patient, come in,

and from them some distinguishing feature is obtained which points more strongly to one remedy.

Often our best cures have been obtained by a remedy, chosen solely by generals, which was not known to possess any striking resemblance to the common symptoms of the disease, doubtless due to want of further proving.

How often do we find that we cure symptoms whose existence was unknown to us, and the patient coming back and asking if the medicine were intended to cure polyypus of nose, or, as in a lady I had recently, a leucorrhœa of twenty-five years' duration. She thought she had mentioned the fact.

William Harding, 39 (old hospital case, by kind permission of Dr. Epps). Blind since 1897 after meningitis. On *general and mental symptoms alone* I prescribed his remedy.

September 20, 1909. Puls. 10M, one dose, sac. lac. daily.

October 29. Puls. 10M, one dose, sac. lac. daily. Since then, till date, no drug, and *still improving*, even to selecting colours in last two weeks.

The case calls for no change of remedy—*so hands off*.

Began to get sight back four weeks after first dose; can now read large print, tell colours, and play cards; still improving.

I hope some day to report more on the case, but it illustrates the value of treating the patient.

The results will surprise any who try, and by "the fruits shall ye know them."

In chronic disease treat the patient. This cannot be emphasized enough. We know the saying, "Take care of the pence and the pounds will take care of themselves." In homœopathy, "take care of the generals and the particulars *must* take care of themselves."

He also showed the disappearance of symptoms from above downwards, the pains leaving rest of body but persisting in wrists and ankles, then eventually going. This is always a good indication of cure, because going in a definite order. It is really a working of the trouble to the periphery, again from within outwards.

I once gave 10M bryonia (single dose) to an allopathic scoffer for rheumatism in the knees. In four hours he

could hardly bear the dreadful aggravation, and he then felt the pain suddenly leaving the knees, and shoot down legs as if going out at his toes, entirely disappearing the following day.

But lastly, and much the most important, it illustrates the single remedy, in potency, in single dose.

It is a matter of almost every-day experience to prescribe a drug in potency which the patient has been taking some time for years for some chronic complaints without much benefit, and for the potentized drug to succeed where the other failed.

Many who now use potentized drugs to 30th or 200th still keep repeating daily, and they acknowledge that their patients express feeling better at first, but soon lapsing into same old way—in reality worse by far, because they are having implanted in their system a drug disease, a thing to be more dreaded than original trouble.

In chronic cases you must give your drug time to work. It will most likely bring back old, or indeed new, symptoms, upon which the next remedy should be based. Because a remedy is the right one to-day, that does not necessarily mean that it will suit next time, and the second prescription should, as in the first, be based on the totality of the symptoms then existing. There is no other guide to it.

More cases are spoiled by too early repetition than by any other mistake. Prescribe in haste, and repent at leisure. It requires far more knowledge and confidence to know when to keep your hands off than to lay them on. Hasten slowly is a good motto, and never more so than when using potentized drugs.

Case 2.—A. E., engineer, aged 47. Well built, apparently healthy; complaining of excessive flatulence and distension of abdomen for last ten years, with great rumbling in upper part of abdomen, especially about 4 to 7 p.m., and always waking him from sleep at 4 a.m. Usually gets > by excessive escape of flatus, otherwise much pain. Causes great discomfort, as escape is audible.

Stomach.—Appetite good, but heaviness for hours after food, with very great distension; no special desires or aversions in food, though likes the taste of salt, and < pastry.

Rectum.—Bowels act fairly regularly, sometimes ineffectual urging to stool, or only small hard balls, with straining; bleeding from small hæmorrhoids; itching of anus excessive when constipated, < heat of bed, preventing sleep.

Head.—Throbbing headache, begin occiput and work over head to left eye; < stooping, < motion, must keep absolutely still; < lying, want to keep head erect; > warmth, as usual, shivering accompanies them; > pressure, > darkness. Excessive sweat, streaming, on least exertion.

Throat.—Tickling cough when chilled or in draught.

Urine.—Brickdust sediment very often, and especially before itching anus.

Mental.—None special; very punctual; like things done in hurry.

Generals.—No marked increase from either hot or cold; stand both, though preferred warmth; great desire for open air and exercise; < change weather; < stimulants. This is a general as “personal,” and not any particular aggravation. Sweating on least exertion, especially head, which > him generally.

There are no very marked symptoms, general or mental, except the < stimulant and sweating so profusely; but the particulars are very striking, so markedly that the < 4 to 8 p.m. becomes a general, and must rank high. This, together with the flatulence, and especially the > from passing of flatus, also the brick-red dust deposit in urine, makes one think of lycopodium with nat. mur. close behind.

January 10, 1910. Lycop. 10m (Skinner), one dose.

January 12. Itching anus, without the usual constipation.

January 13. Flatulence so excessive as to give great pain; this continued for two days, and the patient, not knowing what drug had been prescribed, said, “I should have taken lycop. for this.” He is a very intelligent lay homœopath, and had been taking lycop. 3x on and off for years at intervals.

January 19. Return of headaches, very severe; lasted two days.

January 23. Began to have rheumatic pains in left leg, which kept him awake for three nights—so severe that he wired to know if he might take rhus or bryonia. He was advised to keep his hands off, as the pain would likely pass off in few days. He very wisely did. Had similar rheumatic pains in same leg twelve years ago, but had been perfectly free in the interval.

January 25. Left wrist suddenly became very sore and weak; could not hold anything, nor yet bear weight of arm resting. He

experienced this same feeling twenty years ago, then due to a bad twist. Had to give up work for two years. It was massaged and rubbed with every kind of liniment then known. This very sore for the time, but > 27th.

So here we have a man, not exposed to any risks or conditions which usually bring on his complaints, and indeed having forgotten of their existence, being suddenly attacked with a return of old troubles in a very definite order, the more recent appearing before what happened years ago; and all reappearing in the "reverse order of their coming," which is the proper order, if the drug is the true homœopathic similimum, and is a good prognostic sign. Again, this returning of symptoms shows the drug to be still acting, and must, therefore, not be repeated.

This is his first experience of high potency, in which he had no faith, but he declares it has fairly shaken him up, and made him feel better generally than he has done for twenty years.

The following are the direction of symptoms during cure : (1) From within-outwards, *i.e.*, from the deeper or more vital parts to the more superficial. Hence the > first in the loves or hates before the more gross symptoms.

(2) From above-downwards.

(3) In the reverse order of their appearing.

Kent writes, p. 31, Philosophy: "You would naturally expect, if it is the interior of man that is disordered in sickness, and not his tissues primarily, that the interior must first be turned into order and the exterior last. The first of man is his voluntary, and the second of man is his understanding, the last of man is his outermost; from his centre to circumference; that is, *from above downwards, from within outwards*, from the more important to less important organs, from the head to the hands and feet. Every homœopathic practitioner who understands the art of healing knows that symptoms which go off in these directions remain away permanently. Moreover, he knows that symptoms which disappear *in the reverse order of their coming* are removed permanently. It is thus he knows that

the patient did not merely get well in spite of the treatment, but that he was cured by the action of the remedy, because if the disease were allowed to run its course, such a result would not take place. The progression of chronic diseases is from the surface to the centre."

These facts can be verified almost daily on your patients. In fact, I invariably warn them of its possible occurrence when taking on a new case, and tell them that in proportion as the old symptoms are thrown back upon the surface so is their recovery. Complaints of the inner parts, heart and chest, must in recovery be accompanied by manifestations upon the surface, in the extremities.

Take a case of rheumatism of heart getting better—often accompanied by the knees or feet becoming rheumatic, and they feel annoyed. And if the doctor does not know or appreciate what is taking place he prescribes for the superficial manifestations, only to drive it back again into the system, with disastrous results.

This explanation to the patients is only their due—it saves much worry to both patient and doctor. How often do we find those who want immediate relief despite the explanation, and it takes all the grit and confidence of the medical attendant to withstand the appeal; but we are standing for principles, and the man who yields does so to the hurt of his integrity and his success—because out of apparent chaos order quickly comes, and he earns the confidence and respect of the patient for having borne them through a critical period. On the other hand, you may lose your patient. I lost two new ones last week because they were not prepared to have return of old trouble brought to the surface. They will try other means, and when that fails I expect to see them back. If they want to be cured they must face it.

I mentioned at beginning that he was apparently healthy or strong. This is important as a guide to the potency. As he remarked to me afterwards, "What would have happened to me if I had not had a fair constitution to withstand it all?"—a very pertinent question. It is here where physical examination and a knowledge of pathology are absolutely

essential. Where deep tissue changes are present, *e.g.*, old phthisical condition of lung, kidneys, or liver destroyed, we must be careful, as such aggravation often cannot be recovered from. Many such have been prematurely sent to their graves, and where tissue changes are known, it is better to go low—to say 200th, than risk a 10M.

It seems strange that a patient should express themselves as feeling very well indeed without any marked diminution in symptoms, but the innermost part is telling that change is going on. "I don't know why it is, but I do feel better." You have got the right drug—keep hands off, and soon the symptoms will go. You are clearing your house in proper order—get the source clear, and what springs from it must of necessity be pure.

Dr. STONHAM said that they must acknowledge that Dr. Weir was aiming at a counsel of perfection. The cases he had given had been most carefully worked out. He had successfully treated his patients with only a single dose, and that was the counsel of perfection and a true Hahnemannian proceeding, though he did not think that Hahnemann touched the ten-thousandth dilution, seeing that his potencies were made by hand.

Dr. JAGIELSKI thought all present were very greatly indebted to Dr. Weir for his splendid paper, which invited practitioners to strain their philosophy somewhat. If they considered that a homœopathic philosophy had to be dealt with, the meaning of it was that practitioners should know what could act as a remedy, and what in fact could act in any way upon the body of a man, who not only had to take medicines, but in the first instance had to take food. The dietetic system had always been the most prominent of all, and the primary fact which practitioners had to take into consideration was the conditions under which the patient lived and all the surrounding circumstances. Especially ought practitioners to know about food. Could anyone give him a *Materia Medica* on the food which people ate? Could anybody tell him the action of it? Frequently he found among the articles which were assimilated every day very strong poisons, and homœopaths ought to advise patients not to take any food which they knew would be antagonistic to the remedies which were being administered. It might be stated that very often remedies did not act, because the action of the food was antagonistic to the

remedy, and it was not infrequently found that directly certain articles of food were taken off the patient's diet he recovered.

Dr. MILLER NEATBY, as almost the oldest member of the Society left in the room, rose not as a critic of Dr. Weir's paper, but as a profound admirer. He supposed all could confirm Dr. Weir's dictum, that the fact of a patient coming and saying he felt better in himself was the most hopeful thing that could happen to a practitioner in treating a case. He (Dr. Neatby) had got into the way of telling a patient who said that he felt very much better, although there was no change in local conditions, that that was the very best news he could give him. That had happened so often in the experience of them all that it could not be put down merely to the general optimism of the patient who liked to tell the doctor something nice when he came. It bore out the fact also that, as homœopaths, they dealt with a patient rather than with a disease, a fact which he thought might have been insisted upon more in the discussion on the alternation of remedies. It had been said by one or two speakers that remedies might be alternated because one of them would appeal, as it were, to one particular sphere of the body. At the time that remark was made it had seemed to him to be inconsistent with the homœopathic principle of treatment. One part of the body was not being treated, but the whole patient, and he did not think one ought to speak of "unrelated conditions" existing at the same time in the body. He did not think if a patient had a headache and some affection of the spleen at the same time one should speak of those things as unrelated. Surely, they must be related, and it was the practitioner's duty to treat the patient as a whole. The cases brought forward by Dr. Weir had been interesting, and in particular, as they brought out another great truth, namely, the importance of generals. In the rush and hurry of work, especially of out-patient work, one was perhaps apt to forget the great importance of the generals, and it was most important or them all to be reminded from time to time of these things.

Dr. PERCY PURDOM mentioned the case of a man he saw last year, who complained of spots before his eyes and also intense burning pains under the left ribs and in the left side of his head. He administered a dose of lachesis 200, not having any higher potency. After three weeks he saw the patient again who said he had completely lost all the burning sensation in the ribs and head, but still had the spots before his eyes. He (Dr. Purdom) did not give him any more medicine, but in another three weeks the patient came back saying he was just about the same, and he gave him a

second dose of lachesis 200 ; and in a month the man reported these spots had disappeared. The lachesis was worked out entirely on the generals, and the spots which were the first things complained of were the last to go, this being the right order in which symptoms should disappear—*i.e.*, the reverse order to the way they came. With regard to the question of the single remedy *versus* alternation, he had seen a case of influenza the previous day which had been treated by another doctor with homœopathic medicines in alternation, with no result. The remedies did not seem to him (Dr. Purdom) then to be indicated, so he took the opportunity of changing the medicine and he administered arsenicum 200, one dose, and the patient went to sleep soon after ; for the first time in three days and has steadily improved since.

Dr. EADIE mentioned the case of a distinguished surgeon who had prescribed belladonna plasters for two of his friends with gouty tendencies and who suffered from stiff backs from golfing. The result of the application of the plasters was that both patients came out in rashes lasting two years, and the surgeon had since been very chary of using such plasters. With regard to the question of generals, he could support everything which had been said. One had to go on generals, especially in animals. Dr. Burford had used a *reductio ad absurdum* argument regarding the single remedy in acute disease (to which he entirely demurred), and especially mentioned peritonitis. One, fortunately, did not see many cases of peritonitis at the present day, but he had seen a case—exactly one of those described in Treves' book—the facies of the patient being that of a man over whom the shadow of death was hanging. He (Dr. Eadie) selected and administered a single dose of bryonia 30, and the effect in an hour was remarkable. What he maintained was that in acute diseases the symptoms were so prominent that one could hardly overlook the right medicine ; but it was much more difficult to get the right remedy in a chronic disease.

Dr. WOODS said that as bearing out the fact that a cure must proceed from within, outwards, they could all recall cases of skin disease, where the patient had some slight eruption which came up in a week or so after taking the remedy. On the rash appearing the patients generally wanted some medicine or lotion to send it in again, saying they could not stand their appearance. If the patients were asked how they felt, they replied, "I am much better in myself, but I want this skin eruption cleared off," and one had to explain to them that to clear it off would mean that it

would have to be driven in again, making them feel much worse. He had noticed especially since he had been in the hospital, patients coming in with skin diseases which, when brought out from within, and apparently made worse, always left the patients much better in themselves.

Dr. WEIR said he had really nothing to reply to. The fact that Dr. Jagielski had brought out with regard to the antagonistic qualities of certain foods was quite well known. For instance, if a patient was taking lycopodium he must not be allowed to eat oysters; a thuja patient should never have onions; a rhus patient should never be allowed a bath. He himself had been bothered with palpitation, and Dr. Miller, Glasgow, had administered to him, *natrum mur.* 10M, but no improvement resulted until he discontinued smoking, since when the improvement had been really marvellous.

A CASE OF RICKETS.¹

BY A. E. HAWKES, M.D.

Honorary Medical Officer, Hahnemann Hospital.

Mrs. R. has had five children, and the history of these confinements and their sequel constitute this paper. The first child was born on May 1, 1901. He was quite healthy to all appearance, and he continued well until he "got a chill" when about 12 months old. He only lived three weeks after this chill, all available means used to deal with the broncho-pneumonia being ineffectual. On the occasion of his birth there was severe *post-partum* hæmorrhage, which was successfully dealt with by means of the Dublin douche.

The next child was born on May 29, 1902. The labour was very tedious, the first stage having to be terminated by rupturing the membranes. There was much flooding on this occasion also, due to *post-partum* inertia of the uterus. This little girl has given hardly any trouble. Her legs were not very straight, but they came right without any artificial

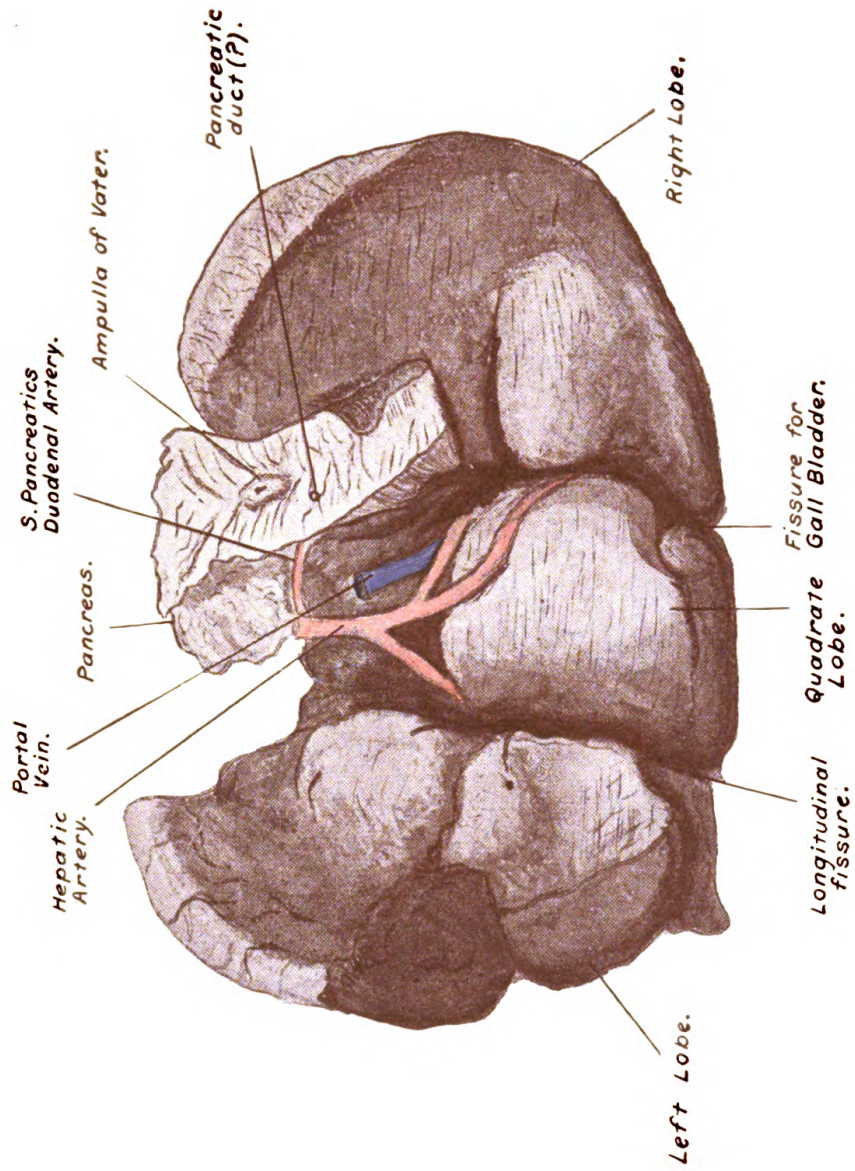
¹ Read at a meeting of the Liverpool Branch, February 10, 1910.

support. At times a little strabismus has occurred, but this is the only defect noticed.

Another child was born February 5, 1904. At the time of this baby's birth the flooding was severe, and hot douches had to be resorted to. She appeared healthy at birth, except that an icteric tint was observed from the first, and this no treatment helped in the least. The physical signs consisted of extreme induration of the liver. The motions were very pale and the child did not thrive. On the contrary, it was heavy and dull, and took but little notice of anything. Dr. Warrington, a well-known pathologist, saw the little patient and assisted in treating it; but nothing did any good. The jaundice increased, the eyelids became black, and the elbows also, and the child only lived five weeks. An elaborate and careful examination was made by Dr. Warrington, and this revealed congenital absence of certain of the biliary ducts. A complete diagnosis can hardly be said to have been made during life, but the accompanying drawing, for which I am indebted to Dr. Douglas-Crawford, gives a good idea of what actually caused the death of this child. This hepatic condition does not, I gather from my reading, indicate any form of ill-health in the parents, specific or otherwise. In some instances the ducts are blocked as early as the third month of intra-uterine life, or this may not occur until a much later period. It is likely that an irritating catarrh may cause the inflammatory closure of the ducts. This partial occlusion and ultimate closure can have but one end, and it is said that no child has ever been known to live eight months under these conditions.¹

The next child was born in April, 1905. During this pregnancy the mother was very ill, especially during the last three months. She had to keep to her room for some months. A month before the actual birth there were threatenings of approaching labour, and these signs continued every day. Eventually the labour occurred, but not till the full time. It was very tedious, and the child only just breathed.

¹ Dr John Thomson, "Allbutt's System of Medicine."



The mother remarked that during the last fortnight of intra-uterine life the movements became weaker and weaker.

The flooding on this occasion was more severe than ever. The uterus had to be manually emptied of clots; the hot douche was used, and for a long time bimanual pressure had to be kept up, one hand externally pressing on the fundus uteri, the other maintaining counter-pressure on the cervix.

The convalescence was very slow, and the patient had to keep her bed—as usual—for a month. Up to this time no ante-natal medication, rightly or wrongly, had been administered; but during the next pregnancy, but not even then till about the fifth month, calc. carb. 6 was given, and apparently with good effect.

Early in this pregnancy, Mrs. R. was very depressed having regard to her distressing experiences, and the desirability of terminating the pregnancy was discussed, and perhaps not very promptly negatived.

The mother was encouraged, and the pregnancy was more hopefully sustained, many little changes of air and surroundings being available.

Much milk was taken, and a good deal of the food known as "Force." This labour occurred on December 5, 1906.

It was quickly over, about five hours sufficing for the child's delivery, and the flooding was kept in check by the method advocated by Bishop, to which I shall take occasion to refer, as well as to the controversy the method gave rise to, at the end of this narration. It may be stated that the first child was not nursed by the mother.

The little girl (the second child) was suckled for five months, and then she was fed on milk, Benger's food, and so on.

The last child, a boy, was nursed only a few days; the effort was found to be too much for the mother, and the attempt had to be abandoned.

An attack of influenza at the end of the month rendered this step the more inevitable.

During the first six months this child thrived, and was doing well until—as I was unable to give any good reason

why it should not be done—vaccination was carried out. Calf lymph was used, and every precaution taken. The arm did well, no undue inflammation having resulted, and no vesicles or vesicular rash occurred elsewhere.

Within a few days the child ceased to look well, and he temporarily turned against the Gaertner's milk which had been relied on as soon as the mother—two or three days after the confinement—had found herself unable to nurse her baby. Within a few days of the vaccination an ulcer appeared under the tongue. It was whitish, and in a few more days a slough separated, and at least one other similar ulcer appeared.

This occurred about June 20, and very shortly afterwards the arm and tongue got well enough for him to be taken to a neighbouring sea-side resort. He still continued to relish and thrive upon the Gaertner's milk.

This visit began on July 21, and ten days afterwards he was taken suddenly ill with enteritis, much blood and mucus escaping from the bowel. He became so ill that his mother felt compelled to give him a few drops of brandy, and the stimulant seemed to revive him. This was the beginning of a long and anxious illness. Merc. cor. 3, and subsequently arsen. 3, helped the diarrhoea, but for a long time there were eight or ten, or even more, evacuations during the day. We thought the Gaertner had become rancid, and it was at once stopped and barley-water substituted. This availed but little, and yet it was continued with a few drops of brandy, which seemed to us all essential.

Milk was not tolerated, and veal broth, carefully prepared, was added to the dietary. Still very poorly, he was brought to Liverpool, and podophyllin 3 was tried, but the diarrhoea persisted. Cold sweats still further debilitated the little patient, and as the parents had become very apprehensive, a specialist in children's diseases was asked to see him, which he kindly did. His prescription was merc. dulc., gr. $\frac{1}{20}$, triturated with bismuth nit., gr. 5, three times a day. In accordance with my invariable custom, I carried out this medication, and so kept faith with the consultant, who, as he considered, had gone some way towards meeting my views.

For diet was ordered weak albumen water, with sugar of milk. This was given very frequently, and soon weak veal broth and sterile water, with five drops of valentine, were added to the list. Whey was also ordered to be administered as the patient improved, for a favourable prognosis was given at this time. Finally, a little cream was suggested, and this was fairly well tolerated.

The powders were not long continued, but the consultation on the whole was a great help. The dietary was persevered with for six or seven weeks—viz., till the end of October. By that time the patient had improved but little, and the emaciation, cold sweats, and general weakness were much in evidence. There were dark ecchymoses under the eyes; the conjunctivæ were blue; the gums looked black over the imbedded teeth, which were slow to come through. At this time Horlick's Malted Milk was used, and well borne, and this was continued for seven months.

By this time the patient was about a year old; the wrists were swollen as well as the ankles; the limbs were very sensitive to the touch, and not the slightest attempt at standing was made. The one hopeful sign was the mottling of the skin; at any rate, the mother thought so.

Early in January the femora swelled, and then bent, and greenstick fractures, necessitating splints of the nature of the Liston splint, which my son, Dr. James Hawkes, applied for me, occurred.

These splints were kept on for four months. The child was carried about in the splints, which for obvious reasons required much attention. The diarrhœa having subsided, the patient was put upon bread and milk, which agreed, and he was taken to Southport, which locality suited him well. He used to lie on his back and play with his hands and such toys as were suitable for him. He rallied from this time, and improved generally but slowly. In December he could stand and push a chair along, and at the end of March he could walk a little, and since then he has not "looked back."

The following features were marked in this case: The peculiar shape of the head, the backward abnormal

dentition, the enlarged wrists, the beading of the ribs, and the late walking, as well as the crying out from pain on being handled, however gently.

Sweating of the head was marked, and concurrent attacks of broncho-pneumonia threatened the life of the little patient. The diarrhoea, which was so persistent, varied much, but green mucous evacuations were the most frequent, and their excoriating influence still further aggravated the condition.

Laryngismus stridulus was not a feature of the case, unless the attack to which Dr. Watson was summoned for me was of that nature.

Tetany was not a marked feature, nor do I remember the abducted thumb phenomenon in this case. Bosses of the cranial bones were not particularly observed.

The beading of the ribs, as I have said, was very well marked, forming the so-called rosary. These have been noticed in the foetus. They are due to an enlargement of the ends of the ribs at their junction with the costal cartilages. Cheadle tells us that partial fractures may lead to these beads at the back of the ribs. The clavicles did not exhibit any marked deformity. The imperfectly calcified bone is the keynote to the condition we have to deal with in rickets.

There is excessive formation of cartilage, and this cartilage is greatly increased in vascularity.

It has been observed that rickety bones contain only 32 to 52 per cent. of lime instead of 63 to 65 per cent.

As improvement sets in, the vascularity diminishes, the spongy tissue hardens and becomes condensed by the formation of bone rich in lime salts.

In rickets the ligaments are soft and easily stretch, and the flabby muscles fail to maintain the sufferer's figure erect. The skin is at least pallid, and, as has been observed above, it may be somewhat pigmented.

The mucous membranes are easily afflicted with catarrh—bronchitis, enteritis, or gastritis. Whooping-cough forms a serious complication. The heart is often pushed outwards towards the left, and a white patch of thickened pericardium is often found.

That the liver may be the seat of a diffuse fibrosis may throw some light on the case of occluded bile-ducts I have above recorded.

The spleen is the subject also of fibrosis, and the condition simulates that of splenic cachexia.

The urine of a rickety child is not now considered to contain an excess of lime.¹

Merc. cor., arsen. alb., calc. carb., calc. phos., phosph., were the chief medicines used, and fatty inunctions were not neglected.

It is perhaps necessary to say that I seldom alternate medicines, but that in this case if calc. phos. happened to be the medicine exhibited, I did not stop giving it if a few doses of phosph. seemed requisite for an intercurrent bronchial attack.

It is due to the memory of our friend Dr. A. C. Clifton to state—for he was spending a short time with me while this case was in progress—that he emphasized the need for calc. carb., as he looked upon the blue appearance of the sclerotic as specially calling for this medicine.

This appearance, Dr. Gordon tells me, is due to atrophy of the sclerotic, thus enabling the choroid to be more in evidence.

In conclusion, I find myself compelled to refer those interested in the treatment of *post-partum* hæmorrhage to the papers of Mr. Bishop and Dr. Gordon Fitzgerald, in the 77th volume of the *Practitioner*.

¹ See Dr. Cheadle's article, "Allbutt's System of Medicine."

MINUTES OF THE SOCIETY MEETINGS.

THE FOURTH MEETING of the Session 1909-10 of the British Homœopathic Society was held at the London Homœopathic Hospital on Thursday, January 6, 1910, at 8 o'clock, Dr. McNish, President, in the chair. There were also present: Dr. Speirs Alexander, Dr. Burford, Dr. Clarke, Dr. Cooper, Dr. Cronin, Dr. Roberson Day, Dr. Eadie, Dr. Gilbert, Dr. Goldsbrough, Dr. Green, Dr. Greig, Dr. Hey, Dr. Jagielski, Dr. Johnstone, Dr. Kennedy, Dr. McCandlish, Dr. Moir, Dr. E. A. Neatby, Dr. Miller Neatby, Dr. Pincott, Dr. W. Roche, Dr. Sandberg, Mr. Knox Shaw, Dr. Stonham, Dr. Thomas, Mr. Wilkinson, and Mr. Dudley Wright. Apologies for absence were sent by Dr. A. E. Hawkes, Dr. Murray Moore, and Dr. Roberts.

NEW MEMBER.

Harold Fergie Woods, M.R.C.S.Eng., L.R.C.P., London, of the London Homœopathic Hospital, was duly elected a member of the Society, and introduced to the President.

VISITOR.

Dr. William Robertson, of Streatham, was present as a visitor.

SECTION OF SURGERY AND GYNÆCOLOGY.

Dr. George Burford, of London, gave a short demonstration of surgical methods observed in the clinics of Vienna, which was followed by a discussion. Dr. Burford's remarks, with illustrations and the discussion which followed, appear on pp. 141-146 of this issue of the Journal.

A paper was afterwards read by Mr. Knox Shaw, entitled "On the Present Position of Prostatectomy," which was also discussed and appears on pp. 153-158.

THE FIFTH MEETING of the Session 1909-10 was held at the London Homœopathic Hospital on Thursday, February 4, 1910, Dr. Stonham, Vice-President, being in the chair. There were also present: Dr. Speirs Alexander, Dr. Cooper, Dr. Burford, Dr.

Cronin, Dr. Roberson Day, Dr. Ellwood, Dr. Hey, Dr. Jagielski, Dr. Pincott, Dr. McCandlish, Dr. Murray Moore, Dr. E. A. Neatby, Dr. Miller Neatby, Dr. Powell, Dr. W. P. Purdom, Dr. Pullar, Dr. Sanders, Mr. Knox Shaw, Dr. Weir, Dr. Wheeler, and Dr. H. Fergie Woods. An apology for absence was sent by Dr. Goldsbrough.

NEW MEMBERS.

David Ridpath, M.D., C.M.Edin., of Sunderland, and Henry Robert Ramsbotham, M.A., M.B., B.Ch.Oxon., of "Fair Head," Ripon Road, Harrogate, were elected members of the Society. Dr. Ramsbotham was introduced to and welcomed by the Society.

VISITORS.

Dr. Hare and Dr. A. Wheeler, of London, were introduced as visitors.

SECTION OF MATERIA MEDICA AND THERAPEUTICS.

Under the auspices of this Section a paper was read by Dr. Murray Moore, of Leamington, entitled "Alternation of Remedies in the Practice of Homœopathy," and also a paper by Dr. John Weir, entitled "Some Cases illustrating the Homœopathic Philosophy," both of which were followed by discussion, which, with the papers, appear on pp. 165-175 and pp. 182-190 respectively of this issue of the Journal.

DR. DYCE BROWN.

A resolution of sympathy with Dr. Dyce Brown, in his lengthened enforced absence and confinement to his room, owing to illness, was unanimously passed.

The SIXTH MEETING of the Session 1909-10 was held at the London Homœopathic Hospital, on March 3, 1910, Dr. Stonham, Vice-President, in the chair. There were present: Dr. Blackley, Dr. Burford, Dr. Roberson Day, Dr. Eadie, Dr. Ellwood, Dr. Goldsbrough, Dr. Hey, Dr. Jagielski, Dr. F. Nankivell, Dr. E. A. Neatby, Dr. Miller Neatby, Dr. Powell, Dr. Searson, Dr. Thomas, Dr. Margaret Tyler, Dr. Watson, and Dr. Weir. An apology for absence was sent by Dr. Deane.

NEW MEMBER.

William Robertson, L.R.C.P. & S.Edin., L.F.P.S.Glasg., of Elm-hurst, Streatham Common, was duly elected a member of the Society.

SECTION OF GENERAL MEDICINE AND PATHOLOGY.

Under the auspices of this Section a number of cases were exhibited, comprising, amongst others, infantile scurvy, retinal hæmorrhage, chronic plumbism, lymphadenoma, angio-neurotic œdema, and, a case of chronic deafness, and another of alopecia illustrating the therapeutics of the X-rays. Full particulars of these cases and the remarks of the members upon them will appear in a future issue of the Journal.

REQUEST FOR AUTOGRAPHS.

The Honorary Secretary will be greatly obliged if any Fellows or Members of the Society who may have in their possession an autograph of the late Dr. Quin, Mr. Cameron, Dr. Drury, or Dr. Carfrae, if they will be kind enough to forward the MS. or letter containing the same to him for insertion of the autograph in the Roll of the Society.

PROCEEDINGS OF THE LIVERPOOL BRANCH.

SESSION 1909-10.

The FOURTH MEETING of the Liverpool Branch of the British Homœopathic Society was held at the Hahnemann Hospital, Liverpool, on January 13, 1910, the following members being present: Drs. A. E. Hawkes, Proctor, Chas. Hayward, Cash-Reed, Watson, and Bryan (Hon. Sec.).

In the absence of Dr. John D. Hayward, Dr. Watson took the chair.

Dr. Watson showed a case of pyloric obstruction, on which gastro-enterostomy had been performed last June, mention of which he made in his paper read at the previous meeting (see p. 139).

Dr. Cash-Reed exhibited an ovary which he had removed earlier in the day from a young girl aged 20. The specimen showed a few small papillary growths on the outside only of the ovary. The ovary was not cystic, nor did the growths break down easily or bleed readily, and were probably of an adenomatous character. One similar growth was cut off from the ovary left behind. At the time of the operation no growths were observed on the peritoneum, nor was ascites present. Dr. Chas. Hayward suggested the patient taking thuja.

Dr. Cash-Reed also showed a foreign body which he had removed from the vagina of a patient in the out-patient department. It consisted of four pieces of steel about 8 in. long and $\frac{1}{4}$ in. wide, bound together by wire, and had been imbedded in the anterior vaginal wall. The patient denied any knowledge as to how it got there, and it was suggested that it might have been put there at some time for the purpose of procuring an abortion. Dr. Hawkes suggested that it might be the interior of an ordinary ring pessary, from which the outer rubber coating had disappeared. An old pessary was cut into, and found to contain bands of steel arranged in a similar manner to the specimen shown.

Dr. Hawkes exhibited a man suffering with a fracture of the last cervical vertebra.

After an examination of these cases they were discussed by the members present.

The FIFTH MEETING of the Session 1909-10 was held in the Hahnemann Hospital, Liverpool, on Thursday, February 10, the President, Dr. John Hayward, in the chair. The following members were also present : Drs. A. E. Hawkes, Chas. Hayward, Cash-Reed, Proctor, Gordon, Watson, and Bryan.

After reading and confirmation of the minutes, the President called on Dr. A. E. Hawkes to read a paper entitled "A Case of Rickets," which appears, with a coloured illustration, on p. 193 of this issue of the Journal.

Dr. Hawkes was thanked for his interesting paper, which was discussed by the members present.

The meeting then terminated.

SUMMARY OF PHARMACODYNAMICS AND THERAPEUTICS.

Extracts from Exchange and other Journals by the Editor in collaboration with John G. Blackley, M.B.

Apocynum in Acute Alcoholism.—Dr. H. G. Sloat has tried apocynum in the alcoholic ward of the Metropolitan Hospital, New York City, between twenty and thirty cases being under observation. The decoction was used, and upon admission to the ward a patient was given 1 drm. of the drug well diluted. After a lapse of three hours he was given teaspoonful doses of a mixture of 1 drm. of the decoction in 4 oz. of water. The drm. doses were repeated on the morning of the second and third days in most cases. In some severe cases of delirium tremens one of these doses was given on the fourth day, but not often. The average length of stay in the hospital with this treatment was seven days, whereas usually it had been fourteen or twenty-one. The nervous restlessness disappeared on the second day, and on the third the patient was walking about the ward asking for nourishment. Patient left stating that the craving for drink ceased after a few doses of the medicine. (*Hahnemannian Monthly*, January, 1910, p. 52.)—ED.

Castanea vesca. Involuntary Proving.—A strongly built young farmer, suffering from enlarged cervical glands, ate seven or eight raw chestnuts one evening. Later he was seized with diarrhoea and vomiting, and the urine became very cloudy and altered in colour. He was very thirsty. In two days there was pain across the back with feeling of great weakness. He could hardly stand upright, and wanted nothing to eat all the time. (Dr. George Black, in the *British Homœopathic Review*, February, 1910, p. 69.)—ED.

Cocaine. Poisoning from Local Application.—At 2 p.m., Dr. A. G. Gibson was called to see a married lady, aged 40, suffering from the most violent spasms. In consequence of throat irritation she had been occasionally painting her throat with a 2 per

cent. solution of cocaine hydrochloride. Before luncheon she painted her throat because of a "choky feeling." She repeated this again after luncheon. The sensation became worse; she felt she could not breathe. Her maid, on being summoned, found her in violent spasms. Five minutes later Dr. Gibson found her making intense muscular efforts, quite oblivious of her surroundings, and occasionally uttering piercing cries. Many of her movements were of a voluntary type, for, on restraining her wrists, she made painful efforts to get free. She was placed on the floor. Her face was intensely red, not livid; eyes more prominent than normal, pupils medium and equal, pulse strong, full, relatively slow. Breathing not obstructed. For a few moments she would remain quiet, then clench her teeth, strike out with her arms, and the whole body would become stiff with tonic muscular rigidity. During the spasms she was totally unconscious, but in quiet intervals enquired why she was on the floor. Movements were so violent as to require chloroform, by a slight administration of which the convulsion was allayed. The whole attack lasted fifteen to twenty minutes. The return to normal state was rapid. In twenty minutes after being put into bed she was able to get up and relate her symptoms. Her memory was blank from the time of ringing a bell for the maid until she found herself in bed. The only thing she felt impressed with was she was full of fight. She felt no ill-effects until the next day, when she lacked some of her usual energy. The attacks resembled hysteria, but were concluded not to be so in that they did not avoid self-injury, the patient was unconscious, was not a hysterical subject, and had no seizures before. An examination of the bottle containing the cocaine showed a deposit at the bottom in which there was a fungoid growth. (*The Lancet*, February 26, 1910, p. 568.)—ED.

Colchicum.—Dr. A. L. Forbes reports some experience with colchicum, in which this medicine gave prompt relief in bloating of the abdomen; in a case of strangulated hernia with great distension, hiccough, and prostration; in intense hiccough, accompanying cancer of the stomach, and in mucous colitis as a symptom of general neurasthenia. (*Homœopathic Recorder*, January, 1910, p. 17.)—ED.

Homatropin. *Toxic Symptoms.*—Dr. E. G. Whiana, Assistant Ophthalmologist to the West Philadelphia Homœopathic Hospital, reports two cases in which serious symptoms followed the use of homatropin as a mydriatic. The solution used in each

case was Merck's, freshly prepared in the ordinary strength $\frac{1}{2}$ gr. to $\frac{1}{2}$ dr. and instilled into the eye one drop every ten minutes for one hour. The first case was that of a man, aged 30, who was treated at 9.30 a.m. and sent home, which he had not reached at 1 p.m. A careful search found him sitting on a kerbstone, in an opposite direction from his home. On being seen later he said that after leaving the doctor's office, he had no idea as to the direction he should take to reach home and wandered aimlessly as long as his weakened legs would carry him. He then sat down and went to sleep. He was put to bed in a dark, quiet room, and by 8 p.m. had recovered his natural poise. The second case was that of a girl, aged 12, whose mother stated that when the drops were being put in her eyes she complained of being tired and wanting to go to sleep. She stumbled and nearly fell down some steps, seeming to have lost strength in her legs. While riding in a car back to the office she was very talkative, and imagined she saw little play-mates and circus parades in the streets. She had to be carried into the doctor's office. In a dark room, when a cold compress was put on her forehead, she became very violent, striking at anyone who came near. Speech was confused and incoherent; silly laughter, kicking at imaginary objects, very restless, jumping up and down, refusing to lie quiet. If spoken to sharply she would answer intelligently, and then wander off again. The symptoms continued until 6 p.m., when she gradually quieted down and slept all night. The next day her condition was normal, except for some nervous restlessness. (*The Medical Counsellor*, January, 1910, p. 10.)—ED.

Natrum muriaticum. *Involuntary Proving.*—Dr. T. G. Stonham reports the case of a gentleman, aged 42, in which natrum muriaticum 30 in pilules night and morning unmistakably produced three or four loose, pappy, painless stools daily, with weakness, loss of flesh, and depression. After a fortnight he came over chilly in the afternoon, and the temperature rose to 102.3° F. This recurred for several days until under advice he ceased the pilules, and in three days felt better again. Conjunctivitis, for which the medicine had been given, grew worse with the illness caused by the medicine. Dr. Stonham considers this case supplements the provings of natrum muriaticum in there having been produced actual fever as registered by the thermometer. The patient was evidently a sensitive as regards homœopathic medicines. (*British Homœopathic Review*, February, 1910, p. 77.)—ED.

Quinine. *Poisoning.*—Salamon relates the following case of a woman with lupus erythematosus, for which she took muriate of quinine in substantial doses without special inconvenience. Having a relapse, she adopted the same treatment, but this time, after taking 0·3 gr. she was seized with nausea, inclination to vomit, and buzzing in the ears. She therefore diminished the dose to 0·15 gr. In spite of this, however, when she was seen by Dr. S. on the following day she was manifestly very ill; the whole face was bloated and œdematous, and from the inner canthus of each eye extended thick bloody crusts as far as the margins of the lupus, which latter was studded with innumerable slight hæmorrhages. In addition, there was purpura hæmorrhagica of both legs, and a considerable hæmorrhage under one conjunctiva. Other prominent symptoms were: acute dyspnœa, hæmatemesis, bloody stools, hæmaturia, and hæmorrhages from the mucous membrane of the mouth and nose. (*Münch. med. Woch.*, 1908, No. 34.)—J. G. B.

Sea-water Injections.—Dr. Rollin A. Stevens, of Detroit, reports eight cases of chronic disease in which injections of isotonic sea-water were of marked benefit. (For a history and technique of this plan of treatment reference may be made to the *Medical Annual*, 1910, pp. 98-106; also to the *JOURNAL OF THE BRITISH HOMŒOPATHIC SOCIETY*, 1906, p. 386). (1) Cancer of nose in a lady aged 87. Had had much X-ray treatment. Improvement was very marked when bi-weekly injections of sea-water were begun with the X-ray. The case appeared hopeless at the beginning, but after several weeks it took on quite an encouraging aspect. (2) Cancer of nose of several years standing in widow aged 65 years had been treated by X-ray and fulguration, with improvement and relapses. Then followed radium, and bi-weekly injections of isotonic sea-water of 50 to 100 c.c., with much improvement in the general condition, but with no local effect. (3) Very rapid growth in cancer of the vagina, following removal of uterus and appendages: upper vagina hard, full of nodular masses. Severe hæmorrhage, hæmoglobin 55 p.c. Injections twice a week for two months. Improvement has been beyond belief; size of growth much diminished and symptoms relieved. (4) In a case of eczema of the face in a man which followed pyogenic infection of the pelvic region, the eruption healed after eight injections in three months. (5) Tuberculosis of wrist and hands in man seventy years of age and sixteen years' standing. Several sinuses discharging pus.

Much improvement followed injections given irregularly for three months; discharge of pus practically ceased and sinuses nearly all healed. (6) In keratoderma of hands and feet in a young unmarried woman, aged 22, no improvement ensued after injections of 75 to 100 c.c. twice a week, fourteen in all. (7) In a widow, aged 45, emaciated, with large glands for years, and history of overwork and gonorrhœal pyosalpinx, injections of 50 c.c. were followed by chill, fever, delirium, aching, coryza lasting eight hours, followed by improvement in general condition. Injections of 30 c.c. did not produce reaction. (8) Varicose ulcer in a man aged 75. Ulcer rapidly healed after injections of 50 c.c. in August, but a new one broke out on the other side. Injections of 125 to 200 c.c. then given, and the ulcer was healing nicely. Local dressings of cold boiled water were used. (*Cleveland Medical and Surgical Reporter*, March, 1910, p. 71.)—ED.

Serum-therapy. *Auto-serotherapy in Ascites.*—MM. Audibert and Monges have lately treated with complete success a woman suffering from relapsing ascites of hepatic origin for which paracentesis had been performed regularly every fifteen days for many months, from twelve to fifteen litres being removed each time. Their *modus operandi* is as follows: After the skin is rendered aseptic and anæsthesia induced by means of ethyl chloride, the left flank is punctured with the needle of a sterilized syringe of 10-c.c. capacity; having aspirated a syringeful of the ascitic fluid the needle is partially withdrawn and then plunged into the cellular tissue of the abdominal wall, where the ascitic fluid is gradually reinjected, beginning with a dose of 3 c.c. The subsequent injections are gradually increased until the whole syringeful is used. The injections are made every six days and continued over a period of several weeks, and involve neither pain nor unpleasant effects of any kind. The most remarkable result in this case was the establishment of polyuria; the quantity of urine, which had previously been 500 gm. only, gradually increased until, for a couple of days after each injection, it stood at 2,000 gm. After this it fell, but never went below 1,200 gm. The improvement in the ascitic condition was so great that six weeks had already elapsed and no fresh paracentesis had been necessary. (*Presse Médicale*, 1909, No. 87.)—J. G. B.

Spongia.—Dr. C. E. Chase, of Utica, contributes a short paper on spongia, in which the leading characteristics and uses of this

remedy are brought out. For instance, spongia is the keystone of the arch among remedies for catarrhal or croupous laryngitis, standing between aconite and hepar sulphuris. Its action is deeper than that of aconite, but it has the same nervous anxiety, sudden waking from sleep with fear of suffocation, and loud, dry, barking cough. The cough is usually better by lying down, and by eating and drinking, especially warm drinks. It is excited by deep breathing and talking, and by dry cold winds. The glands are affected by spongia, they swell and become painful and tender. It is a remedy in goitre, especially the exophthalmic form, as in the latter the condition of the heart with the accompanying symptoms are similar to those produced by spongia. It also has a place as a remedy in endocarditis of rheumatic origin, and in chronic orchitis and epididymitis. It is related to other remedies, in croup to iodine bromine, and kali bichrom.; in bronchial affections to phosphorus and sanguinaria, and in heart cases to aconite, spigelia, cactus, lachesis. (*North American Journal of Homœopathy*, January, 1910, f. 37.)—ED.

Tuberculin in Headache from Cerebral Tumour.—Dr. Charles Mercier showed at the Medical Graduates' College and Polyclinic the case of a boy who was believed to have cerebral tumour of tubercular nature, whose main symptom was headache. He had purposeless vomiting occasionally, but no optic neuritis. When first seen at 8 years of age the headache was almost continuous, severe, and incapacitating. He could neither work nor play, and spent the greater part of the day in lying down. His expression was of dazed bewilderment, combined with suffering. From the beginning of the treatment by tuberculin (presumably by injection) he began slowly to mend. He now, eighteen months after, during which time he has been taking tuberculin, averages one severe and two slight headaches every week. The improvement was slow, but very decided, and was attributed by Dr. Mercier to the tuberculin. (*The Lancet*, February 26, 1910, p. 560).

Typhoid Fever. Treatment.—An interesting and exhaustive paper on "The Treatment of Typhoid Fever" was presented to the Bureau of Clinical Medicine of the American Institute of Homœopathy, by Dr. H. B. Minton, of Brooklyn, and followed by a discussion taken part in by members from all parts of the United States. The points made by Dr. Minton were briefly as follows: (1) With regard to prophylaxis, on the part of the

public it should become generally known that "the earlier a patient can be placed on a liquid diet and put to bed the less liable he is to experience a severe attack of the disease. From this point of view a patient exhibiting slight rise of temperature, backache, or headache, with a general feeling of malaise, requires attention. (2) The anorexia which marks the early stages of the disease is an indication for a very limited dietary. The main indication in feeding the patient is to maintain a period of absolute quiescence in the region of the local lesions, and yet not to allow the body proteid to be too much reduced. Dr. Minton recommends 8 oz. of modified or diluted milk given in alternation with 8 oz. of water every two hours. If milk is distasteful or produces toxic symptoms it should be replaced by strained gruel, a malted milk, or white of egg in water. With such a diet grape or orange juice may be used, which proves very grateful to the majority of patients. (3) The importance of water internally exceeds its importance externally. In exceptional cases, if the temperature is unduly high, tepid sponging may be adopted. (4) Alcohol should be withheld altogether whenever possible, but may be used if stimulation is required in the event of enfeebled circulation. (5) Rectal irrigation may be employed for the relief of meteorism. (6) In the case of hæmorrhage, irrigation should at once be ceased. Cold may be applied to the abdomen. Moderate collapse will probably control the hæmorrhage and should not be counteracted by stimulants. Rhus, ipec., china, ham., lach., ac. nitricum are the most valuable remedies in this condition. (7) If perforation occurs, immediate operative measures offer the only hope of saving the patient. (8) As regards medicinal treatment, Dr. Minton follows Dr. P. P. Wells, who contributed an article in the *American Homœopathic Review*, vol. iii., on the subject. The symptoms of the disease are such that they can be classified into three groups—the cerebral, the abdominal, and the mixed. Belladonna corresponds to the first group with hyos. lach., opium, and stram., to be compared with it. Arsenicum is indicated for the second group, with which is to be compared carbo v., china, colch., merc., nux vom., secale and sulph. For the third group bryonia is the leading medicine, and with this should be classed gelsem., baptisia, arnica, calc., nux vom., puls., rhus, and veratrum.

In the discussion most of Dr. Minton's suggestions were commended, although some speakers advocated a "water" diet only, and others protested against "starvation" of the patient. Dr. Blackman, of Brooklyn, commended echinacea in

low types of the disease, and Dr. Sawyer, of Chicago, pyrogen. Dr. Hawkes, of Los Angeles, considered that the bowel should be washed out twice only at the beginning of the illness, and he feeds his patients on water and fruit-juice until they have an appetite come for some simple article of diet. Dr. Van den Burg commended the use of the Brand bath, in which the temperature is varied from 90° to 65° F., according to the condition and reaction of the patient. Attention to details in the use of the bath is all-important. (*The Journal of the American Institute of Homœopathy*, February, 1910, pp. 112 to 124.)—ED.

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PNEUMONIA IN CHILDREN ; ILLUSTRATED BY
FIFTY CONSECUTIVE CASES TREATED AT
THE NEW ORPHAN HOUSES, BRISTOL.
WITHOUT MORTALITY.¹

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It is not my intention to weary you with a full and exhaustive description of such well-known and frequently occurring diseases as the pneumonias of childhood, but rather to touch upon a few of the more important or more interesting facts in connection therewith, with especial reference to cases which have occurred in a series of fifty consecutively treated at the New Orphan Houses of Ashley Down, Bristol, hoping that in the discussion which will follow, many of my *confreres* will also contribute to our knowledge,

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from their experiences in the treatment of this serious and often fatal affliction of childhood.

Let me say, at the outset, that I propose to treat of acute lobar and broncho-pneumonia as ordinarily seen in children, leaving out of consideration the chronic, tubercular and aspiration and deglutition forms.

The chart before you will show you graphically the relative incidence of these two diseases—for I speak of them as separate entities, though it may at times be difficult to distinguish them clinically—in children under 5, as given by Holt, from a series of 370 cases. You will notice that the prevalence of lobar pneumonia is greatest at a rather later age than is the case in broncho-pneumonia occurring primarily, though it is not so uncommon in early infancy as is often supposed, while after the 15th year, according to Osler, its frequency again begins to increase. In the series of cases under consideration the ages varied between 4 and 16, and averaged $9\frac{1}{2}$.

For purposes of prognosis, it is important to differentiate between the two forms, broncho-pneumonia being a much more fatal disease in children than the lobar variety, though it may not be possible to draw the distinction from the physical signs, and even after death the macroscopical appearances may be identical, as the areas of lobular consolidation may run together, producing solidification of a whole lobe.

Lobar pneumonia generally occurs in children whose previous health has been good, and in 95 per cent. of cases is due to the pneumococcus of Fraenkel, while broncho-pneumonia is prone to occur in the debilitated, rachitic, or delicate child, and is associated with a variety of organisms.

Two of my patients had two attacks of the disease, both after an interval of $13\frac{1}{2}$ months.

We will now devote our attention to lobar pneumonia. Its *pathology* is well known to you, the essential feature of the morbid anatomy of the disease being, in the first stage—that of congestion—a hyperæmia of the parenchyma of the lung with œdema, passing as exudation increases and the alveoli become filled with red and white corpuscles, fibrin and

desquamated epithelial cells, into the second stage, that of red hepatization, which in turn gives place, as the alveolar contents become decolorized and degenerated, to the stage of grey hepatization, followed lastly by the stage of resolution, in which they become degenerated and liquefied and are removed by the lymphatics, or coughed up. .

Lobar pneumonia is said to affect the apex of the lung more commonly in children than in adults and each side with about equal frequency. Holt's statistics of 950 cases under 14 years of age, showing the right lung to be affected in 45.5 per cent. (in my cases 35.5 per cent.), the left in 41.5 per cent. (47 per cent. in my cases), and both lungs in 13 per cent. of the cases (17.5 per cent. in my series being thus affected); the order of frequency in the various parts of the lung being given as left base, right apex, right base and left apex, and the same order of occurrence was observed in my cases, the left base being affected nearly twice as frequently as the right apex and base, which suffered equally, and seven times as often as the left apex.

About 60 per cent. of the cases are said to occur in *boys*. In my series of 36 cases, 14 were boys and 22 girls; so, though drawn from a population in which the girls are about twice as numerous as the boys, the reverse relation obtains.

The *onset* of the disease is often very acute, and in young children not infrequently accompanied by vomiting or convulsions. Pain is usually present and is pleuritic, being often complained of, not in the chest, but in the abdomen or loin, the epigastrium being a frequent situation, or it may be referred to the iliac region and give rise to a suspicion of appendicitis. Thus, in my cases, two patients complained of pain in the epigastrium and in one the seat of pain was the shoulder and neck.

The usual *course* of the disease is from five to eight days, though it may be from three to five days, and in discussing the question of the possibility of cutting short an attack of lobar pneumonia, we must remember that there is an abortive form, in which, by the second or third day, the temperature has fallen to normal and all the physical signs

have disappeared. In one series of collected cases, the fatal attacks averaged thirteen days in duration and the non-fatal eight days.

In my cases, the average was nine days, or if reckoning continued temperature due to empyema and other complications, in which the temperature rose again, it was thirteen days. The shortest duration in my patients was four days, and the longest six weeks.

Coming now to the *symptoms*, we find that the *temperature* usually rises suddenly and remains high, averaging 104° or 105° F., though there may be a fall of one or two degrees in the morning, and under three years of age the temperature tends to be more markedly remittent. Defervescence is usually by crisis, though not so constantly so as in adults, this generally occurring between the fifth and eighth days, though it may not take place till the ninth or tenth day, or even later, but the tendency after the twelfth day is for the temperature to fall by lysis, and this is also the case in infants, Rotch stating that under three years of age about one-third of the cases terminate by lysis. Nineteen of my cases terminated by crisis and nine by lysis, the average day for the former being the sixth.

In 567 non-fatal cases recorded by Holt, the seventh day was much more frequently the critical day than any other. False crises are not at all uncommon and occurred frequently in my series of cases, but can usually be distinguished by an absence of a corresponding lessening of the rapidity of the pulse and respirations. A post-critical rise of temperature may be due to an extension of the disease to a fresh area, or to pleurisy (as is well shown in the chart of Case 30), and this latter is apt to be purulent (Case 40).

The highest temperature recorded in my cases was 105·6° F.; in one case the temperature fell six degrees within twelve hours and in another 6·2 degrees within fifteen hours. Heart failure and diarrhoea are prone to occur after the crisis.

The *pulse* is typically full and bounding at first, averaging 150 to 170 beats per minute; as the disease progresses the tension diminishes and the rate increases, while it may

become irregular, intermittent, or dicrotic. The highest pulse-rate observed in my cases was 144.

Respiration is short, jerky and laboured, its rate averaging 50 to 80 per minute; one of my cases was found to beat 88 times in the minute. The pulse-respiration ratio, instead of being four to one as normally, may be only two to one, and this disturbance of the normal ratio is a marked diagnostic sign of the disease.

Cough may be absent for several days at the beginning of an attack, its absence proving misleading.

Flushing of one or both cheeks is usual, but may not be on the same side as the affected lung, though in four of my patients this was the case.

A few points in connection with the *physical signs* may be noted.

Dulness may be absent in children and there may instead be a tympanitic note at the base of the lung from a distended stomach or colon. The *breath sounds* may be weak or absent, if the tubes are filled with mucus or fibrin, simulating pleural effusion. Typically, there is in the first stage diminished resonance, with feeble high-pitched breath sounds over the affected area and hyper-resonance with exaggerated breath sounds over the unaffected parts of both lungs. This exaggerated breathing may be mistaken for bronchial breathing, but is heard only during inspiration, while the latter is higher in pitch and heard with almost equal intensity in both inspiration and expiration. In the second stage, well-marked dulness, bronchial breath sounds, increased vocal resonance and fremitus are the rule.

Rotch considers that central pneumonia is especially common in children, symptoms of pneumonia being present but no physical signs; these may not come to the surface for some days, or not at all. Holt, however, doubts the possibility of pneumonia existing in the centre of a lung for several days, and has never seen it *post mortem*. He says that consolidation may exist in the part of the apex covered by the shoulder, or along the posterior border of the lung, without the possibility of detection. In doubtful cases the regions high up in the axillæ and under the clavicles

should be watched, as the earliest signs may be found there.

Complications.

Pleurisy always occurs if the inflammation is superficial ; its frequency and severity is said to be a peculiarity of pneumonia in children. Evidence of it is recorded in sixteen of the thirty-six cases in my series.

Empyema is not an uncommon complication in children ; it occurred twice in the series under consideration. Its symptoms are but a continuation of the previous illness, the temperature as a rule never falling to normal, but the fever persisting and taking on an irregular type (shown in chart of Case 39). The physical signs are variable, bronchial breathing and vocal fremitus are often still to be found, and an exploratory puncture (or more than one) may be needed to clear up the diagnosis.

Pericarditis is rare, but occurred with effusion in one of my patients in conjunction with right-sided pneumonia and pleurisy, though more usual in pleuro-pneumonia of the left side.

Peritonitis causes few symptoms except abdominal pain, tenderness and distension, which were observed in two of my cases.

Otitis media is not infrequent, occurring in 18 per cent. of Morse's cases. A sudden rise of temperature may be the only suggestion of its occurrence. It may give rise to rigidity of the neck simulating meningitis.

Meningitis is rare, but occurred once in my series with Kernig's sign, retraction of head, left facial paresis, left external rectus paralysis and early optic neuritis on the left side. Iodoform 3x was helpful in this case. I remember seeing a case in Paris in which pneumococci and polynuclear leucocytes were found in the cerebro-spinal fluid obtained by lumbar puncture.

Diagnosis.

Leucocytosis is a marked feature, beginning shortly after the onset and reaching a maximum shortly before the crisis.

A count of 12,000 to 30,000 is usual in a young child, and may reach 40,000 or 50,000. Holt says that absence of leucocytosis in a strong child who is acutely ill is strong presumptive evidence against pneumonia.

From *broncho-pneumonia* lobar pneumonia is distinguished by the following characteristics of the former: it occurs chiefly in weakly children, usually attacks both lungs, and is secondary to bronchitis; its onset is insidious, course prolonged, and temperature irregular, and the physical signs show a patchy distribution; dulness, bronchial breathing and increased vocal resonance and fremitus are not well marked—in all of which it stands in contrast to lobar pneumonia.

From *pleural effusion* diagnosis may be impossible, as in both there may be loss of resonance and bronchial breathing without any special change in vocal resonance and fremitus, these latter signs being of much less value in children than in adults.

From *meningitis* it is distinguished by the moderate fever, slow pulse and irregular respiration of meningitis, or by the results of lumbar puncture. Kernig's sign is stated by Guinon to occur in pneumonia, though not so marked as in meningitis. The two diseases may co-exist, as already mentioned. If nervous symptoms are present from the beginning, there is probably no meningitis, but if they develop suddenly during the course or towards the close of the disease, it should be suspected.

Prognosis.

This varies with age, being much better in early childhood than in infancy or adult life. In 1,482 cases of all ages, collected by Holt, the mortality was 4 per cent; while of 187 of his own cases, mostly under 2 years, 11 per cent. died; and in Morse's statistics of 118 cases, 32 per cent. in the first year of life were fatal, and 18 per cent. in the second year, the mortality being lowest where the temperature did not rise above 103° F., and highest in those cases in which it was 106° F., or over; the degrees of fever

between these points had no effect on the mortality. No case died in which the pulse-rate was under 140 or respiration below 55. A continuance of the fever after the tenth day is serious, and also an excessive amount of pleurisy (pleuro-pneumonia).

Treatment.

Osler says: "We have no specific treatment for pneumonia," and Hutchison states that beyond putting the little patients to bed and nursing them, there is no other occasion for treatment. He treats his hospital cases as out-patients.

The patient should be placed in a warm room but with plenty of fresh air; food should be given at regular intervals of not less than two hours and often four hours. No external applications are needed unless for pain, in which case a mustard poultice may be used. If restless, fretful, or sleepless, or the temperature high, tepid or cold sponging, or both, may be used. When I was at the London Temperance Hospital, it was Dr. Soltau Fenwick's practice to have children with pneumonia to lie unclothed in bed, with a cradle over them covered with muslin, and a hot water bottle at the feet, but when the temperature fell they were well covered up. This treatment certainly seemed to add to the comfort of the children, and appeared to have no ill-effect. Holt very truly states that some nervous children are less disturbed by the temperature than by the means used to reduce it; he considers that stimulants are not required in the majority of cases, but collapse must be watched for at the time of the crisis, and if the pulse is weak, compressible and rapid, or the face pale and extremely cold, brandy should be given.

Empyema is usually treated by operation, but in neither of my cases, nor in one following broncho-pneumonia and another occurring primarily, was anything required besides aspiration and the administration of hepar sulph. or pyrogenium.

The homœopathic treatment of lobar pneumonia will be considered later, together with that of broncho-pneumonia.

BRONCHO-PNEUMONIA.

This disease is divided into primary and secondary varieties, the former being the less frequent and usually occurring in children under 2, probably from the embryonic character that their lungs still possess. It is rare after 4 years. This form is generally due to the pneumococcus. The secondary forms are often due to mixed infections—strepto-, staphylo-, and pneumococci, and the *Bacillus influenzae* being the most usual organisms.

In 443 cases reported by Holt, 37 per cent. were primary, while of the 63 per cent. of secondary cases, 9 per cent. followed bronchitis of the large tubes, 20 per cent. were associated with measles, and 15 per cent. with whooping-cough. Nearly 70 per cent. of his cases were found to occur in the colder months of the year. Relapses are common. One of my patients had two attacks.

Morbid Anatomy.

The essential feature of this form is an inflammation of the smaller and terminal bronchi, which spreads through their walls to the adjacent and terminal alveoli, thus differing from lobar pneumonia, in which the air vesicles are primarily affected. Areas of collapse, from obstruction of the bronchial tubes or feeble respiration, are not uncommon. In 82 per cent. of Holt's autopsies both lungs were found to be affected, and in but 9 per cent. only a single lobe. The posterior part of the lower lobes was most frequently implicated, and the left side generally more extensively than the right. Of the thirteen cases of which I have detailed notes, in only two cases was one lung alone recorded as affected, in each case the lower lobe of the left lung being involved.

The *onset* of the primary form is abrupt, with a rapid rise in temperature. When the secondary form supervenes upon an attack of bronchitis, the symptoms are found to become more severe, the temperature rises, and both pulse and respiration become more frequent. When occurring in the course of one of the infectious diseases, the onset is apt to be insidious.

There is no typical *course*. It may be protracted, or, on the other hand, very acute—high temperature, extreme prostration, cyanosis and rapid respiration being the only symptoms, and death taking place in twenty-four hours. Of seventy-eight non-fatal cases given by Holt, in 11·5 per cent. the fever lasted less than a week, in 66·6 per cent. from one to three weeks, and in 21·9 per cent. from twenty-one to ninety days; only 7·7 per cent. of my cases, however, lasted more than three weeks, the average duration of fever being 12·6 days, a very considerable saving of time under homœopathic treatment.

Considering now the *symptoms*, we find that the *temperature* usually rises gradually to 103° or 104° F., showing morning remissions of three to four degrees it may be, and falls irregularly by lysis, a termination by crisis being very rare, though in three of my cases this took place—in two instances, I believe, under the influence of sulphur, and in the third case within forty-eight hours of the administration of a dose of influenzinum 30. An inverted type of temperature may be seen (as in Case 1 on eight successive days), but is of no special significance. If, instead of remitting, the temperature remains high and rises, a fatal termination usually results. Pyrexia may persist for weeks, as we have seen, but with the exception of one case in which it lasted forty-eight days, owing to the occurrence of an empyema, in no one of my patients did it persist for more than sixteen days, the highest temperature recorded being 104·6° F.

The *pulse-rate* varies with the severity of the attack and the amount of nervous excitement, and usually ranges between 130 and 160, reaching in one of my cases 180 beats per minute. While regular and full at first, it tends later to become weak and irregular, and is apt to remain rapid after the temperature has fallen.

Respiration often shows a change of rhythm, a pause taking place after inspiration instead of after expiration, and is usually accompanied by an expiratory moan, which is very characteristic. The rate depends largely on the amount of alveolar involvement, and is usually from 50 to 80 per minute, the highest rate observed in my cases being 79. Irregularity of rate is common, and it may be of the

Cheyne Stokes type, which is usually of grave import. Retraction of the epigastrium and intercostal spaces is often seen, and painful respiration may be indicated by a frown or suppressed cry.

Cough is more constant than in lobar pneumonia, and is usually short, hacking and painful. It may last from the commencement of the disease till after resolution takes place.

Cyanosis and *dyspnœa* commonly occur, either from the blocking up of alveoli or from a temporary atelectasis of a portion of lung. In the latter case, the temperature is not raised and patches of dulness are found. If these symptoms do not pass off in a few days, a fatal issue is likely.

Physical Signs.

Localized fine râles are the first distinctive signs of broncho-pneumonia and then the breath sounds become feebler and higher in pitch. Dulness may be absent, though commonly areas of diminished resonance may be detected between the scapulæ and at the bases, with bronchial breath sounds and perhaps increased vocal resonance and fremitus. Rotch states that the earliest signs are usually found high up in the axillæ; and Holt says that in an infant it may be impossible to detect auscultatory signs in quiet respiration, but if the child be made to cry, or take a deep breath, bronchial breathing and râles may be brought out. Holt describes two types as complicating influenza; in the first there is high temperature and prostration for several days before any signs of pulmonary disease can be detected; while the second variety is of rapid course, only lasting three or four days, with very high temperature and some general symptoms. Several cases of the former variety were observed in which one was puzzled to know what was developing, as the child was evidently more ill than one would expect with uncomplicated influenza, while for a few days no signs of pulmonary mischief were forthcoming.

Complications.

Pleurisy is common and occurred six times in my thirteen cases, on one occasion becoming purulent.

Peritonitis may occur as in lobar pneumonia, and symptoms suggesting its presence were seen three times in my patients.

Meningitis is another complication, and in two of my cases there were symptoms giving rise to a suspicion of it, though in one case (No. 8), with headache and retraction of head and partial Kernig's sign, there was *otitis media*, from which another patient also suffered.

Endocarditis is stated to be extremely rare, but was thought to be present in one patient, an interesting case probably of general streptococcal infection starting with pustular eczema of the genitals.

Diagnosis.

The diagnosis from *lobar pneumonia* has already been referred to.

From *bronchitis* it is distinguished by the more severe general symptoms, the patchy distribution of the râles, and by dulness and cyanosis if present; but the physical signs do not give much help, though the development of fine crepitations towards the base of one lung is very suspicious of lobar pneumonia.

From *tuberculosis* a diagnosis may be impossible in the earlier stages, and cases of delayed resolution show a special susceptibility to the tubercle bacillus. Newsholme says that "in children the term broncho-pneumonia not infrequently conceals an acute tuberculosis, especially when the pneumonia occurs after imperfect recovery from such diseases as whooping-cough and measles." Sputum may be obtained from a child by inversion during an attack of coughing, or by inserting a piece of gauze on forceps into the pharynx; this excites coughing and the sputum may be caught on the gauze.

The ophthalmic or cutaneous reaction to tuberculin may assist

Prognosis.

Hutchison says that 17 per cent. of the total infantile mortality is due to broncho-pneumonia and that half of hospital cases die.

Holt gives the death-rate in private practice as 10 to 30 per cent. ; in 461 institution cases it was 65.5 per cent. My series of fourteen cases was without mortality, and a like result was given by Dr. Watkins in reporting a similar number of cases from the London Homœopathic Hospital, although in this collection all the patients were under five years of age.

Age is an important factor ; under two years of age Rotch says the mortality may be 69 to 70 per cent., and Osler gives it as 30 to 50 per cent. under five ; though he says that in this disease the truth of the maxim, "Never despair of a sick child," is exemplified ; as long as food is well taken, retained, and digested, no case need be considered hopeless.

Temperature is also important, the lowest mortality being when the highest temperature is about 104°F., rising if the maximum is either less or more than this. Cases with a steadily high temperature are said to do better than those with wide fluctuations, though if the temperature is very high the patient generally succumbs.

Prophylaxis.

It is most important to give early and careful treatment to every case of bronchitis in an infant : the value of this care is illustrated by the fact that though bronchitis is very common in the children of the better classes, broncho-pneumonia is much more frequent among the poor. In convalescence from whooping-cough and measles it is very important that the patient should not be exposed to cold, especially at night, when the temperature falls. Catarrhal affections of the nose and throat should be attended to and treated with antiseptic lotions. I remember that, when in Paris, Hutinel taught that after streptococcal affections of the mouth and nose, a chill, or intercurrent affection, often leads to broncho-pneumonia, and that anything which tends to lower the resistance of the lungs in measles does the same.

Treatment.

The temperature of the sick-room should be from 65° to 70° F., but with plenty of fresh air. Hutinel advises a change

of room if the patient is not getting on, and Holt goes further, in recommending a change to another room two or three times a day. It is important to vary the position of the patient at frequent intervals.

Milk and broths should be given at about two-hourly intervals (Bovine I have found very useful in these cases), if food is refused. Rotch advises the employment of a stomach-tube, though I do not think that children under homœopathic treatment are likely to need such violent measures. Holt says that "alcoholic stimulants are needed in all secondary cases, and in a large proportion of those which are primary," but from this dictum I should dissent, though alcohol is often required. He also recommends the use of a jacket made in three layers—gauze next the skin, then wool, and covered with oiled silk; carelessly made or applied poultices are apt to do more harm than good, but there is no doubt that for pain a lightly made jacket poultice containing mustard gives great relief; or ice poultices may be used instead, if not continued for too long.

For high temperature, with nervous symptoms, a bath at 90° F., or colder, may be used for infants, or a pack for older children. At the large Paris children's hospital—des Enfants Malades—the treatment consists, as a rule, solely in the use of baths at 95° to 100° F., mustard baths, or mustard-and-water packs. For dyspnoea, due to tenacious mucus, or for troublesome dry cough, steam inhalations will be found useful, but should not be continuously employed, and steam tents are best avoided.

If there are symptoms of atelectasis, or the presence of increasing cyanosis, rattling of mucus in the throat and weak pulse indicating a state of impending suffocation, every effort must be made to arouse the child and excite coughing. The patient may be immersed to the shoulders in a bath of mustard and hot water (four or five tablespoonfuls of mustard to the gallon), the chest vigorously rubbed and squeezed, or even slapped, and cold water dashed on the face and neck. Oxygen inhalations for ten minutes in every hour may be used. Rotch says that "most of the drugs commonly used are, as a rule, of more harm than benefit," with which

opinion we may be willing to agree, as regards allopathic practice. Hutchison says, "you may give small doses of expectorants if you like," which does not indicate a very profound faith in their virtues; while Savill recommends small, frequent doses of tincture of belladonna, and Osler advocates one-drop doses of tincture of aconite in cases in which the onset is abrupt and accompanied by high fever.

For heart failure, inhalations of amyl nitrite and hypodermic injections of nitro-glycerine ($\frac{1}{800}$ gr. every hour for a child of one year), strychnine ($\frac{1}{800}$ gr. every three hours for a child of the same age), or ether, are advised.

In discussing the homœopathic treatment of pneumonia, it will be convenient to consider lobar pneumonia and broncho-pneumonia together, as the pathological condition does not constitute the important factor in the selection of the appropriate remedy. A few medicines only—all of which have been used in this series—are to be brought to your notice, and the list is not to be considered in any way complete or exhaustive, as if, indeed, it were possible to make it so.

Aconite.—The sphere of this drug is in the earliest stage, before exudation has taken place, when the cough is dry and the well-known combination of symptoms present. Pneumonia and pleurisy from cold winds is an additional indication.

Antimonium tartaricum seems to be indicated particularly in the later stages and in broncho-pneumonia which begins with bronchitis and spreads downwards. It appears to me, nevertheless, to do good in the 3x trituration when given earlier in the disease, and Edmonds says, in his book on the "Diseases of Children," that he is generally in such a hurry to exhibit this remedy that he cannot resist alternating it with aconite. This, however, is not a practice to be recommended. Threatened paralysis of the lung is the most characteristically homœopathic condition for this drug, with coarse rattling, but inability to raise the mucus, cold sweats, pale or cyanosed face, and Nash gives drowsiness as an additional indication. This presents a perfect picture of

many cases of broncho-pneumonia, with collapse of the lung, and in this state antim. tart. may be given with confidence. I usually employ the 6th dilution. In Hughes' experience, it yields in efficacy in acute broncho-pneumonia to phosphorus, but this I cannot agree with. Antim. tart. needs to be distinguished from ipecac., which has a somewhat similar rattling of mucus and nausea, but is useful at an earlier stage, and in more rapidly developing cases. The great distinguishing feature, however, is that the ipecac. patient has a strong cough, and is able to raise the expectoration. The anorexia and thick white coating on the tongue are marked features of antim. tart.

Arsenicum iodide.—In the paper already referred to, Dr. Watkins lays stress on the value of this medicine in cases of influenzal origin, and in the ensuing discussion Dr. Blackley gave it as his opinion, that in such cases it was a waste of time to give other medicines. While not able to go so far as this, my experience confirms their high opinion of its value in influenzal cases, and it also proved useful in one case (No. 26) of delayed resolution of lobar pneumonia. More precise indications cannot be given, as the partial provings made seem only to record a short hacking cough.

Belladonna, says Kent, will cure pneumonia and pleurisy. It is indicated when the general state of the patient shows the characteristic febrile condition, with flushed face, &c., and he prefers to lie on the unaffected side. This was well illustrated and proved curative in Case 46, though the left lung was affected, while belladonna usually prefers the right side.

Bryonia.—With this medicine also the right side is more typically involved, but the patient prefers to lie on the affected side, and is afraid to move. It is indicated especially in the lobar form, particularly if pleurisy is marked, and after exudation has taken place. It follows aconite well, the patient's distress being now due, not to mental anxiety, but rather to oppression of the chest; the cough is rather looser, but still shakes the patient, who complains also of heat, soreness, and pain behind the sternum. Hughes says it is more homœopathic to lobar pneumonia than phos-

phorus, and claims for it the power of absorbing the disease. Rusty sputum is an additional indication. Though used several times in my cases, I did not observe any striking result from its employment.

Calcarea carb. was used a few times among my patients, and in one case (No. 14) of broncho-pneumonia appeared to bring about recovery after several other medicines had failed, sweating about the head directing one's attention to it. *Calcarea* would, of course, be particularly suitable for fat, scrofulous children, and is said to be indicated by a cough which is dry at night and loose in the morning.

Chelidonium is a powerful remedy when the right lung is affected, especially if there is pain in the right shoulder or involvement of the liver, as exemplified in two of my cases (16 and 34). Ludlam recommends it also for broncho-pneumonia in children, where there is excess of secretion, but inability to raise it. I have had no experience with this medicine in such cases.

Hepar sulph. I have found useful in cases of empyema, being generally sufficient to clear up this condition after one, or perhaps two, tappings. It is also mentioned by Farrington as being useful during the stage of resolution in pneumonia.

Influenzinum has proved of good service in two or three cases complicating influenza, and in one case (No. 5) appeared from the rise of temperature following the administration of single doses of the 30th dilution to give rise to a temporary negative phase. The place of this nosode in the "Materia Medica" does not appear to be settled at present, and it requires proving. The 30th dilution was used.

Kali carbonicum was used in only one of my cases (38), the patient having persistent pain in the left side of the chest, relieved for a day only by bell. 1x, and then recurring. After the use of this remedy the pain speedily disappeared and the consolidation of the lung with it. The pain kept the patient awake. The indications for kali carb. are given by Farrington as stitching pains in chest wall, occurring independently of movement (bry. < movement), and

especially over the lower half of the right lung. Aggravation from 2 to 3 a.m. In infantile pneumonia, with intense dyspnoea, breathing, wheezing and whistling; mucus abundant, but raised with difficulty. Also in the later stages of lobar pneumonia, with similar symptoms.

Phosphorus has been the most frequently used medicine in the lobar type (illustrated by Chart 30, exhibited), though Hughes says it is more applicable to broncho-pneumonia and is the one medicine which has given him satisfaction in treating this disease in children.

The accounts of poisoning by phosphorus given by him seem to justify his use of the remedy. It is said not to cause hepatization, but it does produce pains similar to those occurring in pneumonia.

Phosphorus gives rise to a feeling of weight and oppression at the chest, with a raw feeling in the upper part. It is apt to be indicated at the beginning of hepatization, but more frequently when one wishes to promote resolution. Farrington says it is almost certain to be the remedy when bronchial symptoms are prominent.

Pyrogenium may be thought of in cases of protracted temperature, especially if any septic process is suspected. It rendered me good service in three cases, one (No. 39) a case of empyema, in which hepar and bell. failed to clear up the case. Another, a case of delayed resolution of lobar pneumonia associated with pericarditis, and the third a patient with double pneumonia running a course of six weeks, resulting in fibroid change in one lung, reported in the *British Homœopathic Review* of April, 1907. The charts of two previous cases I am placing before you.

Sulphur.—With this medicine I have repeatedly proved the value of Dr. Clarke's statement of its power of bringing down the temperature and shortening the course of lobar pneumonia; a rapid fall of temperature occurring in no less than fourteen of my cases after its administration, usually in the 30th dilution, too frequently to be mere coincidence. This is shown in the chart of Case 44, in which, however, a few doses were again needed to complete the cure. In this patient, an old-standing eczema also disappeared

after the use of sulphur. I will briefly refer to a case of measles in which pneumonia apparently followed a chill, the eruption fading, but again becoming more pronounced; with improvement of the pneumonia under the use of sulphur 30.

Ethel L., aged 11, was admitted to the infirmary on January 24, 1908, for measles. The disease ran an uncomplicated course till the 29th, when the temperature was raised, and the patient was restless and thirsty, with a dry tongue. Ars. was given. On the previous day the patient had been moved into another dormitory in a different wing of the building. Two days later there were signs of pleurisy over the lower lobe of the right lung, and the rash was noted to be less distinct. Bry. 6, 2h.

On February 2 the signs of pleurisy were less marked, but there was now consolidation of the middle lobe of the lung, the temperature being 102.2°F., pulse 124, and respirations 44. Sulph. 30 was given every two hours. The next day the temperature was down, pulse 76, and respirations 20, and the medicine was stopped.

On the 4th the temperature was again raised, pulse 108, and respirations 46, with signs of consolidation of the upper lobe of the right lung. Repeat sulph. 30. Two days later the patient was better again, the temperature, pulse, and respiration having fallen. The rash, which had become more intense again, was now fading. No more medicine was given.

On the 7th the only physical signs noted were prolonged expiration and occasional rhonchus at the right apex, and these soon disappeared.

Farrington seems to esteem sulphur more in the suppression of chronic eruptions, recommending arsenicum for the retrocession of measles. Sulphur is also useful in continued or remittent fevers, the patient approaching a typhoid condition and becoming drowsy, with a dry, red tongue. It may be given to a torpid case to produce reaction, or to clear up a protracted case threatening to become tuberculous; but it is said that if tuberculosis has already developed, it will hasten the end. Kent recommends sulphur for chronic cough or chilliness following pneumonia.

BRONCHO-PNEUMONIA.

No.	NAME	AGE	SEX	SIDE	LOBE	SITE OF PAIN	DURATION OF FEVER (Days)	CRISIS OR LYSIS	COMPLICATIONS, &c.	TREATMENT
1	Ellen McC.	5	F.	R. and L.	R. upper and lower. L. upper	—	13	Lysis	Influenza	Ars. iod. 3x.
2	Edith T. ..	?	F.	L.	Lower	Left side	4	Lysis	Influenza and pleurisy	Bry. 3x—phos. 6—antim. tart. 3x.
3	James M. ..	6	M.	R. and L.	R. upper and lower. L. lower	Right side	11	Lysis	Influenza, pleurisy, and cardiac weakness	Antim. tart. 3x—bry. 3x—ars. iod. 3x, and sulph. 3
4	Ernest W. ..	9	M.	R. and L.	L. lower. R. upper	Lower part of sternum	6	Crisis	Influenza and pleurisy	Ars. iod. 3x and sulph. 3.
5	Ernest W. ..	12	M.	R. and L.	R. middle and lower. L. upper	R. shoulder, L. hypochondrium	16	Lysis	(?) Influenza. Pleurisy. Abdominal distension. Difficulty in micturition	Bell. 3—bry. 1—infl. 30.
6	Albert C. ..	8	M.	R. and L.	R. middle and lower. L. upper	—	48	Lysis	Otitis media. L. pleurisy. R. empyema. Abdominal pain and tenderness	Harpar 5—ars. iod. 3x.
7	Edward O. ..	1½	M.	L.	Lower	L. side	9	Lysis	Eczema. (?) Endocarditis. (?) Streptococcal infection	Ant. tart. 2.
8	Reginald B.	7	M.	R. and L.	R. upper, middle, and lower. L. lower	R. side	14	Lysis	Otitis media. Meningeal symptoms, Diarrhoea	Ars. iod. 3x—verat. v. 1x.
9	Samuel F. ..	10	M.	R.	Upper and lower	Chest	7	Lysis	Severe headache and delirium. General bronchitis	Ars. iod. 3x.
10	Phillip B. ..	7	M.	R. and L.	R. upper and middle. L. lower	L. iliac region	9	Crisis	Difficulty in micturition. Diarrhoea	Ant. tart. 2—infln. 30.
11	James G. ..	8	M.	R. and L.	R. middle. L. upper	Chest	8	Crisis	Influenza. R. pleurisy. Cardiac weakness	Sulph. 3.
12	William D.	6	M.	R. and L.	R. upper. L. lower	Chest	9	Lysis	Influenza. Cardiac weakness. (Inverted temperature)	Bry. 3x—phos. 3—ant. tart. 3x—sulph. 3.
13	Ernest H. ..	8	M.	?	?	?	?	?	Pertussis
14	Gladys H. ..	8	F.	R. and L.	R. lower. L. upper	Abdomen	10	Lysis	Vomiting. Headswelts	Phos. 6—calcar. 30.

LOBAR PNEUMONIA.

No.	NAME	AGE	SEX	SIDE	LOBE	SITE OF PAIN	DURATION OF FEVER (Days)	CRISIS OR LYSIS	DAY OF CRISIS	COMPLICATIONS, &c.	TREATMENT
15	Windsor K.	13	M.	R. and L.	R. upper, middle, and lower. L. lower	R. side	42	Lysis	—	Influenza. Diarrhoea. Abdominal distension, terminating in cirrhosis of lung	Phos. 3—sulph. 3—pyrogen. 6.
16	Reginald N.	4½	M.	R.	Upper	R. chest	7	Crisis	8	Herpes. Loose, light-coloured stools	Chel. 1x—ver. v. 1x.
17	Lilly K.	15	F.	L.	Lower	?	13	Lysis	6	Pleurisy (pleuro-pneumonia)	Phos. 6
18	George M.	5	M.	R. and L.	R. upper. L. lower	?	6 (?)	Crisis	?	..	Sulph. 3.
19	Nelly P.	18	F.	R.	Upper and lower	L. chest	6 (?)	?	?	..	Ars. iod. 3x.
20	Maud L.	6	F.	R.	Lower	?	?	?	?	..	Phos. 2.
21	Sarah A.	11	F.	R. and L.	Upper	R. side	8	Lysis	—	..	Phos. 2.
22	Grace F.	12	F.	R.	R. middle. L. lower	?	?	?	?	..	Bell. 2x—phos. 3.
23	Jane J.	11	F.	R.	Upper	?	?	?	?	..	Bell. 5x—sulph. 3.
24	Mabel C.	11	F.	L.	Lower	R. side	6	Crisis	6	R. pleurisy	Phos. 5x—sulph. 3.
25	Mabel C.	12	F.	R.	Upper, middle, and lower	R. side	23	Lysis	—	Pericarditis, with effusion. Pleurisy	Aconite 3x—spig. 1—bry. 1—ar. iod. 3x—pyrog. 6.
26	Selina S.	13	F.	R.	Upper	R. side	23	Lysis	—	Pleurisy. Delayed resolution	Ars. iod. 3x.
27	Winifred S.	10	F.	L.	Lower	Shoulder	5	Crisis	5	L. side face flushed	?
28	Annie H.	16	F.	L.	Lower	L. side	6 and 7 (3rd week)	Crisis	6	Pleurisy. Diarrhoea at crisis	Sulph. 3.
29	Bessie B.	9	F.	L.	Lower	L. side	4	Crisis	4	Herpes. Pleural effusion	Phos. 6—sulph. 30.
30	Marcha L.	15	F.	L.	Lower	L. side	6 and 14 (pleurisy)	Crisis	6	Herpes. Double pleurisy. L. side face flushed	Phos. 6—sulph. 30.
31	Ethel L.	11	F.	R.	Middle and lower	R. axilla	9	Crisis	9	Measles. Retrocession of eruption	Bry. 6—sulph. 30.
32	Charles J.	7	M.	L.	Lower	Chest, L. shoulder, and neck	5	Crisis	5	Influenza. Pleurisy. Cardiac weakness	Phos. 3—sulph. 3—ars. iod. 3x.
33	Henry D.	6	M.	R. and L.	R. and L. lower	L. side	6	Crisis	6	..	Antim. tart. 3x—sulph. 3.
34	Leonard P.	13	M.	R.	Lower	R. side	3 and 14	Crisis	3	..	Chel. 3—bry 6.
35	Edward S.	?	M.	R. and L.	R. upper and lower. L. lower	General	7	Crisis	7	Epistaxis. (?) Influenza	Phos. 6.
36	Frank C.	10	M.	L.	Upper	Epigastrium	8	Lysis	—	Meningitis and albuminuria	Iodof. 3x—plumb. 12.
37	Frederick H.	7	M.	R.	Upper, middle, and lower	R. side	5	Crisis	5	Influenza. R. side face flushed	Sulph. 3—phos. 3.
38	Maria S.	13	F.	L.	Lower	L. chest	7	Lysis	—	Pleurisy	Bell. 1x—phos. 3—kali carb. 3.
39	Maria S.	14	F.	R.	Upper and lower	R. scapular region	12 and 31	Lysis	—	Empyema	Pyrogen. 6—ars. iod. 3x—hepar 3.
40	Rose D.	8	F.	?	?	?	7 and 17	Crisis	7	Empyema	Bell. 1x.
41	Leigh O.	11	M.	?	?	?	—	—	—	Cardiac weakness	Ver. v. 1x—phos. 2—hepar 3x—nit. 780.
42	Lilly A.	16	F.	L.	Lower	?	?	?	?	Epistaxis	?
43	George L.	4	M.	R.	Lower	?	?	?	?	..	Ver. v. 3x—phos. 6—sulph. 30.
44	Herbert F.	6	M.	L.	Upper and lower	Lower part of chest	7	Crisis	6	(?) Influenza. Double pleurisy. Eczema	Ver. v. 1x—sulph. 30.
45	Jack V.	8	M.	L.	R. upper. L. lower	General	10	Crisis	10	Influenza. Delirium	Phos. 3—sulph. 3.
46	Ben B.	15	F.	L.	Lower	Epigastrium	6	Crisis	6	Influenza. Pleurisy. Diarrhoea	Phos. 3—bry. 3x.
47	Annie P.	15	F.	L.	Lower	L. chest	6	Crisis	6	Pleurisy	Ant. t. 3x—bell. 1x.
48	Ida C.	5	F.	L.	Lower	R. chest	4	Crisis	4	Pleurisy	Ant. t. 3x.
49	Lizzie S.	5	F.	R.	Lower	L. chest	?	?	?	..	Ant. t. 3x.
50	Elsie B.	5	F.	L.	Lower	L. side	6 (?)	?	?	Pleurisy	Sulph. 3.

Veratrum viride has perhaps given rise to more discussion as to its value in pneumonia than any other medicine, having been accredited with the power of aborting the disease, or of suddenly killing the patient, by its advocates and detractors respectively. In one case in which I used it early, in alternation with phosphorus, as recommended, it failed to abort the disease; in two others, in which it was probably used too late in the course of the pneumonia, it was followed by marked cardiac weakness, while in other cases it appeared to have no effect. Hale uses it in the incipient stage when only engorgement exists, and says it will arrest the course of the disease; he gives five to seven drops of the 1x dilution every half to one hour, in children. His indications for *veratrum viride* are, a full, bounding, incompressible pulse (acon., hard, quick and small), tongue yellow at the sides with a red streak in the middle. He states that it has been found by clinical experiment to be a cardiac tonic in small doses, the pulse being first slowed and blood-pressure reduced; later the pulse rapidly increases and blood-pressure rises. He says that the congestion and inflammation produced is a secondary effect, and so in treating the congestive stage of pneumonia it must be used below 2x; if used at all in the later stages (and he is not at all sure that it should be so used), it must be in minute doses. Burt believes that "there is no remedy in the *Materia Medica* which will so quickly and surely produce congestion and inflammation of the lungs." He mentions gastric disturbance as a special indication for its employment. Hughes says that *veratrum viride* is evidently antipathic and will have none of it. Farrington also holds that it may abort the whole disease. He states that it produces marked arterial excitement, giving rise to engorgement of the lungs and later, symptoms of heart failure. *Veratrum viride* is not indicated when hepatization has taken place, but before this it lowers the pulse, reduces congestion and modifies the pneumonia. It is also indicated, in his opinion, in profound engorgement threatening the death of the patient.

Nash relates how he once left a patient relieved by this remedy of an acute and violent attack of pneumonia, to go to a neighbouring town and when he returned found the

patient dead; and states that he has known other cases treated with *veratrum viride* die suddenly when they were reported better. He says that patients with weak hearts are killed by this powerful cardiac depressant and teaches that it is wrong to depress the pulse regardless of all other conditions.

Dr. STONHAM said Dr. Bodman had given a most lucid exposition of pneumonia and its treatment, and he had to be congratulated on having treated fifty consecutive cases without a single fatal result. Pneumonia was one of the most favourable diseases that homœopaths could choose with which to compare the homœopathic with other treatment. Statistics were numerous, and they were of more than ordinary value, because the disease was "clean cut," and cases were very similar. Dr. Bodman had not referred to one medicine which seemed to him (Dr. Stonham) to be very useful, namely, *lycopodium*. That was often very valuable in cases of broncho-pneumonia, or even lobar pneumonia in children, being most efficacious after the disease had been running for some days, when the crisis ought to appear and did not do so and the case was threatening to break down. For that condition *lycopodium* was very useful.

Dr. BLACKLEY considered the paper a model one, as it bore the stamp of being the result of clinical experience, and a little clinical experience, in his opinion, was worth a great deal of theorising. It should be remembered that the symptoms of the disease were not so sharply defined in children as in adults, and also that the stages of the disease were not so rigidly marked, particularly in cases of lobar pneumonia. In the adult the various stages were mapped out with almost mathematical accuracy, but in children this was far from being the case. This was probably one of the reasons why the aborting of pneumonia was heard of from time to time, although not so much of late years. Modern research, indeed, pointed in an opposite direction; that is to say, there was a well-defined period of evolution for lobar pneumonia, and, short of interference by way of toxins, antitoxins, or nosodes, jugulation was not to be expected. He, for one, entirely mistrusted the accounts given of the abortion of lobar pneumonia, either by *veratrum viride* or by any other drug. Dr. Bodman's statistics were particularly encouraging; it was what the members had been led to expect from previous papers by Dr. Moir and Dr. Watkins. All the statistics which had been

compiled from the London Homœopathic Hospital reports showed wonderfully favourable results, more favourable, indeed, than those given by Tessier, for adults, in his celebrated paper which created a sensation at the time it was published in the middle of last century. The results of the homœopathic treatment of pneumonia in Paris and elsewhere were compared by Tessier (*a*) with the ordinary treatment of the day, and (*b*) with the so-called "expectant treatment" in vogue in Vienna. Tessier's death-rate was 5 per cent. only, and, at the same time, in the Leopoldstadt Homœopathic Hospital in Vienna, there was a death-rate of only 6 per cent. Under expectant treatment the death-rate ranged from 7 to 21 per cent., whilst under the ordinary treatment as carried out in Paris and Lyons the death-rate was from 35 to 50 per cent. But Dr. Bodman in his statistics of infantile pneumonia had "gone one better," for in his series of cases there had not been a single death. He (Dr. Blackley) was afraid his own results were not so good, but he took it that Dr. Bodman's children living in an orphanage were seen earlier in the course of the disease than they would have been in Great Ormond Street, where children very often arrived in almost a moribund condition. There was a specimen on the table (shown by Dr. Hare) of the lungs of a child who had been brought into the hospital and placed in one of his (Dr. Blackley's) beds overnight, dying the next morning of septic pneumonia. Such cases materially helped to raise a death-rate. Since Tessier's death, Jousset had been the great authority in France upon the homœopathic treatment of pneumonia, and he (the speaker) would like to refer to a point which Jousset was never tired of reiterating, namely, that he considered that to begin the treatment of cases of pneumonia with aconite was a sheer, absolute and culpable waste of time, for the reason that in bryonia and in phosphorus homœopaths had not only agents which produced certain definite and microscopic changes corresponding closely to the disease, but they produced the pyrexia as well. There was no reason whatever to begin by giving aconite when bryonia or phosphorus, as the case might be, covered the fever at the same time. Tessier's usual plan in adult cases was to give bryonia in the day and phosphorus at night; and the method certainly succeeded wonderfully well. With regard to children, his (Dr. Blackley's) experience favoured, in the majority of cases, antim. tart. rather than phosphorus. In a child one did not get either the typhoid aspect or the unequal pulse calling for phosphorus, that one did in adults. He also thought that in the majority of cases of children suffering from lobar pneumonia

antim. tart. was more useful than ipecac. He quite agreed with Dr. Bodman that the use of steam, intermittently, in the room, was useful, but he had always very strongly objected to the steam tent. With regard to oxygen he had never obtained the slightest help from it, and he thought it was an absolute waste of time and money to administer oxygen in cases of pneumonia. With regard to the pneumococcus and the possibility of aborting pneumonia, he remembered an experiment of Fraenkel's, made *in vitro* it is true, but none the less striking on that account. Fraenkel took a culture of the pneumococcus, and found that it could be maintained at a temperature of 106°F. for seventy-two hours without losing its virulence, and very often it was four days before it was rendered absolutely inactive. That showed what very slight prospect there existed at present of being able to abort pneumonia in the living subject.

Dr. ROBERSON DAY thought the paper in its way was quite a classic. It seemed to him a unique record that fifty cases should have been treated without a death. In thinking over the matter and wondering why in the London Homœopathic Hospital similarly good results could not be shown, it appeared to him there were certain fallacies in collecting statistics. With due respect to what Dr. Stonham had said about such cases being "clean cut," there were various other factors which entered into the question of the statistics, for instance, the question of environment. He took it that Dr. Bodman had had a singularly favourable field for his observation. His cases were drawn from one large institution where the patients resided and were under constant and careful supervision, so that the very beginnings of the disease were noted. Further, the children had not to be brought from a dirty home through streets in the inclement weather to a hospital, so that in Dr. Bodman's cases homœopathy had had its very fairest chance, and hence the magnificent results which had been shown that evening. In private practice good results were certainly obtained from a limited number of cases. Some years ago he saw, in consultation with one of the members of the Society, that gentleman's own child, who was from seven to ten months old. It was a most serious case, the respirations being higher than he had ever seen before; they ran up to the almost incredible number of 112 per minute. Yet the child, having been in good circumstances and under watchful care, made a very satisfactory recovery. Another case occurred in the hospital, and it bore out the same point. He admitted it for gastro-intestinal trouble. Whilst in the hospital an epidemic prevailed of measles, and the child

contracted measles and was isolated. Then followed broncho-pneumonia, following on which the child developed a septic throat, and swabbings revealed the diphtheria bacillus. That was followed by laryngeal complications, necessitating tracheotomy. The child successfully pulled through the operation and then developed albuminuria, but finally, after a most anxious time, as all the appliances necessary, medical and surgical, were to hand, the child made an uninterrupted recovery. In comparing the statistics as given in other institutions, it was most important to bear in mind the age. There was no factor which played a more important part. Children under two had the very highest mortality. In looking through the list which Dr. Bodman had passed round he noticed but very few patients under that age. Some years ago Dr. Moir had read a paper, and had collected 101 cases under two years of age, which gave a mortality of 16·8 per cent. Such figures were very favourable compared with the statistics gathered from allopathic institutions. For instance, Holt, in connection with children under two, gave 75 per cent., and the Hospital for Sick Children 26 per cent., the Pendlebury Hospital at Manchester 21 per cent., and the East London Hospital no less than 64 per cent. mortality. As soon as the patients exceeded the age of two the prognosis was very much more favourable. With reference to the pulse and the respiration, these must be very carefully watched, because when their normal ratio becomes separated, the pulse becoming very rapid and the respiration departing from it, a fatal termination might be expected. In those cases, to improve the pulse, no doubt brandy in small doses might be administered, and it was used in the London Homoeopathic Hospital in that way with great benefit. With reference to the physical signs, percussion was of little value in children. So much depended on the force with which one percussed, and it was impossible to find dulness unless it was very well marked and revealed much more surely by other methods. A tympanitic note could always be obtained if one hit hard enough; it was conducted from the abdominal organs, a dilated stomach, or anything. An auscultation was the physical method upon which most reliance was placed. It revealed the patches of consolidation with great exactitude. The peculiar breathing and the fine crepitations were pathognomonic. There were cases where those physical signs could not be obtained, the patch being deep-seated. He had seen cases run from start to finish without any definite physical signs, but from the temperature and general behaviour of the cases it had no doubt been broncho-pneumonia. The cases

where otitis had supervened were mostly those where the influenza infection had been present. The influenza germ had a peculiar affinity for wandering along the Eustachian tubes. With regard to treatment, he must say that at the commencement he had found aconite of use, and he would also highly praise the mustard bath. In all complications of the lungs children were benefited by the mustard bath. Especially was that the case in connection with hospital patients, who needed their skins cleansed, the counter-irritation of the mustard had a very beneficial effect. In the London Homœopathic Hospital poultices were never applied. With regard to oxygen he had seen cases where it had been of the greatest value. With regard to medicines, antim. tart. for broncho-pneumonia, and phosphorus for lobar pneumonia, could not be dispensed with, and in the later stage, to assist resolution, iodide of arsenic.

Dr. JAGIELSKI enquired whether Dr. Bodman had ever used or had had any experience of the sour-milk treatment.

Dr. GOLDSBROUGH remarked, with regard to statistics, that Dr. Bodman's series of cases could not by any means lead to deception as to the inference to be drawn from statistics. He had been quite frank in his statement, that the cases were treated in the New Orphan Houses at Bristol, and the ages had been given in the table which was published. He (Dr. Goldsbrough) noticed, on glancing at the table, that there was only one case under two years of age. He took it that all the children in the Orphan Houses were brought up under one régime, which was a most important point in considering a series of cases; the régime of course being, he supposed, observed by all the officials who had the care of the children. An erroneous conclusion could not be possibly drawn from the statistics presented, and under the circumstances the results were as satisfactory as they possibly could be. In earlier years he had had the opportunity of seeing a great many cases of pneumonia in general practice, and on the whole homœopathic treatment had yielded very great satisfaction. He had often verified the point brought out in reference to diagnosis, that physical signs could often only be observable from crying or forced respiration in very young children. With regard to the selection of medicines, he offered a slight criticism of one of Dr. Bodman's statements. Dr. Bodman had said that the pathological condition was not the important factor which determined his choice of medicines. He (Dr. Goldsbrough) presumed that while Dr. Bodman was speaking he was referring to some pathological state, and Dr. Goldsbrough presumed that in selecting

medicines Dr. Bodman would not sit down and search out the "Materia Medica" to find a group of medicines, but that he would keep the pathological condition in his mind to suggest a group, one of which he would possibly select on some definite totality of symptoms. That was a point which should be brought out, and Dr. Bodman should be asked to reply to it with a view to elucidating the method of prescribing. Dr. Goldsbrough had used antim. tart. more than any other medicine, in pneumonia in children. The 6th dilution had been the one which had served him the best, although he had used it in the 3x and the 12 and the 30. Arsenicum iodide he believed was of most value when given at the end of a case, when the temperature did not fall, and also in cases of delayed resolution. In such cases he had found the 6th dilution most serviceable. There were two other medicines which he regarded as quite invaluable if they were chosen on their particular indications, namely, chelidonium and calc. carb. With regard to phosphorus, he had not used it very often in the ordinary pneumonias of children, but in lobar pneumonia, following measles, which was usually double, phosphorus was the medicine *par excellence*. Sulphur should follow it, especially if resolution was delayed. He wished to ask Dr. Bodman if he had used the local application of iodine in any of his cases.

Dr. MILLER NEATBY had the honour to find himself in agreement with most of the points contained in the paper. Dr. Bodman had mentioned that lobar pneumonia was not so uncommon in children as was generally supposed. He (Dr. Neatby) had been talking to a member of the Society some time ago on the subject, and that gentleman had been disposed to question the frequency of the occurrence of lobar pneumonia in children; but, from a search he (Dr. Neatby) had recently conducted into the question, he found that during the past ten years the proportion of *definite* cases of lobar pneumonia amongst children up to 7 years of age was remarkably high. Dr. Stonham had said the symptoms were "clean cut." That was so to a certain extent, but there were margins of variation. Dr. Blackley had mentioned the fact that the face was almost always flushed, but he (Dr. Neatby) had been struck in his investigation by the fact that, though the majority of the patients had flushed faces, a good number had pale faces. That was a warning to avoid routine in treatment. When one found a drowsy child with a very white face, one would give antim. tart. at a very early stage, if not at the very beginning. He had noticed that drowsiness was one of the earliest symptoms,

and that, combined with the white face, would suggest antim. tart. rather than, say, phosphorus. Speaking of physical signs, he was reminded of an article on chronic bronchitis in this month's *Practitioner*, wherein the writer stated, in regard to distinguishing between simple and tuberculous chronic bronchitis, that physical signs were exceedingly doubtful articles in children; in fact the writer dismissed the idea that a tubercular condition could be diagnosed simply by a physical examination of the lungs; and certainly with reference to percussion that was so. Often there were no signs at all; one was convinced at the outset that the case was one of pneumonia, but no physical signs, or only shadowy ones, were found, about which no two people would agree. Another thing he had noticed was that the signs sometimes did not appear until quite late. In one case he had had, the signs of consolidation were not discovered until after the crisis. With regard to treatment, he had not much to add to what Dr. Bodman had already brought forward. If pain was located in the upper part of the right chest it was an indication, if other things confirm the suggestion, for calcarea. He noticed in his investigation that arsenicum iodide was nearly always given late on, after crisis, with a view he supposed of hastening resolution. Dr. Day had mentioned a case where the respirations went up to 112; he (Dr. Neatby) had seen the record of a hospital case in which the respiration reached the abnormal figure of 120 per minute.

Dr. McCULLOCH, while congratulating the author on his excellent series of results, in this serious malady of infancy, would ask him what number of his cases had so completely recovered as to have "uncrippled" lungs, in regard to remote constitutional effects in after-life. He referred to the well-known sequelæ of adhesions of the serous surfaces by neoplastic tissue, sequelæ that were commonly over-looked and not anticipated as they should be. It would be admitted that it was extremely difficult to prevent some of the adhesions, for reasons that would suggest themselves, but time does not permit of entering into them. He desired to emphasize the importance of inter-lobar and parietal adhesions in regard to prognosis. What would be thought of the physician who in cases of septic endocarditis was content to claim complete recoveries, where swelling, temperature and pain in the joints had disappeared with general restoration to health, while the valvular and pericardial changes were not followed up, nor opportunely dealt with by a course of after treatment? Pulmonary adhesions in the pneumonias of infancy, more particularly when complicated with pleurisy and empyema, were extremely difficult of detection

by our ordinary methods of physical diagnosis. He thought it was no mere presumption to say that, where evidence of pleuritic friction existed, there must always follow some adhesion. Such adhesions were commonly found *post mortem*, and were to a large extent responsible for the badly formed chests and other physical defects noticeable among our growing youths to-day. By improved skiagraphic methods we are able to show those areas of the lung where the air was not freely entering; such areas might correspond to the adhesions or condensations of the lung parenchyma—the aerated parts of the lung adjacent to such patches were characteristic on the screen. Moreover, in order to bring about resolution of these “lung-hampering” adhesions, for which the time-honoured resolvents of iodine and the iodides have hitherto been relied upon, we were now able, thanks to Sir W. Crooks and eminent physicians, to apply “a molecular mechanism” in the X-rays, which decomposed, or to use a stricter term, analysed, the unbalanced molecular constitution of the neoplastic protoplasm, while it left that of the normal cellular elements unchanged. This solution of the neoplasm was not followed by a synthesis or reconstitution of the molecular elements, and elimination by the emunctory channels was rendered possible. He further suggested the necessity of employing spirometry, for testing the lung capacity after recovery from pneumonias, and the importance of insisting on a prolonged course of breathing exercises. Dr. Kennedy had just reminded him of an extremely useful external application, which greatly superseded poulticing and fomentations; it had been in use some years and was called “antiphlogistine” in America and “thermofuge” in this country. He considered the timely use of this as invaluable, and had last had experience of its use in his little daughter’s case last winter, when she seemed hopelessly moribund from double pneumonia, after severe measles.

Mr. EADIE said he would like to mention an experience which he had had about three years ago. He diagnosed a case as pleurisy associated with pneumonia. He inserted a needle to confirm the diagnosis and drew off what he thought was pus; a portion of rib was excised, but nothing at all was found in the pleural cavity. Some little while ago he was asked to operate in a case—which he had not seen previously—in which the house surgeon assured him pus had been found by an aspirating needle on two occasions. Having regard to his previous experience he was very sceptical, but on the house surgeon’s diagnosis the patient’s chest was opened and the pleura found normal. In both cases

the needle had apparently gone into a bronchus and drawn off muco-pus. That was a point to remember, because it was not a pleasant thing to happen. He was rather interested in Dr. Fenwick's treatment of putting the cradle on children. Personally, he was of opinion that too heavy bed-clothing was put on children, healthy or otherwise. A lot of people thought that weight necessarily meant heat; that was quite a mistake. With regard to oxygen, a former house surgeon of the Hospital told him of a little "nipper" of 4, who, whenever the oxygen was produced, would sit up alertly and say, "He is dead; that is the stuff they kill them with." Apparently that little boy had diagnosed the value of oxygen very accurately.

Dr. PERCY PURDOM remarked that he thought Dr. Blackley was quite justified in denouncing the use of aconite in cases of pneumonia, because by the time there were enough physical signs present to diagnose pneumonia aconite would never be indicated. Kent said that aconite had no ultimates, but one might get an acute onset of fever which might need aconite, and aconite would cure the patient, but he could not imagine how anybody could prove that pneumonia was going to develop, and that, he thought, had led to so-called cases of aborted pneumonia. With reference to *veratrum viride*, he thought the essential feature which Kent made out was that it was like aconite, except that the patient, instead of being restless, was absolutely calm. He (Dr. Purdom) had never seen a case of acute fever in which the patient had been calm and quiet, and therefore he had never seen a case where *veratrum viride* would be indicated.

Dr. BODMAN, after thanking the members for their kind reception of his paper, said in reply, that he was quite prepared to agree that statistics might be most misleading and could prove anything; therefore on a small series of 50 cases one could not build too substantial a structure; one or two fatal cases would be sufficient to make all the difference. With regard to the question of aconite which Dr. Blackley had dismissed so summarily, if it was indicated by the symptoms its administration could hardly be looked upon as a waste of time, but if it was not definitely indicated he should be quite prepared to agree with Dr. Blackley, that to simply give aconite because the case was one of fever would be a waste of time. With regard to Dr. Day's remarks, it was quite true that the environment of his 50 cases was remarkably good. As he had said, Holt gave the death rate in private practice as from 10 to 30 per cent. and in institution practice 65 per cent., and his (Dr. Bodman's) cases might be considered as

private practice. In answer to Dr. Jagielski, he had found that sour milk was used in one of the Paris hospitals for children, though he had never known of its being administered in pneumonia. In reference to Dr. Goldsbrough's question, the children under two years of age in the institution were quite small in number; the majority were much above that age and were all pretty much under the same régime. The pathological state was certainly of some importance, though it must take second place to a symptomatic selection. His chief idea was that one should not build a wall between broncho-pneumonia and lobar pneumonia, and because a drug was generally used in the one condition, to exclude it when one had to treat a case of the other kind. He had used a local application of iodine for pleural effusion, but not in other cases. In answer to Dr. McCulloch, none of the cases had been subjected to X-ray diagnosis. So he could not speak definitely of the amount of adhesions, but in only two or three cases could he recollect definite evidence of adhesions. With reference to Mr. Eadie's remarks as to operations found to have been performed unnecessarily, he (Dr. Bodman) would lay stress on the recommendation not to operate at all, if possible, but to give homœopathic treatment a chance of clearing up the case. Leucocytosis was of value in distinguishing from tuberculosis. Flannel sleeping suits were very useful for children, preventing them from becoming uncovered. With regard to Dr. Purdom's remarks as to *veratrum viride*, if one were going to give it in the mother tincture or first decimal dilution, one did not need to have a very close resemblance between the symptoms produced by the drug and those present in the patient.

THE SURGICAL ASPECT OF APPENDICITIS.¹

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MR. CHAIRMAN AND COLLEAGUES,—When I promised to give a short paper on “Appendicitis and its Surgical Treatment,” I understood it would be for June, and so thought there would be plenty of time to go into the subject

¹ Presented to the Section of Surgery and Gynæcology, May 5, 1910.

thoroughly. However, a few days after my promise was given, Mr. Eadie (Secretary of the Section) asked if I could not manage to give it in May instead of June. This I consented to do, but am afraid, as a result of this, that my paper to-night will be rather scrappy, and not so thorough or so interesting as I should like to have made it. The study of appendicitis is now so huge that I have but touched on its salient features, and must crave your indulgence in bringing before you such an interesting subject treated in such a fashion.

For example, I have not included in this paper either the embryology, pathology, or bacteriology of the appendix, but must refer you to such works as "Keen's Surgery," or "The Vermiform Appendix and its Diseases," by Kelly and Hurdon. In the compilation of this paper I have used these works very extensively, and, in a lesser degree, an article by Osler.

As a homœopath, I shall be doubtless condemned by many of my colleagues for the general tenor of some parts of this short paper; but, as a surgeon, I trust to be more leniently judged by my fellow users of that most useful and indispensable instrument—the scalpel!

To-night, then, I propose briefly to look at the study of appendicitis under the following heads:—

- (1) History of appendicitis.
- (2) Anatomy.
- (3) Morbid anatomy and etiology.
- (4) Physiology.
- (5) Symptoms and complications.
- (6) Diagnosis.
- (7) Prognosis.
- (8) Treatment—Medical, Surgical.

(1) HISTORY OF APPENDICITIS.

The first case recorded of disease of the appendix is the classical case of Mestivier, which was reported in 1759. At the autopsy on this patient a large, very rusty pin was found in the appendix.

In 1766, Joubert Lamotte published a paper on a case of appendicitis which died from the results of a large faecal concretion in the appendix.

The *Bibliothèque Médical* for 1814 gives an account of a boy, aged 13, who died from an "adynamic fever." At the autopsy a great number of lumbricoid worms were found in the intestines, including four in the vermiform appendix.

In 1812, the first case was reported in England by a London physician of the name of Parkinson, and he actually recognized that the patient died from a perforation in the appendix! To him belongs the honour of having first recognized this fact.

In 1824, a Frenchman, Louyer-Villermay, published a paper on "Observations pour servir à l'histoire des inflammations de l'appendice cécale." To him belongs the honour of first recognizing appendicitis as a distinct and separate disease.

In 1827, Mélier writes: "This disease is considered extremely rare. Observe, however, that the five cases which form the basis of this paper have been collected in a short space of time, and that two among them were reported by the same physician. These facts entitle us to believe that if such affections have not been more frequently observed it is because the appendix has not received sufficient attention, and because lesions situated in it have been overlooked at autopsies." Then he winds up by writing: "If it were possible, indeed, to establish the diagnosis of these affections in a certain and positive manner, and to show that they are entirely circumscribed, the possibility of an operation might be conceived. Some day perhaps this result will be reached." Fancy this in 1827!

In 1836, Richard Bright and Thomas Addison, in "The Elements of the Practice of Medicine," devote no fewer than six pages to "Inflammation of the Cæcum and the Vermiform Appendix."

In 1846, Voltr pointed out that the condition known as perityphlitis is not primary, but consecutive to inflammation of the vermiform appendix.

In 1847, Hancock, an English surgeon, reported a case

to the Clinical Society of London. Suppuration and perforation of the appendix had taken place. After the operation there was considerable discharge, and, on the fifteenth day, two faecal concretions were found in the wound, and from that time the discharge lessened and the patient made a good recovery.

In 1850-51, Gay reported a case of "internal strangulation between the vermiform appendix, which had become adherent to the ileum and a band of false membrane."

In 1867, Willard Parker, of New York, published four cases in which he had treated abscess in the right iliac fossa consequent on inflammation of the appendix by incision and evacuation.

In 1871, Weber published an article on "Abscess of the Vermiform Appendix."

In 1881, Lawson Tait wrote: "So satisfied have I been with the results in abdominal section that in the next case of peritonitis to which I am called, of whatever sort it may be—even puerperal—I shall advise and perform abdominal section; shall cleanse out the cavity and drain it, and if the operation be not deferred until the patient is moribund, I believe this treatment will prove eminently successful."

In 1881, Heming Burchard, of New York, read a paper on "Operative Interference in Acute Perforative Typhlitis." Here we have the term "typhlitis" used, and it was not until about 1886 that the terms typhlitis, perityphlitis, and paratyphlitis were practically discontinued owing mainly to Fitz, who secured recognition for the diseases of the appendix as a distinct class by themselves.

In 1884, Krönlein, of Germany, operated and resected the appendix *in toto*, after having placed a double ligature at the base of the appendix and a single ligature round the mesentery.

In 1885, Charters Symonds, of Guy's, did the first "interval" operation for appendicitis, but without removing the appendix. This was performed on a man whom Dr. Mahomed, also of Guy's, diagnosed as suffering from appendicitis. This operation was performed extra-peritoneally through an incision almost exactly similar to that used in ligaturing the external iliac artery.

In 1887, we find Frederick Treves and Morton operating on the appendix, and in 1888 Treves wrote: "In the majority of cases it would probably be wiser to remove the appendix. If this is done as much care must be taken to close the divided end of the tube as would be taken to close a hole in the small intestine. A mere ligature would not suffice."

And, finally, in the same year, N. Senn wrote, speaking of non-perforated cases: "Drainage in such cases is unnecessary and should be dispensed with."

This, gentlemen, is a brief outline of the history of appendicitis, and I have but tried to give an account of the main incidents as they have been brought to our notice, hence you may miss many names, such as Pepper, who, in 1883, described the relapsing form; and Bull, McBurney, Weir, Keen, Denver, and others, all of whom have given us interesting articles. So that I hope I shall be forgiven if, in trying to be brief, I have omitted any really important link.

(2) THE ANATOMY OF THE VERMIFORM APPENDIX.

The vermiform appendix, says Paul Reclus, "is the diverticulum of a diverticulum, the cæcum of a cæcum." Morphologically, as well as structurally, the appendix is merely a portion of the general cæcal pouch which has remained in an early stage of development and corresponds to the long terminal portion of the cæcum found in lower animals. The appendix is pushed to the left, and apparently carried back by the predominating growth of the anterior wall of the cæcum. Hence in about 90 per cent. of cases it usually branches off from the inner or inner and posterior wall of the cæcum, about 1 in. below the lower border of the ileum, where the latter enters the large bowel. The direction, however, that is taken by the appendix is most variable. Lafforgue, for example, found it hanging into the pelvis in 41.5 per cent. of 200 cadavers of all ages and both sexes; pointing towards the spleen in 26 per cent.; resting on the iliacus in 17 per cent.; and retrocæcal in 13 per cent. Thus for all practical purposes we may say

the appendix points either *up and in* or *down and in* in over 50 per cent. of cases examined.

As a result of the free movements of the appendix it may become adherent in various situations—to the omentum, mesentery, parietal peritoneum, the rectum and bladder, or the internal genitalia of the female. A fistulous communication may be established between the adherent appendix and the other parts of the bowel, *e.g.*, the cæcum, ileum, and rectum, and finally it may be found in a hernial sac, or when the cæcum remains in its primitive foetal location it may be found in the left iliac fossa.

The size of the appendix is as variable as its position. Wista and Luschka give 1 in. to 9 in. as its length; Trevor and Georgieff 1 in. to 9½ in.; diameter, about ½ in. It is provided with its own mesentery, and between its layers we find unstriped muscular fibres, the appendicular artery and its branches, with the accompanying veins, nerves, and lymphatics.

The lumen of the appendix opens into the cæcum about 1 in. below the ileo-cæcal valve. For a description of its structure and of the distribution of the blood-vessels and lymphatics I will refer you to any work on anatomy.

(3) MORBID ANATOMY AND ETIOLOGY.

This can be conveniently studied under: (a) Predisposing causes; (b) exciting causes; (c) essential causes.

(a) *Predisposing causes* may be *local* or *general*. Among the most important are the normal, anatomical, and physiological conditions. The appendix being a blind sac of relatively great length and small calibre, and resembling the tonsil in its abundant lymphoid tissue, and bordering upon a cavity particularly rich in bacteria, favours the stagnation of ingesta and an increased virulence of the contained micro-organisms, whilst the presence of so many follicles affords an excellent means of entry for bacteria. A similar *locus minoris resistentiæ* is created when the normal appendix becomes adherent to an adjacent structure—a frequent complication in pelvic inflammation, tumours, &c.

W. P. Manton states that in his experience moveable kidney is the most frequent cause of chronic appendicitis; whilst, on the other hand, C. P. Noble, in 100 operations on moveable kidney, only observed the association in six cases!

Age.—Appendicitis is distinctly a disease of early life, being commonest between the ages of 10 and 30.

Sex.—Sonnenburg found in 1,000 cases of appendicitis, 67 per cent. were males. Roux, in a series of 670, 53 per cent. males; Barbier, in a series of 616, 76 per cent. males.

Nationality and Diet.—Lucas Championnière, in an analysis of 22,000 patients, among Roumanian patients, found but one case of appendicitis! They live mostly on vegetables, as also do the Japanese and the tribal Arabs, amongst whom appendicitis is very rare, but the Roumanians and Arabs living in towns, where meat is freely partaken of, are frequently attacked.

Hereditary Influence.—This cause may be due either to a peculiar form of the appendix, to diminished resistance to infection, or perhaps also to the mode of life and the diet being similar.

(b) *Exciting Causes.*—(i.) *Digestive Disturbances.*—In many we find a history of chronic constipation and indigestion. In some an attack of diarrhoea precedes the appendicitis, but even in these we mostly have habitual constipation. At times an attack can be traced to an indigestible meal. (ii.) *Menstruation.*—The probable explanation of this cause may be that the congestion of the whole splanchnic area which accompanies the lowered blood-pressure of the peripheral circulation during menstruation creates a favourable nidus for the activities of the micro-organisms found in the appendix. (iii.) *Trauma* is frequently a direct cause of appendicitis—straining in heavy lifting, a hard bicycle ride, jumping, swimming, have each been noted. Exposure to cold might also be mentioned under this head. (iv.) *Foreign bodies and concretions.*—These are very varied, e.g., fishbone, core of apple, pins, worms, fæcal masses, &c., &c.

(c) *Essential Causes.*—The immediate cause of appendicitis has been stated to be “microbic infection.” The normal appendix containing the infective agents which,

though dormant in the healthy condition of the bowel, awake to activity under favourable circumstances. The experiments of Roger and of Klecki show that it is not necessary to introduce virulent bacteria into the appendix to produce an inflammation. Nicolaysen, after experimenting in various ways, states that appendicitis is primarily due to the extension of an infective enteritis, and Dieulafoy believes that in associated suppurative cholecystitis and appendicitis, that the involvement of the appendix is secondary, and is due to descending infection.

Appendicitis as a Local Expression of a General Infection.

—The frequent association of appendicitis with rheumatism and other diseases has been noted. In my own experience I came across a family where five members were in bed at the same time suffering from appendicitis. I was called in to operate on the youngest, but found it too late to do anything, the child dying that same evening. Two days later I was called to operate on one of the others. In this patient perforation with abscess formation was present. I operated at once, and the child did well. The others got well without surgical interference. I suspected the drains as being the cause of this outbreak, and when tested they were found to be very leaky and defective.

(4) PHYSIOLOGY OF THE VERMIFORM APPENDIX.

I shall be content with this part of the subject just to quote the opinions of a few writers.

(1) *Lieberkühn* states: "The surface of the vermiform appendix is full of glands, secreting a fluid which mingles with the fæces in the cæcum, and, by diluting these, prevents their remaining stationary and doing harm. The fact that the appendix contracts at the same time as the cæcum prevents any foreign body entering the lumen."

(2) *T. Vosse*: "The surface of the appendix is full of glands which secrete a mucus. . . . As there is a tendency for fæces to accumulate and harden in the cæcum, there must be some provision by which they are rendered more fluid. Glands are present in the cæcum for this purpose, but they

are not sufficient and require aid, and the function of the vermiform appendix is to provide additional secretion."

(3) *G. von dem Busch* emphasizes Lieberkühn's views and adds: "The appendix must be considered as a second salivary or pancreatic gland, while the cæcum is a second stomach."

(4) *H. H. Smith* writes that the appendix exerts some influence on the action of the cæcum in digestion is quite probable, as its mucous coat differs very materially from that of the cæcum and colon in the arrangement of capillaries and mucous crypts. The presence of a vermiform appendix in certain herbivorous animals, and its absence in the carnivora, would also seem to indicate that this organ has some influence on the digestion of vegetable matter.

(5) SYMPTOMS.

(1) *Pain in the abdomen*, sudden and severe, primarily referred to the epigastrium. It usually reaches its acme of intensity about four hours after its onset, and in the majority of cases gradually subsides. When it ceases suddenly within the first thirty-six hours, we must look out for liberation of the infective material into the caput coli, rupture, or complete gangrene. The secondary pain, occurring after the first thirty-six hours, is usually not colicky but of the typical inflammatory type. Severe pain after the primary subsidence is always a signal of great danger, as it means perforation or the beginning of peritonitis.

(2) *Nausea and Vomiting*.—(a) The primary nausea and vomiting are reflex due to over-distension of the appendix. (b) The secondary nausea and often persistent vomiting are due to infection of the peritoneum.

(3) *Abdominal sensitiveness* is at first diffuse, although the abdominal wall is not practically rigid. When the appendix becomes fully distended and tense it will not tolerate pressure, and then there is marked rigidity of the abdominal muscles. As soon as the acute tension subsides, the general sensitiveness disappears, and we get

a tenderness, more or less marked, localized over the appendix area.

(4) *Temperature* is always present in the early stage of an acute infective case. This is, however, a symptom that is often misleading in the later stages, and at times must be practically disregarded.

(5) *Leucocytosis*.—A sudden fall in the total number of leucocytes is a very unfavourable sign. Beginning recovery is manifested by a rise in the absolute number of mononuclear and eosinophile leucocytes.

(6) *Tumour* is very variable, and may even sometimes be absent.

(7) *Pulse* varies tremendously, but if the rate of the pulse keeps high, even when the temperature improves, then I think we must be on our guard.

Other symptoms we might just mention are: (a) Great irritability of the bladder. (b) Urine may be scanty and often contains albumin and indican. (c) The decubitus is often dorsal and the right leg semi-flexed.

COMPLICATIONS.

- (1) Suppurative peri-appendicitis.
- (2) Generalized peritonitis.
- (3) Intestinal obstruction.
- (4) Septicæmia.
- (5) Pyæmia.
- (6) Pylephlebitis.
- (7) Hepatic abscess.
- (8) Subphrenic abscess.
- (9) Lung and pleural affections.
- (10) Vesical and renal complications.
- (11) Fatal hæmorrhage.
- (12) Vascular complications.
- (13) Retro-peritoneal infections, &c., &c.

(6) DIAGNOSIS.

The diagnosis of acute appendicitis is rarely difficult, the symptoms occurring in such uniform order—first the pain,

then the nausea and vomiting—then local sensitiveness to pressure, and then rise in temperature from 99° to 105·5° F., and finally the leucocytosis.

The differential diagnosis in acute attacks of appendicitis involves an exclusion of : (a) Cholelithiasis ; (b) acute intestinal fermentation ; (c) renal calculus and retention ; (d) acute tubal affection ; (e) rupture of intra-abdominal abscesses ; (f) gastric and intestinal perforations ; (g) intussusception ; (h) twisted tumour pedicle ; (i) tuberculosis of the intestine, especially of ileum ; (j) typhoid fever ; (k) acute cystitis ; (l) gynæcological affections—and here I think an interesting paper could be given on the relationship of appendicitis to gynæcological affections.

These are some of the conditions which should be mentioned in making a differential diagnosis, but owing to the extraordinary positions in which the appendix may be found, this number might be greatly increased, but I will spare you this this evening gentlemen.

(7) PROGNOSIS.

I think we must at once state that this depends entirely upon the form of the attack, but there is always so much uncertainty about each individual case that the prognosis should be a guarded one. Fortunately the great majority of cases recover.

(8) TREATMENT.

And now, gentlemen, we come at last to the *Treatment* of appendicitis. My paper this evening is to be confined to the surgical treatment of this most interesting affection, so I will not take up your valuable time by mentioning the various drugs which we as homœopaths know to be so very helpful. I cannot, however, let this opportunity slip by without mentioning what Osler says from the physician's standpoint : "So impressed am I by the fact that we physicians lose lives by temporising with certain cases of appendicitis, that I prefer in hospital work to have the suspected cases admitted directly to the surgical side. The general practitioner does well to remember, whether his

leanings be toward the conservative or the radical methods of treatment, that the surgeon is often called too late, never too early." With the latter part of this statement I must frankly say, gentlemen, that I fully agree, and after ten years of operative work I can say I have never yet lost a single case of appendicitis to which I have been called in time. It is true I have lost three cases which I will briefly submit to you.

(1) That of a patient who had been sent into the Buchanan Hospital with "stoppage of the liver" (*sic*) as a diagnosis. In this case the liver was all right, but there was a perforated and gangrenous appendix, and a huge abscess. Even here, although the patient was quite collapsed, he rallied considerably after the operation, but died on the sixth day.

(2) That of a lad, aged $10\frac{1}{2}$, who was almost moribund on admission. Slight improvement followed the operation, but death took place on the third day.

(3) A grossly neglected case, diagnosed as appendicitis, and yet not seen by the medical attendant from Saturday until the following Thursday. The child was then hurriedly sent $9\frac{1}{2}$ miles in a cab, and operated on as soon as possible, but death took place in forty-eight hours.

One more item from Osler, with which I do *not* agree. "There is no medical treatment of appendicitis! There are remedies which will allay the pain, but there are none capable in any way of controlling the course of the disease." Imagine this statement, in A.D. 1910!

The time for surgical intervention in appendicitis may be considered in four periods: (i.) Early operation, performed within the first forty-eight hours; (ii.) intermediate operation, from the second to the fifth days; (iii.) late operation, after the formation of abscess; (iv.) interval operations, which are performed sometimes after an attack, in the quiescent state.

(i.) With regard to the early operation performed within the first forty-eight hours, we can say it is *safe*, because we can never tell which cases may go on to suppuration. It is also more easily done, for there will not be any dense

adhesions to be dealt with, and the appendix can more easily be reached than at a later stage, when there may be matting together of the intestines. Further, the patient may be saved days of acute suffering, as the attack is reduced to a brief surgical illness instead of a protracted illness of weeks or months; and, lastly, the liability to recurrent attacks is obviated, for at this early stage the appendix can be removed, whereas sometimes at later stages it is impossible to do so on account of the matting together of the intestines. Recovery from the attack *may* take place under conservative treatment, recovery from the disease is certain only when the appendix has been removed.

(ii.) *Intermediate Operation.*—This is the operation that calls for so much judgment and anxious thought on the part of the surgeon, for he has now to consider the difficulty and danger of breaking-down adhesions, lest he be the means of spreading a localized infection, and many surgeons prefer to wait and see if the disease will abate, or if a well-defined abscess will form which can be evacuated. The class of case one has to consider under this heading may be divided into three:—

(a) Cases which are evidently getting worse, as shown by continued pain, swelling, tenderness, muscle spasm, and increasing temperature and quickened pulse. These cases, I think, should be operated on without delay.

I was called to see Miss H., of Bexhill, late one Friday evening. She had been in bed ten days with appendicitis, but as pulse was getting more rapid, and the general condition was deteriorating, a consultation with view to operation was decided on. On examination, pulse was 104, and evidently an abscess had formed. Owing to the absence of a near relative I could not get permission to operate for more than three hours. During that time the pulse had risen to 124.

At the operation there was evidently a deep-seated and large abscess. Instead of opening this I simply put a large drainage tube right on to the site of the abscess, after breaking down some of the adhesions. Although no pus escaped for sixteen hours the temperature and pulse began to come down soon after the operation, and the patient made an uninterrupted recovery.

A second case, with deep-seated abscess, I treated in the same way and the patient did splendidly.

(b) Cases in which the patient, although not growing worse, is not distinctly improving. If no improvement takes place for a few days, in my opinion the surgeon should not hesitate to perform the radical operation.

(c) Cases which are certainly improving. These require careful watching, as they are sometimes most deceptive. Of this class Jacobson says: "There may be a mitigation of all and a complete disappearance of most of the symptoms, and yet during the period of their subsidence the diseased process has gone on steadily."

Mrs. M., aged 54, had had apparently a mild attack of appendicitis, the pulse never reaching 100, and the highest temperature 100.2° F., for a few hours only.

Patient was up and about, and only symptom remaining was some pain on deep pressure over McBurney's point. As patient had had several "passing" attacks of appendicitis and she was contemplating a sea voyage, I recommended an operation.

At the operation I found a distended and flaccid appendix which contained over a drachm of pus! Yet here we found pulse and temperature practically normal, and patient able to get about quite well without pain.

(iii.) *The Late Operation.*—This is one performed after the formation of a well-defined abscess, or else undertaken for a spreading peritonitis. What anxious times we have experienced with these cases, gentlemen; and how we wished that we had been called in earlier.

Finney says of this class that "the presence of pus in an appendicitis case is *prima facie* evidence of a mistake on the part of somebody—the patient, the physician, or the surgeon"!

Miss T.'s Case.—Repeated slight attacks, finally a severe one; doctor called in; sent on to me at once; deep-seated abscess; localized peritonitis. Rather protracted convalescence, owing to a hard concretion, which did not come away until one week after operation. Final result excellent.

(iv.) *The Interval Operation.*—This operation is performed on a patient who has already had two or more attacks of appendicitis, and is performed while the patient is in apparently

good health. To this class belongs the subacute cases. This is an operation that is practically safe. Lennander operated on 271 cases of this sort without a single death. Personally I have operated on a large number falling under this head, and it is remarkable to find such a diversity in the positions, size and state of the appendix. The last case I operated on of this division is still in hospital, but has done well and is now convalescent. It was rather an interesting one, as in addition to the appendicular mischief, we had found her to be suffering with a right cystic ovary. She had no pain or temperature, only slight tenderness on deep pressure over McBurney's point, and the pulse was normal. At the operation the appendix was covered with a meshwork of small but dilated blood-vessels, and was quite stiff and erect as though it had been composed of erectile tissue. The lumen was practically obliterated, and I could find no foreign body at all in the minute lumen. The ovary, of the size of an orange, was of course removed at the same time.

And now we come to the class of case which can only be described as *desperate*. Here the surgeon has simply to consider the advisability of "giving the patient a chance," and from personal experience I would unhesitatingly say, unless the patient is really moribund, operate and give the patient a chance.

Van Lennek, in the *Hahnemann Medical Monthly* of January, 1898, quotes such a case, a child aged 12, sent to him with supposed tubercular peritonitis and so far gone that the operation was commenced almost without anæsthesia. On being opened pus poured out as from a geyser, and it was estimated that fully two gallons were evacuated. The abscess was bounded by the floor of the pelvis, the abdominal walls, the spine and the diaphragm! The patient made a surprising, though tedious recovery. One of my own cases was bad enough, but scarcely in the same state as this remarkable case.

Mr. M. aged 55, fat, unhealthy, alcoholic, two weeks' history, highest temperature 101.4°F. , pulse had been 120, when I saw him, 95, but he was evidently collapsed, sweating profusely, and looked very grey. Abdomen distended, marked rigidity on

right side of abdomen, filthy tongue and foul breath. Advised immediate operation. Appendix practically sloughed away, huge, intensely foul abscess, large quantities of fæces in abscess cavity, protracted but perfect recovery.

And now, finally, gentlemen, as to the operation itself—

- (1) Freeing appendix, ligaturing base, resecting cuff of peritoneum, and burying stump under the cuff so formed.
- (2) With deep-seated abscesses, rather than open at once, place large drainage tube in site, and let abscess open of itself.
- (3) Invaginating stump of appendix into the cæcum.
- (4) When bound down, dividing at base, closing cæcum, cutting down on to it and dividing peritoneal and muscular coats, appendix can then be shelled out: or with very dense adhesions, after dividing base, it is slit open and mucosa removed. Lastly stitching appendix to abdominal wall and leaving a fistula.

Mr. KNOX SHAW remarked that the subject was full of interest and full of difficulty. He never saw a case of acute appendicitis without feeling some difficulty in deciding as to what was the best course to pursue. He was certain that if every case was operated upon—as some surgeons advised—within twelve hours of the onset of the attack, a very great number would be operated upon quite unnecessarily. He was perfectly sure that a great number of cases got perfectly well without any surgical treatment whatever. Some patients recovered and never had another attack; but some would have other attacks, and if that was the case then he thought an operation during the quiescent period was advisable and salutary. Since he had learned the value of the Fowler position and the Murphy method of a continuous rectal infusion, he felt that surgeons were not called upon to operate so urgently or immediately as in the past, because the great dread before these methods of treatment were adopted was that if a general infective peritonitis ensued the case was bound to be a fatal one. Cases were not so likely to be fatal nowadays with the onset of acute general peritonitis. He remembered the case Dr. Moir mentioned quite well. The child was taken ill in the early morning, and Dr. Moir saw it after breakfast. Dr. Moir then said he would bring a surgeon. They went together and saw the child about half-past one or two o'clock. The patient was seriously ill, with general peritonitis, and an operation was the

only thing to be done, although they could not guarantee the operation would save the child's life. The parents were very anxious to have another opinion, and though only an hour or two elapsed between Dr. Moir first seeing the case and the other consultant's visit, the child was then dying, and did die before the next morning. There was a certain class of case where the action of the toxin on the peritoneum was so great that the patient was overwhelmed with it before anything could be done, and he thought such cases would be lost no matter what surgical operation was performed. He remembered a case when he was surgeon to the Buchanan Hospital. He had seen a young girl in the morning who was leaving the hospital perfectly well after an eye operation. After lunch he was telephoned for, and was asked to see her again. She appeared as if she were dying from some internal hæmorrhage. This was in his early days, and at that time not much in the way of abdominal work was done—for appendicitis certainly. By next morning the patient was dead, within twenty-four hours of being in apparently good health. A *post mortem* was made, and the onset of acute peritonitis was discovered. The source of the peritonitis was not discovered, but he believed he would have found a small perforation of the appendix if it had been carefully looked for. He did not, himself, dread abscess so much, because he believed if the peritoneum was shut off and the wound was not closed, and rectal infusion were used, a large number of cases would be cured. He had an instance only the previous week of a patient having been seen by an allopathic doctor, who called in a very well-known surgeon, who advised an immediate operation. The patient desired to have homœopathic treatment, and a very well-known homœopath advised no operation, but in order to protect himself he asked him (Mr. Shaw) to see the case. He did so between twelve and one in the morning, and he felt the very great responsibility of advising whether an operation should be performed or not. In the end he gave his opinion in favour of delay, because, though the onset had been acute and the abdominal pain had been general, yet as the twenty-four hours went on it had been lessening, and although the patient obviously was very ill, with a high temperature and rapid pulse, the symptoms were localizing themselves in the right iliac fossa. The rigidity was very marked on the right side, but was lessening very materially on the left side of the abdomen. He felt a very grave responsibility in the matter, because the husband of the patient and her friends were set against an operation. He was thankful to say

that things went on very well, and they were justified in treating the patient medicinally. He did believe very strongly in operating in the interval stages, and he was inclined to think there was a good deal in what Mr. Moynihan called appendicular dyspepsia. A good deal of ill-health was caused by chronic irritation and stricture of the appendix.

Mr. WRIGHT agreed most fully with what Mr. Shaw had said with regard to withholding all operative measures in doubtful cases, and to illustrate how just his remark was, Mr. Wright mentioned a case which he had seen a short time ago, which would show that not only would surgeons operate on a great many cases that needed no operation, but would operate on a great many which were not, possibly, cases of appendicitis at all. The case he had in mind was one in which an eminent allopathic physician was first called in and gave his opinion that the case was one of appendicitis, and would probably require an operation. The patient's people were homœopaths, and they asked him, Mr. Wright, to see the case. Some hours after the first man had seen the case a change had taken place, so much so that he (Mr. Wright) began to doubt whether it was a case of appendicitis at all. The patient complained then of what he had not formerly done, namely, a sense of retraction of and some pains shooting down into the testicle. There was tenderness at McBurney's point, and several of the classical symptoms put him on his guard, and he advised that at any rate at that particular moment an operation was not necessary. The pain rapidly subsided, and three days later the patient passed a small calculus. He mentioned that to show how even a really experienced physician had been mistaken and how cases which were sometimes submitted to operation might not be really appendicitis at all. The case which Dr. Pritchard mentioned, in which the appendix contained pus, was an interesting one, and Mr. Wright recalled a very similar case himself, in which the patient had an attack of appendicitis, in fact had had two or three recurrent attacks. The case was admitted into the hospital with a view to operation, after having had an attack, and going about apparently quite well. It was arranged that the patient should be operated upon during the quiescent period. As was usual in those days, a consultation of several physicians took place, and they all expressed the opinion that the patient ought to be operated upon, except one gentleman who was very strongly against it, suggesting internal treatment, his view being that there was no sign of anything wrong with the appendix at all. He did not put it that there had never been appendicitis,

but he thought at any rate at that particular time there was no evidence of the appendix being involved. However, the weight of evidence was against him, and the operation was performed. He (Mr. Wright) removed an appendix which was, practically, a bag of pus—and a very big bag. He mentioned the case as showing that a patient might be practically free from any acute symptoms, and yet might go about with an appendix containing pus in the abdomen. With regard to the case Dr. Pritchard mentioned, where the fæces were loose in the abscess cavity, he would like to ask if the fæces had obtained access to the abdominal cavity, or were only in the abscess cavity? Was there generalized peritonitis?

Dr. PRITCHARD replied, localized.

Mr. WRIGHT said in that case there was a much better outlook than if the whole of the abdominal cavity were invaded; but, at the same time, even then he congratulated Dr. Pritchard on the successful outcome of the case. Such cases were always extremely anxious ones. Undoubtedly the rectal irrigation and the Fowler's position were of great value when dealing with peritonitis in appendicular cases.

Mr. EADIE said he had been very much interested in Mr. Wright's case of the renal calculus. Quite recently he himself had seen in a large London hospital a very similar case, in which a man was admitted into a surgical ward for operation for appendicitis. Fortunately for himself the patient passed a stone with his urine just prior to going into the theatre to be operated upon. It was very difficult, sometimes, to tell whether one was dealing with a case of appendicitis or renal calculus; it was not an uncommon mistake to make, and a surgeon need not be held up to ridicule for making such an error. A point he had been struck with in the treatment had been the use of enemata. If given early they would relieve practically every case. A great many cases were subjects of chronic constipation, and a great deal of fæcal matter would be removed by one or two enemata. The problem, when to operate, was to him a very interesting psychological study. His experience was that the younger men tended to advise immediate operation as soon as diagnosis was made. The older men tended to choose the latter alternative between dangerous operation and a dangerous delay. He supposed through having sat at the feet of Messrs. Shaw and Wright, he had naturally come to think that a good many cases did not require operation at all. With regard to Dr. Moir's case of the pin-point hole, he thought that

condition was quite recognized nowadays. In quite a number of appendices the muscular coat was deficient in places, so that mucous membrane and peritoneum were in contact, giving what was called "hiatus muscularis," and if there was a catarrhal inflammation inside the appendix it could easily and rapidly extend through into the peritoneum. Whether one should operate or remove an appendix after a patient had had one attack with abscess, which had been opened, but appendix not removed, he did not know what the experience of the members might be, but his own had not been happy. The cases with this history he had come across, which had had an abscess and had developed another attack later, had died. With regard to the question of the onset, everyone with experience of appendicitis must have been struck by the curious onset of the disease. Very many patients stated that the attack came on early in the morning, at two or three o'clock, and that they had to get up to defæcate or vomit. It was astonishing how often it came on the first thing in the morning. He did not know why, and he should like to know if any member could suggest a reason for it. With regard to the condition which Dr. Pritchard had mentioned of finding an appendix containing pus, he believed there were a number of such cases on record. The pus apparently lost much if not all its virulence, and the presumption was that if it burst into the peritoneal cavity the latter could perfectly well deal with it itself.

Mr. KNOX SHAW said Mr. Eadie had just made a remark about which he thought he might tell the members something interesting. He had been talking one day on the cricket field to the medical officer of a large public school, containing five hundred boys, and he asked him about his experience of appendicitis in the school, where, he thought, there would be a great number of cases; but the medical officer said he had not had to have the surgeon down to operate on one case all the years he had been there. He told him that when he had a boy with a right iliac pain a castor-oil enema was administered, and there had never been a bad attack of appendicitis in the school. The medical officer was very definite in his own mind that attacks of appendicitis were avoided by giving castor-oil enemata.

Dr. WYNNE THOMAS asked Dr. Pritchard if he could suggest any reason why appendicitis was so much more frequent at the present time than it was twenty years ago; was it possible—it was not an original idea of his own—that the use by the general public of aperient waters had anything to do with it? Aperient waters were sold at every chemist's shop to cure constipation,

but they did not bring down the solid constituents of the motion, but only a watery evacuation—the solid part of the fæces being left behind; and that might have something to do with appendicitis. He would like to mention one interesting case of a patient he had had in the Bromley Hospital about two years ago. The symptoms were a little indefinite at first, but he came to the conclusion that it was a case of appendicitis and advised an operation. The patient said she had had appendicitis before and had got well, and asked why she should not get well again. He replied that the symptoms were getting worse, and that she must agree to have an operation. But she would not. However, the patient got steadily worse, and an operation was decided upon the following morning. During the night she passed a quantity of pus by the bowel, and when he saw her in the morning she said "You are not going to operate; I have got through one attack, and I am getting through another; I have done the surgeons once again."

Dr. SPEIRS ALEXANDER remarked that if he were not a homœopath, he should probably be in favour of early operation. There could be no doubt that the early stage, before inflammation had spread, before adhesions had formed, before pus had collected, was the most favourable time to operate. In America, many surgeons held that directly tenderness on pressure over McBurney's point was obtained, an operation should be performed. Not only did they advocate such an operation, but they prescribed it, and he believed that the great majority of their cases recovered. But the early stage was the homœopathist's opportunity. In his own experience, given one condition, namely, that the patient was seen early enough, in almost every case a good recovery was made without any operation. He also thought that among allopaths also the early stage would soon be recognized as so favourable for medical treatment that operation at that period would be less frequently practised, and for the following reason—he believed that within a short time appendicitis would be successfully treated by them, in common with other microbic diseases, by vaccines. With regard to the question of delay, if the case had passed the initial stage when first seen he was in favour of waiting. If it were a fulminating case, there would of course be no use of operating at all, as the patient would probably die whether an operation were performed or not. But if not a fulminating case, and if the early stage had passed by, and the patient was not getting well, he should advise waiting, for the reason that time would be given for adhesions to form, so that, if suppuration were taking place, the abscess cavity would be limited, and when this had occurred

then would be the favourable moment for operating. There was a common idea about that appendicitis was very much on the increase; he thought that was quite a fallacious idea. There was a time when nothing whatever was heard of appendicitis. There was also a time when nothing was heard about mastoid abscess. Those diseases had not then been recognized, but because since then they have been recognized, and a good deal was heard about them at the present time, people naturally said what common ailments they were. He therefore thought that it was only because the condition had been better recognized of late years than formerly, that the impression was abroad that it was on the increase. Dr. Thomas had referred to the question as to whether the use of aperient waters might have given rise to cases of appendicitis. He thought it was Dr. Kidd who started that idea when he said that he never used to meet with as many cases before their introduction as since then. As far as he (Dr. Alexander) could see, there could be very little relation between such aperient waters and appendicitis, because it was a well-known fact that an immense number of people used them habitually, and never developed appendicitis.

Dr. BURFORD said he had been waiting to hear described the physician's point of view on the subject, but, with one exception, the physicians had been discreetly silent. There was one important point which had not hitherto received attention in the criticisms of the author's statements, namely, that these cases were met with in general practice—cases removed from the consultative support of town, and concerning which the practitioner had to use his sole judgment as to whether each should undergo the palliative treatment of the physician or the rational treatment of the surgeon. He thought if some practitioners recognized the fact that a case of acute appendicitis should be considered as partly within the sphere of the physician and partly within the sphere of the surgeon, and that this duality should never be lost sight of until surgical necessities had been positively and absolutely ruled out, the disease would be very much less fatal than it was. He was, however, not present as an advocate for indiscriminate operation. He had not heard of the word "appendicitis" until he had been several years in practice. Up till then all such cases had been known as typhlitis, and he had been instructed that if there was an acute pain in the right side, and an inflammatory lump, it was a probable case of typhlitis, and typhlitis meant inflammation of the cæcum; the appendix was not at all considered as a dangerous organ. In his early days he

had seen a good many cases of typhlitis treated without operation and under the old allopathic method of the continual giving of small doses of opium; half a grain of opium given in repeated dosage gave wonderful results. At the same time the majority of the cases that died came under the general category of peritonitis. Nobody speculated then as to what caused attacks of peritonitis, and it was owing to Lawson Tait that the differentiation between organic causes of peritonitis was first instituted, and appendicitis began to be recognized as a disease in and by itself—as a disease first of all of the appendix, and in the second place a disease amenable to surgical operation. The combination of appendicitis with gynæcological lesions was not an infrequent combination. Dr. Percy Wilde had invited him to see a case who had already had the advantage of the opinions of two physicians from Guy's, who agreed as to its nature. The patient was a young girl, aged 21, with albuminuria, sweats and high temperature, with the physical signs of peritonitis, which were got rid of, and the patient came to town for operation. It was a case of tuberculous typhlitis and appendicitis. The appendix was removed, but the walls of the cæcum were so necrotic that it was very undesirable to proceed further with regard to that particular part; and he did what he always did under such circumstances, made a special exploration of the pelvis. He found that the ovaries and the tubes were firmly bound down, out of sight, covered by adhesions, evidently the outcome of one of the peritonitic storms that the condition of the appendix had evoked. The patient made an excellent recovery, and had since been to Switzerland year after year without “turning a hair.” It would have been quite easy to have operated on that case as one of pelvic peritonitis, presumably of tubal or ovarian origin, and to have entirely missed the real meaning of the case. A second interesting case of this alliance was that of a lady, aged 45, who had been sent to him at the early part of last winter, who could not get about because of an acute left-sided pain, of comparatively recent origin. There was sufficient in the case to require operation, and an operation was carried through. It was a case of double pyosalpinx; the history did not incline him to the view that it was of gonorrhœal origin, and after removal of the diseased tubes a careful search for the appendix was made. An investigation disclosed a tubercular appendix, which took as long to get out as both of the diseased uterine appendages put together. His belief was, in that case, that the prior lesion was the appendicular lesion, and the secondary lesion was the lesion of the Fallopian tubes. A third and most interesting instance of

this gynæcological alliance was that of an actress, who underwent some three or four years ago an operation for appendicitis. The appendix was removed. Later, pelvic symptoms again developed. He saw the case and removed an uterine gestation on the *left* side. Two or three years elapsed and he again saw the lady for a tubal gestation on the *right* side. All the three tubes had undergone some pathological lesion since adult life had begun. Whenever he (Dr. Burford) saw a lady patient who complained of chronic pain in the right side, he did not fall into the usual error, which he himself and other practitioners had committed in old-time, of considering the case as ovaritis. As a matter of fact there was no such independent disease; in all probability such cases were those of appendicitis, and he had seen many mistakes made in that connection. He advised any practitioner who got such a case to leave ovaritis altogether out of the question, and treat the patient for appendicitis. With regard to the position of physicians in connection with appendicitis, he regarded all cases of appendicitis as in their nature a slight on the prior equipment of the physician. Practitioners had, in cases of acute appendicitis, to deal with an infective disease. Pneumonia was an infective disease, but no surgeon was sufficiently bold to suggest the removal of both lungs, and he (Dr. Burford) knew no reason why in the case of the appendix the prior study of conditions predisposing to the operation of exciting causes should not be placed on such a pedestal as would enable a condition tending to appendicitis to be diagnosed and prevented, with almost the same certainty that the risk of tuberculosis at the present time could be diagnosed and prevented. He had little doubt that eventually the treatment of appendicitis would be the treatment of its causes in the hands of physicians. He urged practitioners not to run away with the idea that the last word in the treatment of appendicitis was being said by the surgeon; the last word still remained to be said and would be said by the physician.

Dr. BYRES MOIR said with regard to Dr. Burford's remark's, that the physicians were gradually going to take every case out of surgeon's hands.

Dr. GOLDSBROUGH remarked that a challenge to physicians had been thrown down, which he did not think they would be behindhand in accepting. He thought Dr. Burford had forgotten one point, namely, that it was not a question so much for the physician as it was for the physiologist. Personally he did not feel dissatisfied with the treatment of appendicitis from the homœopathic standpoint, but he did feel dissatisfied with its

recurrence. An understanding of the etiology of it more thoroughly was necessary to put patients on their guard with reference to diet and general hygiene to prevent recurrence. He would like Dr. Pritchard in his reply to give his opinion as to what precisely would be the signs of a perforation having taken place or of a case having to be brought to the operation table immediately without waiting. In several cases, in Dr. Goldsbrough's, experience at first there had been no resemblance or suggestion that they were cases of appendicitis and yet some incident in the course of the history of the patient afterwards proved that the attacks from which they had been suffering had probably been of appendicular origin. The subject of chronic appendicular dyspepsia had been referred to. He had had a case recently of a man who had been ill for a great many years suffering from pain in the right iliac fossa, with some tenderness, a coated tongue and bad symptoms and dyspepsia. He had improved and was practically cured by an alteration in the diet and by hydrastis and sulphur.

Dr. E. A. NEATBY thought the question of a tumour in the appendix region, except during the very acute stage, was extremely misleading, because after severe attacks no tumour might be felt and even where an apparent tumour was to be felt there might have been no appendicitis. The features with which an appendicitis might be confused were a certain amount of thickening of the cæcum itself, or simply faecal accumulation in the cæcum, or flatulent distension in a thickened cæcum, or again, in some cases of relaxed abdominal wall, the muscle bundles of the oblique muscles seemed to be isolated more or less and yielded the feeling of a somewhat sausage-shaped tumour under the finger. Therefore the presence or absence of a swelling was of very little diagnostic importance. There were a good many atypical cases, especially cases of prolonged pain. In the early days he had been inclined to the opinion that before operation there must have been repeated typical attacks of appendicitis, acute pain with or without swelling, tenderness, vomiting and so on, the patient getting better in a week or two or sometimes in a day or two. But there were many cases which were genuine cases of appendicitis in which there was not that intermittent condition. About a couple of years ago Dr. Croucher, of Eastbourne, had sent a patient who had pain in the right side and very typical symptoms of colitis. He (Dr. Neatby) did not advise operation and Dr. Croucher went on treating the patient. She did not get any better and was again sent up to him, and again he suggested the patient had colitis. But as she did not get

any better Dr. Croucher thought something more should be done, and he opened the abdomen and removed the appendix, which was thick, adherent and long, showing the patient had had appendicitis. Dr. Pritchard had mentioned two conditions which found interesting parallels in the Fallopian tubes. One was an appendix abscess without pyrexia—it might be called pyo-appendix. It was paralleled by non-pyrexial pyosalpinx. In the latter, he (Dr. Neatby) said cases of pyosalpinx existed where quite distinct welling and several ounces of pus were found, and yet not the slightest temperature. In those cases the pus had been found to be sterile: of course virulent micro-organisms had been present at one time to produce the pus, but the antidotal powers of the body had succeeded in overcoming the bacteria and they had died, and ultimately cases showing these features might get sufficiently well, as perhaps to need no operation, or at any rate not to be dangerous. The other condition which Dr. Pritchard had described as a thickened appendix which resembled erectile tissue was interstitial appendicitis. He (Dr. Neatby) had seen the condition much oftener in the case of the Fallopian tube, where a thick and rigid tube was found perhaps a little curved, but often quite straight, which was not usually the case with tumours of the Fallopian tube. These cases he believed were usually due to quite a mild infection.

Dr. STONHAM, said, with regard to the function of the appendix Dr. Pritchard had read out the opinion of several eminent physiologists who seemed to consider that the function of the appendix was to secrete fluid mucus which softened the fæces and rendered constipation less common. He would like to ask Dr. Pritchard whether he had observed that after the removal of the appendix the patients were more subject to constipation than they were before. Another point was with regard to the etiology of appendicitis, a subject which had been mentioned by Dr. Burford and Dr. Goldsbrough. Practitioners did not seem to have much to go by, but one point might give a little help, namely, that there was no appendix in the carnivora, and also that appendicitis was extremely rare in races which lived entirely on vegetable diet. It would seem that possibly some proteid products might be a contributory cause of appendicitis. If that were so it might have some bearing on the dietetic treatment of the appendicitis. It might be that it was a bad practice to give beef-tea and that it was better to keep the patient entirely on vegetable diet during treatment. There was one other point with regard to etiology and that was with regard to the frequency of appendicitis in

children. He should like to ask the author whether he had observed that children who had been troubled with thread-worms were more prone to appendicitis than others. Thread-worms had their breeding grounds in the cæcum, and it was just possible that the appendix might become chronically irritated and more likely to take on inflammation in those children who had worms there.

Dr. HEY said among the points which had been referred to in the discussion no reference had been made to the question of recurrence—how frequently might a patient have attacks and yet survive. Last year he had the privilege of seeing an interesting case with Mr. Shaw. The patient was the daughter of a very keen homœopath and had had many recurrent attacks of pain associated with sickness and slight rise of temperature, the attacks gradually increasing in severity. The father would not hear of operation on any account. At that time, however, the young lady (who had come of age and so spoke for herself) was down with her thirty-fourth attack and insisted on an operation. Under treatment she speedily recovered from the acute attack and was then removed to a nursing home. An appendix, which showed signs of having been subject to severe inflammation, was removed, and in ten days she had made a perfect recovery, and only a week or two ago he heard that she had been mountaineering in Switzerland and was better than she had been for years. A point which he had not heard anyone refer to was the question of recovery after operation. When he was resident at Leith Hospital, early in 1902, a patient was brought in for urgent operation. When the abdomen was opened it was found to be full of a turbid fluid with no sign of "shutting off" at all. There were several doctors in the theatre, but the surgeon went on with his operation without any comment until he had nearly finished, when he looked round and asked what were the man's chances of recovery. Everyone present believed that the chances were very remote. The surgeon, however, had noticed that the man had red hair and predicted that he would recover, and though he had general peritonitis yet he made an absolutely uneventful recovery. He (Dr. Hey) would like to ask if anyone present had had any similar experience with regard to red-headed people, and their powers of resistance in similar grave crises. He had been very much interested in hearing the remarks of Dr. Pritchard and Mr. Eadie with regard to having an appendicular abscess without temperature. He had an interesting case in the hospital just now. A patient was sent in

by a colleague with a history of recurrent attacks of pain associated with swelling in the right iliac fossa. The history went on to say that the swelling became increasingly large with every attack. Various diagnoses were made. One was that there was an abscess, although there was no temperature; others that it might be malignant disease of the cæcum, &c. Personally he reserved his decision till he had opened the abdomen. When the abdomen was opened it was found that the omentum had been carried by Nature in a very wonderful manner as far round the cæcum and appendicular region as it could be, and very firmly glued down in the iliac fossa, effectually shutting off the general peritoneum laterally, but below and above the point of attachment into the iliac fossa one could pass one's fingers behind the omentum and make them meet. With considerable difficulty that mass of thickened and inflamed omentum was detached. He then found the ileum was recurved behind and below the lower part of the cæcum, and fixed there by a dense mass of adhesions—more dense than any he had previously encountered. When those were separated, all one could see was that the appendix was a dense, thickened mass lying along the posterior wall of the cæcum, and firmly adherent in the iliac fossa, so there was nothing to be gained by going further. It was impossible to get out the appendix, so a drain was put in and the wound closed around it. With regard to medical treatment, cases handed over from the allopath to the homœopath were an effectual means of showing the allopath that there was something more in homœopathy than they thought. A year ago last Christmas a patient of his—residing four or five miles distant—had been taken suddenly ill late at night. It was too late to send for him, so the patient's people called in the nearest man, who happened to be an allopath. The allopath reserved his diagnosis till the next morning, and then diagnosed acute appendicitis, and advised immediate operation. The patient's people then thought it was time to send for him (Dr. Hey). The allopath was sufficiently open-minded to meet him, and he (Dr. Hey) agreed with his diagnosis as to acute appendicitis, but differed with him on the question of immediate operation. To satisfy both the patient's relatives and the allopath, he suggested removing the patient to the hospital, and accordingly she was brought to the hospital that (Tuesday) afternoon, and treatment commenced at once. On the Wednesday the relatives came to see her, bringing the allopathic doctor with them. The temperature was down and the symptoms had almost disappeared. He (Dr. Hey) happening to be in the ward,

asked the allopath if he would like to see the patient, and conducted him to the bedside, and when he saw the patient the doctor was absolutely staggered. He drew him (Dr. Hey) aside and asked what he had done. He replied, "We have treated the patient homœopathically."

Dr. CLOWES PRITCHARD, in reply, said although a good many questions had been asked, they had been answered by subsequent speakers. With regard to Dr. Moir's case, he had intended to refer to such cases in his paper, but on reflection he thought if he put everything in, he would never get to the end of the subject. Sometimes one really did not know what to do. He thought all cases should be watched very closely, and the moment the practitioner had made up his mind to operate an operation should be performed at once without waste of time. To sum it up, he thought every case of appendicitis was a separate case in itself, and that one had to treat each individual case on its own merits. Dr. Thomas had asked why appendicitis was more frequent nowadays than it had been in the past. He (Dr. Pritchard) did not know; he did not think it was more frequent, but he thought the impression that it was was because practically every case at the present day was diagnosed as appendicitis. Dr. Goldsbrough had asked what were the symptoms of perforation. They were very often acute, sudden pain with an increase of the symptoms for a time. Sometimes perforation took place with very slight alteration in the symptoms, whereas at times very grave symptoms appeared, and the patient became quite collapsed. He had not noticed that constipation was more frequent after operating for appendicitis. That was a very interesting point; he had not hitherto looked for it. Appendicitis in children he had left severely alone in his paper. That was a subject on which one could write a volume. As to whether it was more frequent in children suffering from worms he did not know. He simply knew that a good many cases had happened, and now and again worms would be found in the appendix.

A CLINICAL EVENING.

IN connection with the *Section of Medicine and Pathology*, a Clinical Evening was conducted on Thursday, March 3, 1910, when the following cases were shown:—

*Chronic Plumbism.*¹

The patient, aged 60, was a house-painter, and had had a history of bad attacks of lead poisoning every year for fourteen years. Was admitted for acute vesicular dermatitis on both legs and forearms, but was found to have a blue line on the gums and a good trace of albumin in the urine. Wrist-drop was not noticed at first, but when it attracted attention was found to be very complete. The common extensor of the fingers, extensor proprius minimi digiti and extensor indicis were involved. The muscles were found to react most readily to faradization, so this was resorted to, and has been kept up regularly since the patient went home. Internally he has taken carbon. sulph. 6 steadily except for occasional intermissions. He can now extend all the fingers a little and can move them quite freely when the wrist is supported. The urine is free from albumin and no other gouty symptoms have appeared.

*Chronic Cervical Abscesses (Non-tuberculous).*¹

Patient is a native of Demerara, aged 29, a music-hall artiste by profession. Ten years ago had blood-poisoning in Demerara, and was laid up for nine months. Shortly afterwards had abscess on cranium, followed by exfoliation of bone, and cervical glands began to enlarge and then to suppurate, beginning on left side. Since this time (1901) has undergone four operations for removal of glands, and has had X-rays tried, all without benefit. He is not losing flesh, and general health remains quite good. Pus from sinuses contains staphylococci, but neither ray-fungus nor tubercle bacillus has been found. Is being treated with staphylococcus vaccine.

*Infantile Scurvy (Barlow's Disease).*²

W. F., aged 1. Admitted November 29, 1909, with pyrexia, great pain in limbs whenever touched, sub-periosteal effusions

¹ Exhibited by Dr. GALLEY BLACKLEY.

² Exhibited by Dr. ROBERSON DAY.

spongy gums, head sweating, and general flabbiness of the tissues.

Under treatment the child lost weight, the flabby tissues being replaced by firm healthy flesh, so that the present weight is the same as on admission, the quality having been changed.

Treatment has been chiefly calc. c. 12 and 30, and dietetic.

(Two skiagrams taken by Dr. McCulloch were exhibited showing very clearly the sub-periosteal effusions. Also a weight chart prepared by Dr. Woods.)

Dr. Wynne Thomas asked what was going to happen to the femur. Was the blood-clot going to be absorbed and the periosteum again become attached to the bone, or was there likely to be some exfoliation of the femur? He had had two cases of infantile scurvy under his treatment some time ago. Both patients were children, one fed on Nestle's milk. Both cases had hæmaturia, one having vomiting in addition, the other epistaxis. Both patients soon recovered under dietetic treatment, which consisted of lemon juice and the juice of fresh meat.

Mr. Eadie said he thought as a rule it was very exceptional for necrosis to take place in scurvy rickets.

Dr. Goldsbrough said he had had one case of infantile scurvy—the first he had seen, where the symptoms were extremely pronounced and the condition of the child was very grave when brought to him. The epiphyses of the upper extremities were separated, the joints greatly swollen, and there were hæmorrhages in various parts. The child rapidly recovered in about a month, under dietetic treatment, with phosphorus as medicine, the joints settling down, and the patient was now a strong boy of 10 or 11 years of age. There was never any disorganization of the joints at all.

*Chronic Bright's Disease.*¹

A. B., aged 11. Suffered from general anasarca and ascites, œdema of genital organs, &c. He was admitted January 10, 1910. Given apis 3x and a milk diet, and very rapidly the œdema disappeared. At first he passed large quantities of urine loaded with albumin; the albumin has lessened in amount, and he now takes apis 30.

Dr. Goldsbrough said he had himself published an almost similar case of Bright's disease to the above some years ago, where apis 3 cleared up the condition in a few days.

¹ Exhibited by Dr. ROBERSON DAY.

*Lymphadenoma.*¹

S. W., aged 21, single female, shop assistant. Lymphadenoma, chiefly neck and axilla. Began five years ago. Operated on two years ago, since when glands increased more rapidly. Marked improvement under calc. c. 10m (two doses). This improvement has continued since.

The patient left the hospital. For the past month she has been receiving ars. iod. 6 t.d.

Mr. Eadie said the teeth were in a very bad condition in this case, and he was perfectly certain that no cases of lymphadenoma would improve until the teeth were attended to.

Dr. Goldsbrough said he generally did examine the teeth in all cases of lymphadenoma, but he had only recently taken the case over from Dr. Moir and had not gone into it as thoroughly as he otherwise would have done. He thought the suggestion an admirable one.

Mr. Eadie had had a case in the hospital which he had intended to show, of a man aged 19, who had had a lymphadenoma for fourteen years. The patient was a carman, and some days ago in lifting a package from a cart he struck the swollen glands; three days afterwards the swelling had increased three times in size, and since that time it had gone on increasing until it was now of very considerable proportions. It was diagnosed as lymphosarcoma, and was one of those interesting terminations of lymphadenoma. Possibly the reason of the rapid growth was that the blow had burst the glands. In lymphosarcoma, the lymph tissue broke through the gland capsule and ran riot among the tissues. Whether the blow had been the means of starting that he was not prepared to say, but the growth had been extremely rapid since.

*Neurasthenia with Bladder Symptoms.*¹

J. C., clerk, aged 33. Admitted to hospital February 15, 1910, complaining of frequency of micturition, with pain in the perineum and stricture of the urethra. He had previously attended as an out-patient under Mr. Dudley Wright, who had passed bougies and given cantharis. History of gonorrhœa, and passing of gravel from time to time. Has become depressed and nervous the last five years; > open air. Dull pain in calves, wrists, forearms, all over head, root of nose, back of eyeballs; < wet weather. Weakness. Palpitation; when excited pulsations all

¹ Exhibited by Dr. GOLDSBROUGH.

over him. All symptoms pointed to pulsatilla, of which one dose of the 10m attenuation was given, the patient being kept in bed. In three days the improvement was most marked and striking. The nervous symptoms disappeared first, then the pains. Frequency of micturition soon markedly diminished. Improvement went on until March 16, when as the condition was at a standstill the pulsatilla was repeated. The patient was discharged on the 18th. (A report from this patient after an interval of six weeks stated that the improvement was entirely maintained.)

*Three Cases exhibiting the Power of Stimulating Absorption possessed by Homœopathic Remedies in High Potency and Unit Doses.*¹

(1) *Acquired Club-foot.*

G. L., case of acquired club-foot, with great rigidity and deformity (equino-varus), in a boy aged 10, dating from his third birthday. Treated by the Nerve Specialist at the Middlesex Hospital as Friedreich's ataxia.

Now, after fifteen months' treatment with homœopathic medicines, in unit doses and high potency, the foot has gradually become straight, the sole now goes to the ground (instead of the outside of the foot and the dorsum of the toes, as was the case), the contractions have nearly all disappeared, the toes can be moved and spread and the foot is supple, the muscles of the calf have developed, and lately the limb has become warm. The other symptoms—stammer, nystagmus, extension of the disease to the other foot—have either cleared up or have not developed.

During the fifteen months the boy has had three doses of zinc. c.m., five of tuberc., one of kali phos., and one of thuja.

(2) *Rigidity of Elbow of 4½ Years' Duration cured in Five Months by Five Doses of Graphites.*

E. D., aged 24, was attending in 1907 for stiffness of left elbow (fixed at an angle of 75°) and of both shoulders, ever since an attack of rheumatism eighteen months before. Was treated with little benefit with rhus, ruta, tuberc., symph., cimex. In February, 1908, had adhesions broken down.

Came back in May, 1909 (fifteen months later), in much the same state, and was given graph. c.m. weekly—four doses only.

When seen again in September there was astonishing improvement as regards movement. Graph c.m. once only.

¹ Exhibited by Dr. MARGARET TYLER.

October 26, shoulder and elbow free, and all the movements restored.

(3) *Case of Retinal Hæmorrhage and Optic Atrophy of Left Eye, as diagnosed by Mr. Knox Shaw.*

Mrs. C. Nine months' blindness of left eye. In six to seven weeks, after one dose of sulph. 200, patient could see. Mr. Shaw reports that the original hæmorrhage has absorbed, but that there is a small hæmorrhage at lower part of retina and a small patch of retinal degeneration. Patient still under treatment.

Dr. Goldsbrough thought Dr. Tyler's first case was distinctly poliomyelitis, and she was to be congratulated on the effects of the medicine. He had been treating such cases for a good many years, and they certainly responded to zincum and calc. carb.

*A Graphites Case.*¹

A case of long-standing epigastric pain, nausea, and retching, with craving for, and relief from, food, and presenting other suggestions for the drug. Relief following graphites c.m. single dose; improvement continued for one year.

*A Case for Diagnosis.*²

J. M., aged 9, reddish or copper-coloured inflammation of the skin on second and terminal phalanges of certain digits of both hands and feet. Beginning usually on dorsum, the process tends to girdle the digit, also sooner or later to break down, exuding pus from beneath a scab. Tends also, apparently, to spread by contiguity from one digit to the next. Accompanied by some tenderness, but not much pain. Of some six or seven weeks' duration.

General health excellent. Nothing in personal or family history. Patient says he had the same thing a year ago, lasting for about a month.

Dr. Goldsbrough said a few years ago Mr. (now Sir) Jonathan Hutchinson published a good many cases of what he called Raynaud's phenomena, *i.e.*, cases of nondescript atrophic affection of the fingers and toes which could not be quite called Raynaud's disease because there was scarcely enough to justify such a

¹ Exhibited by Dr. SEARSON.

² Exhibited by Dr. MILLER NEATBY.

description, but they could not be classified in any other way. It appeared to him (Dr. Goldsbrough) that Dr. Neatby's case came under that category, and he suggested secale as a medicine.

*A Case for Diagnosis.*¹

W., female, aged 19, had swelling off and on for five years of the right hand. Came up larger than now in a few days. No history of injury. Was ascribed by doctor then to a gnat sting. Has gone down several times to almost complete disappearance. Sharp pricking pain through the hand now, the swelling having a semi-elastic feel. It was Mr. Eadie's intention to amputate the hand on the diagnosis of malignant growth.

Subsequent History.—The hand was disarticulated at the wrist. The wound healed by first intention. The growth proved to be an osteo-sarcoma of the fourth metacarpal bone. So far patient has had no evidence of recurrence, primary or secondary.

*Lymphosarcoma.*²

G. O., male, aged 47. First seen in Out-patient Department, May 19, 1909. Complained of swelling behind angle of left jaw, rounded, and about 2 in. in diameter. First noticed January, 1909. Tentative diagnosis of tubercular glands. Tuberculin was given, and the swelling diminished for some little time. In October it commenced to grow rapidly, and was then diagnosed as lymphosarcoma. The patient was admitted to Bayes Ward of the London Homœopathic Hospital on November 13, 1909, for operation, with a large firm mass extending from level of external auditory meatus to clavicle. The skin over the mass was movable and dark red. There was no pain or difficulty in swallowing. The tumour itself seemed movable. General health good. On attempting removal the growth was found to be infiltrating in all directions, involving 2 in. of the great vessels of neck and vagus nerve, which had to be removed with it.

Dr. Hey mentioned the subsequent condition of the patient he had just exhibited. The operation was much more formidable than was at first anticipated, and had he not recently read up the subject he would have been chary at removing 2 in. of the carotid artery, the vagus nerve and the jugular vein, but he saw that that had previously been done in a few cases, and seeing those structures were definitely involved in the growth—so much

¹ Exhibited by Mr. JAMES EADIE.

² Exhibited by Dr. GRANVILLE HEY.

so that the pneumogastric nerve was so altered that it could not be identified without the aid of a microscope—there was no alternative. It was to be expected there would be some nervous phenomena from such interference, and the night after the operation the patient was very restless and in the early morning began struggling vigorously, went very cold, and kept calling out to have the fires lighted. The blocks under the head of the bed, which had been put there to counteract any tendency to hæmorrhage, were removed, and he was given *veratrum alb.* 200 every half-hour. In a few minutes after the first dose he calmed down and did not struggle again. The patient was thirsty and drank hot milk eagerly, vomiting the same at first. The left pupil was much contracted; both eyeballs bulging a good deal. The right pulse was good the whole time, but the left pulse could hardly be felt at wrist. He (Dr. Hey) could not explain that. All through the day the patient was only semi-conscious. The note of the same evening was to the effect that the patient had been sleeping quietly, passed no urine since the operation; was catheterized and only a few ounces drawn off. *Veratrum alb.* 200 was given every two hours, and on the 18th the patient was quite sensible. There were then signs of slight facial paralysis. Evidently the seventh nerve had not been injured at the time of the operation, although that would not have been surprising, considering that part of the parotid gland had to be removed. From that time the patient made an uninterrupted recovery. One interesting fact was that his mental condition has never been so clear since. He had never felt sufficient confidence to return to his work. The old symptoms in the jaw, which he (Dr. Hey) had referred to, disappeared under three irradiations with the X-rays. The man took his food well and had gained in weight since he left the hospital. One reason why he (Dr. Hey) had exhibited the case, apart from the severity of the operation, was in the hope of receiving some suggestions from those present as to any further treatment. Seeing that there were no signs of recurrence in the glands was it worth while attempting to get rid of the recurrence seen, or could any homœopathic treatment which would be serviceable be suggested, or should the X-ray treatment be continued?

Dr. Eadie enquired if there was a gland at the mastoid region.

Dr. Hey replied there was one gland, which had not enlarged since it was first noticed, about a fortnight previously. In fact he thought it was rather smaller when he saw it the previous day.

Three Cases illustrating the Physico-therapeutics of X-rays.¹(1) *Deafness.*¹

F. M., female, aged 18, a domestic. Labyrinthine deafness following scarlet fever in childhood; had also had optic neuritis. Was seen in January, 1909, as an out-patient.

Throat symptoms *nil*, some tinnitus. No very marked changes in either tympanum.

Right ear, Rinne's test, A C. Left ear, A C.

Has had X-rays weekly for two months and fortnightly for three months, and since then monthly applications of same to either mastoid alternately.

Hearing has greatly improved. No treatment for six months.

(2) *Alopecia.*¹

Mrs. F., aged 25, a milliner. Seen June 5, 1909. Premature neurotrophic, universal alopecia. Complete alopecia areata of seven years' duration following upon neurasthenia; no specific origin traceable. Husband was interviewed; married three years. No trace of febrile toxæmia. Her sisters have "thin heads of hair," but otherwise are normal. She was an out-patient at St. John's Hospital, Leicester Square, for two years, where stimulating external applications seem to have been resorted to till the epidermis scaled off in quantities. She lost the whole of her scalp hairs, eyebrows and eyelashes. She then attended the Skin Department at St. Mary's Hospital, where internal medication, presumably pilocarpin nit., was resorted to without success. Arsenic seems never to have been tried. X-ray treatment has restored the hair to the scalp, eyebrows and eyelashes partially.

(3) *Ulcers of Legs.*¹

C. P., female, aged 16, single and no occupation, seen on October 30, 1909, for intractable ulcers on the legs; seven on the right calf and one on the left; had been under specific treatment and the iodides. Clinical aspect suspiciously specific, but no clue to this cause could be ascertained. The ulcers also had the appearance of "Oriental sore," and a search made by the pathologist for spirochætæ was negative. No obvious lymphatic gland involvement in groins. These were, however, irradiated as a preliminary measure, and the floors of the ulcers being protected by lead-foil and zinc ointment, they were also irradiated for brief

¹ Exhibited by Dr. McCULLOCH.

periods. Healing was rapid, the sites of the sores being marked by a coppery stain. No photograph was taken at the outset.

*Chronic Empyema treated with Vaccine Injection.*¹

E. K. S., age 42, a married woman with three children, was taken ill with pleurisy with effusion. On November 3, 1907, she was treated by Dr. F. Cootes, of Leytonstone, for three weeks without benefit. Was then operated on. The wound remained open, and on seven occasions attempts have been made to do without the tube, without success. This continued to October, 1908.

In October, 1908, the patient came to Dr. C. E. Wheeler at the London Homœopathic Hospital, and was treated by him for two months. In January, 1909, she went to Westcliff for change of air. In March, 1909, she was very bad, and Dr. Wheeler advised vaccine treatment, in the hospital. From this the patient was dissuaded by Dr. Cootes, as he knew of a case where abscess of brain had followed such treatment.

In August, 1909, patient again saw Dr. Wheeler. She was admitted to Vaughan Morgan Ward to have vaccine prepared, which was done. The organisms which were obtained from the pus were pneumococci, in pure culture. Twelve flasks were put up—ten of 1 c.c. capacity, two of 0.5 c.c. capacity. The patient then left the hospital with these, and was injected by Dr. Ross, at Westcliff. Dr. Cootes had previously sent pus for examination to the Clinical Research Association, and the report was furnished that no T.B. were found and no pneumococci, but only disintegrated blood corpuscles. (The patient's own statement.)

The following is the history of the injections, of which she had eleven in all; the first five at weekly intervals, then two at ten days, and the last four at fortnightly intervals. The injections were standardized to 300,000,000 per 1 c.c.

First Injection, 9 a.m., 0.5 c.c. (= 150,000,000 organisms).—Felt very ill two hours after. Temperature rose to 103° F. It fell at 9 p.m., and next morning was normal.

Second Injection 0.5 c.c.—Same symptoms.

Third to Seventh Injections of 1.0 c.c.—No reaction.

Eighth Injection.—Temperature rose to 101° F., with malaise, &c., lasting about twelve hours.

¹ Exhibited by Dr. HARE, Pathologist to the London Homœopathic Hospital; a visitor to the Society.

Ninth to Eleventh Injections.—No reactions, patient felt quite well. The wound ceased to discharge after the fifth injection. The patient has felt well ever since, and to the date of this report has put on twenty-one pounds in weight.

Dr. Wynne Thomas said this case reminded him of the case he had had two years ago of a man aged 56, employed by a borough council. He suffered from empyema and the tube was used for some time, attempts being made to close the wound up. After a time the man came back with another collection of pus and again the tube was used. He, however, kept coming and going for about eighteen months, when Mr. Shaw happened to see the case and suggested that a vaccine should be tried. He (Dr. Thomas) had one prepared, and after three injections the wound healed and the patient had experienced no trouble since.

Mr. Eadie said this case reminded him of a case he had again seen a week ago. About six months ago he operated on a patient with a psoas abscess, clearing out the pus and stitching up the wound. The wound opened again, however, with a persistent discharge. Mr. Wright happened to see the case with Mr. Eadie and suggested cataphoresis. He (Mr. Eadie) gave a dose of phosphorus 200 and was making preparations to give the patient cataphoresis, when she arrived with the wound perfectly healed. The patient was now going on perfectly well and with no trouble whatever. If cataphoresis had been used one would have ascribed the good result entirely to that.

MINUTES OF THE SOCIETY MEETINGS.

THE SEVENTH MEETING of the Session 1909-10 was held at the London Homœopathic Hospital on Thursday, April 7, 1910, at eight o'clock, Dr. Stonham (Vice-President) in the chair. There were present also : Dr. Blackley, Dr. C. O. Bodman, Dr. Cooper, Dr. Roberson Day, Mr. Eadie, Dr. Goldsbrough, Dr. Vincent Green, Mr. Granville Hey, Dr. Jagielski, Dr. Kennedy, Dr. McCulloch, Dr. E. A. Neatby, Dr. Miller Neatby, Dr. Nield, Dr. Powell, Dr. W. P. Purdom, Mr. Knox Shaw, Dr. Wynne Thomas, Dr. Weir, Dr. Wheeler, Dr. Woods. Dr. Hare was announced as a visitor.

SECTION OF GENERAL MEDICINE AND PATHOLOGY.

In connection with the Section of General Medicine and Pathology a paper was read by Dr. C. Osmond Bodman, of Bristol, entitled "Pneumonia in Children, illustrated by Fifty Consecutive Cases without Mortality, treated at the New Orphan Houses, Bristol." A discussion ensued, which with the paper will be found on pp. 213 and 235 of this issue of the JOURNAL.

INTERNATIONAL HOMŒOPATHIC CONGRESS.

At a meeting of the Council of the Society, held on April 12, 1910, Dr. Speirs Alexander and Dr. Macnish were elected to represent the Society on a Committee being formed for arranging the International Homœopathic Congress to be held in London, in 1911. Dr. J. H. Clarke is the general secretary of the Congress.

The EIGHTH MEETING of the Session 1909-10 was held at the London Homœopathic Hospital on May 5, 1910, at eight o'clock, Dr. Macnish (President), in the chair. There were present also : Dr. Alexander, Dr. Burford, Dr. Cronin, Mr. Eadie, Mr. Ellwood, Mr. Falconer, Dr. Goldsbrough, Dr. Vincent Green, Dr. Ham, Mr. Granville Hey, Dr. Moir, Dr. E. A. Neatby, Dr. Pritchard, Mr. Knox Shaw, Dr. Stonham, Dr. Wynne Thomas, and Mr. Dudley Wright.

NEW FELLOWS.

Dr. Robert M. Le Hunte Cooper (elected member in 1903), and Dr. Charles E. Wheeler (elected member in 1894) were duly elected Fellows of the Society.

COMMEMORATION OF HAHNEMANN.

On the motion of Dr. Burford it was unanimously resolved that the Society should, through the Société Française d'Homœopathie, place a wreath on the tomb of Hahnemann annually on the 10th of April, the birthday of the founder of Homœopathy.

VISITORS.

Dr. Lang, of the London Homœopathic Hospital, and Dr. Daya S. Kaistha were welcomed as visitors to the Society.

SECTION OF SURGERY AND GYNÆCOLOGY.

A paper was read by Dr. W. Clowes Pritchard, of St. Leonards, on "Appendicitis and its Surgical Treatment," which with a discussion which followed appears on pp. 244 and 259 of the current issue of the JOURNAL.

THE DEATH OF HIS MAJESTY KING EDWARD THE SEVENTH.

At a meeting of the Council held on May 10, 1910, a Vote of Condolence with His Majesty King George the Fifth, and with Her Majesty Queen Alexandra, on the death of His Majesty King Edward the Seventh, in the following terms, was unanimously passed: "The President, Fellows and Members of the British Homœopathic Society respectfully tender to His Majesty the King, and to Her Majesty Queen Alexandra, and other members of the Royal Family, their deepest sympathy in the bereavement which they and the Empire have suffered by the death of His late Majesty King Edward the Seventh, and they beg to assure His Majesty the King of their loyal devotion to His Person and Throne."

The NINTH MEETING of the Session 1909-10 was held at the London Homœopathic Hospital on June 2, 1910, Dr. Macnish (President) in the chair. There were present also: Dr. Speirs Alexander, Dr. T. P. Alexander, Dr. Barrett, Dr. Bennett, Dr. Ashley Bird, Dr. Blackley, Dr. Bodman, Dr. C. O. Bodman, Dr. Burford, Dr. Burwood, Dr. Capper, Dr. Cavenagh, Dr. Clifton, Dr. Cox, Dr.

Roberson Day, Mr. Eadie, Dr. Ellwood, Dr. Gilbert, Dr. Goldsbrough, Dr. Greig, Dr. Clifton Harris, Dr. Hawkes, Mr. Granville Hey, Dr. Reed Hill, Dr. Jagielski, Dr. Johnstone, Dr. James Jones, Dr. Kennedy, Dr. Mason, Dr. McCulloch, Dr. Moir, Dr. E. A. Neatby, Dr. Neild, Dr. Nicholson, Dr. Norman, Dr. Ord, Dr. Pincott, Dr. Powell, Dr. Cash Reed, Dr. Robertson, Dr. Searson, Dr. Shackleton, Dr. Stonham, Dr. Wynne Thomas, Dr. Weir, Dr. Withinshaw, Dr. Woods, Dr. Dudley Wright, and others.

THE DEATH OF KING EDWARD THE SEVENTH.

The President referred to the sudden death of King Edward the Seventh, and called on the Honorary Secretary to read the Vote of Condolence drawn up by the Council. All the Fellows and Members present rose in their places to confirm the vote of the Council.

VISITORS.

Dr. Petrie Hoyle, Mr. Stanley Sanders, Dr. Lang, Mr. Ambrecht, Mr. Purchas, Mr. Nevill Davis, Mr. E. A. Attwood, and some of the Sisters of the Hospital Nursing Staff were present as visitors.

SECTION OF MATERIA MEDICA AND THERAPEUTICS.

An address, illustrated by lantern slides, specimens and apparatus, was delivered by Dr. George Burford, of London, entitled "Radium, and its Recent Therapeutics," summarizing personal visits to Joachimsthal, the European source of Radium, and to L'Institut du Radium in Paris, the head centre of Radium Therapeutics. This was followed by a short paper by Dr. Cash Reed, of Liverpool, entitled, "My impressions of a Visit to the Clinic of the Radium Institute in Paris." Mr. E. L. Ambrecht demonstrated the methods in use for the practical application of radium to various diseased states.

A hearty vote of thanks was accorded to the readers of the papers for the interesting and instructive evening afforded. A short discussion followed, taken part in by Dr. Blackley, Dr. Thomas, Dr. James Jones, Dr. Johnstone, Dr. McCulloch, and others, to which Dr. Burford replied. The papers on Radium, with the discussion, will appear in the October number of the JOURNAL.

PROCEEDINGS OF THE LIVERPOOL BRANCH.

THE SIXTH MONTHLY MEETING of the Session 1909-10 of the Liverpool Branch of the British Homœopathic Society was held in the Hahnemann Hospital, Liverpool, on March 10, the President (Dr. John D. Hayward) in the chair. The following members were also present: Drs. Bryan, Ellis, Gordon, Green, A. E. Hawkes, J. Hawkes, Chas. Hayward, Douglas Moir, Proctor, Cash Reed, and Gordon Smith.

Dr. A. E. Hawkes showed a specimen of hydronephrosis which he removed from a patient earlier in the week.

Dr. Cash Reed mentioned a case of apparent tetanus which was in the hospital. The patient had been operated on and was on the point of being discharged one month after, when she complained of inability to open the mouth. The muscles of the jaw were contracted, hands clasped, and muscles of the spine and arms were very rigid. Knees, when separated, sprang back. Temperature 102° to 103° F. Pulse 120. Condition of wound quite healed. Mouth in very septic condition. Veratrum v. and strychnine 6 were given every two hours, but of no avail. A 15-minim injection of solution of acid. carbolic. 1 in 50 was given with beneficial results, and patient recovered from her spastic condition.

The President then called upon Dr. Proctor to read his paper entitled "Our Therapeutic Position," of which the following is an abstract:—

After passing in review our controversy for the last hundred years, the paper showed how different ordinary scientific discovery is received to-day. Radium, for instance, or X-rays are either accepted or refuted very soon, whilst homœopathy is neither accepted nor refuted.

The ordinary orthodox practitioner adopts homœopathy partially, whilst denying it as a law; and homœopathic practitioners now include all new advances in science as part of their province, in addition to homœopathy, so that on each side there is an intermingling of all principles or systems of treatment. The obstacle to union apparently is the infinitesimal

dose, especially the higher attenuations which carry the mind beyond the reach of physical demonstration.

The objection to the law of similars is not the chief one, seeing that in all ages that has been more or less recognized, and in very recent times such things as the opsonic method is seen to be adopted without scruple, although it is on homœopathic lines. Homœopathic practitioners, on the other hand, fall back occasionally on antipathic methods for temporary relief, though they hold that the law of similars gives more permanent results. The isopathic treatment began in the homœopathic schools years ago, and was looked on with suspicion by many of its adherents, but it seems to be establishing its footing as a reliable mode of cure.

The homœopathic is not the only law of cure, but one of many; and it is a question which is best on special occasions, although the law of similars is preferred as a rule, and as it is the speciality of professed homœopaths, it falls to their lot to cultivate it, whilst they reserve the liberty to adopt any method that promises good to their patients.

The duty of removing toxic products from the body should be insisted on, depuration being an obligation of the first importance, whether addressed to intestinal or urinary toxæmia.

Doubt might be thrown on ordinary drugs being radio-active, and Hahnemann's springing at one bound from material dosage to the thirtieth was not the result of experience, but of his speculation respecting the nature of disease and the necessity of dynamizing the drug to liberate its spirit.

The appeal in future will not be to the Organon, but to experience; no person, however eminent, can stand against the demonstration of facts, and homœopathy must range itself in line with the rest of science.

Dr. Proctor was thanked by the members present for his paper, which was keenly discussed. The proceedings then terminated.

SUMMARY OF PHARMACODYNAMICS AND THERAPEUTICS.

Extracted from Exchange and other Journals by the Editor in collaboration with J. Galley Blackley, M.B.

Aconite in Post-Anæsthetic Delirium.—A man whose arm had been amputated near the shoulder-joint, after coming out of the anæsthetic became seriously delirious. He was very nervous and fearful, tossing and moaning. Repeatedly he declared he would surely die. "At six o'clock I will be dead," he said. This was repeated over and over again with variations. He was fast becoming unmanageable and had to be held in bed. He received aconite 3x and in less than a quarter of an hour he was quiet, and when six o'clock came he laughed when told of his delirious fears. (Dr. Carl Smith, in the *Pacific Coast Journal of Homœopathy*, March, p. 92.)—ED.

Antimonium crudum in Perforating Ulcer of the Foot.—A refugee woman about sixty years of age had perforating ulcer of the foot; the whole foot was swollen and of a bluish red hue. The ulcer was opposite the head of the first metatarsal bone. It discharged quantities of foul pus, and sinuses penetrated deeply between the muscles and the sole and the metatarsal bones, which were eroded. The toe-nails were thickened, misshapen, and covered with ridges; horny callosities covered the soles of the feet. Amputation was decided on; but pending preparations antim. crud. 6x was prescribed and the wound irrigated with sterile water and dressed with sterile gauze. Hydrogen peroxide was also used for the first two or three dressings, but not afterwards. Under this treatment the case improved so rapidly that amputation was postponed. In a month the foot was nearly well and the patient could walk with comfort. (Dr. Carl Smith, in the *Pacific Coast Journal of Homœopathy*, March, p. 92.)—ED.

Conium in Vertigo.—Dr. A. R. Griffiths, of Montreal, Canada, records the case of a man suffering from typhoid fever, who had a

distressing vertigo at the end of the third week of his illness. The disease had run a mild course, and had been helped towards the end by mercurius and lycopodium, but the vertigo persisted. It was intense and distressing, even on turning the head sideways and moving the eyes. He could not turn himself in bed even with assistance without intense giddiness. After the first dose of conium he began to improve and the giddiness was gone in a few days. (*New England Medical Gazette*, May, p. 218.)—ED.

Electro-therapy in Arterio-sclerosis.—Dr. S. T. Bindsall contributes an article in which he advocates the treatment of arterio-sclerosis by electricity. "The Morton wave-current and auto-condensation according to the methods of Dr. Arsonval meet the conditions in the great majority of cases. The arterial tension after each treatment is lowered from 15 to 50 mm. and increased elimination of solids from the urine is noticed where general metabolism is at fault; the use of the leucodescent lamp of high candle power, over the entire body, for 15 to 20 minutes at each sitting will be of great value. The principle laid down by Snow that auto-condensation is indicated in all cases in which hypertension is non-compensatory, and contra-indicated in all compensatory cases, is worth following." (*North American Journal of Homœopathy*, April, p. 252.)—ED.

Glonoine. Poisonings.—Under the heading, "Nitroglycerine Head," Dr. C. E. Laws, Du Pont, Wash., gives a very interesting *résumé* of the effect of nitroglycerine on those who are engaged in its manufacture. It fits in well with our homœopathic proving of that drug known in homœopathic pharmacy as *glonoine*. Here it is taken from the *Journal of the American Medical Association* for March. *Symptoms*: Within a period ranging from a few minutes to an hour or more after exposure the person experiences a sense of heat with fulness in the head and possibly a flushing of the skin. If the heart is examined now, an increased action will be noted, but this is followed by a marked retardation. One premonitory symptom noted by many is a complete loss of vision either in one or both eyes, the headache not coming on until complete restoration of sight. The most distressing and dreaded symptom is the headache which rapidly supervenes. Owing to the direct action of the drug on the muscular coats of the arteries there is a marked dilatation of these vessels. To this dilatation of the vessels of the brain and cord may be laid the cause of the throbbing which the poor sufferer experiences.

He holds his head between his hands to relieve it, and when he steps on the ground or attempts to stoop over, he often cries out with pain. Sometimes he becomes maniacal, running about, shouting, and striking his head against obstacles. The recumbent posture is often unbearable, and he must pass his time in the upright position, sleep being out of the question.

The pain is sometimes located in the back part of the cranium, sometimes it is frontal and at others general. The duration of the attack is from a few hours to one or two days. Nausea and vomiting with loss of appetite are frequent symptoms. The genito-urinary system comes in for its share of disturbance too, there being frequent urination with the passage of large quantities of light-coloured urine of low specific gravity. Nitroglycerine is a marked aphrodisiac, and most "glycerine men" have large families.

All who work with the drug are sooner or later troubled with dyspnoea and tachycardia on exertion. Alcohol causes a flushing in some that very much resembles scarlet fever. Others are unable to touch it at all, and it is a well-known fact that "powder men become easily intoxicated."

Several men have been in the business for many years, one in particular who enjoys excellent health after twenty-five years' service, with the exception of shortness of breath on any undue exertion. There is an increase in the area of heart dulness and a rather slow pulse. Some people enjoy a natural immunity to the action of the drug, while others must acquire it, and the process is painful.

After being out of it for one day sometimes a man goes back to work and becomes sick. This attack, however, is comparatively slight, and he can continue without much inconvenience. Others, while not working, will rub a small amount into the skin or keep some on the hat-band, so that they may always be in condition. There is apparently nothing that will give the poor sufferers relief. In slight cases, in those who are more or less accustomed to the drug, a hearty meal and a good sleep will straighten them out, but in the severe cases all the remedies suggested, such as phenacetin, chloroform, morphia, &c., have little or no effect. Hot baths do well in some cases, but a warm atmosphere aggravates the symptoms. (Quoted in the *Homœopathic Recorder*, April, 1910, p. 160.)—ED.

Meningitis. *Treatment.*—A paper has been read on this subject by Dr. H. B. Minton, before the Homœopathic Medical

Society of the State of New York. Dr. Minton considered the treatment under the following heads: General hygiene of the sick room, baths, lumbar puncture, serum injections, and homœopathic remedies. Enforced rest and quiet are absolutely essential in the treatment of these cases. Any sudden noise or excitement may be productive of much harm. In the epidemic form isolation should be adopted. A simple easily-digested liquid food should be given. If the patient is unconscious or unable to swallow, the stomach tube or rectal feeding may be required. Hot baths are specially recommended in the cerebrospinal type. The temperature of the bath should be 100° to 105° and should be continued twenty minutes and repeated in three hours. As soon as the symptoms warrant the diagnosis of meningitis, lumbar puncture should be made, for purposes of confirmation, for determining precisely the type of disease present, and for such benefit as may be directly attributed to decreasing the intertheal pressure, and in the epidemic form, for the purpose of introducing antimeningococcic serum into the subarachnoid space. The bacteriological findings, either by culture or by direct examination of the sediment, may reveal the presence of the pneumococcus, the tubercle bacillus, or the diplococcus intercellularis. In traumatic cases removal of the excessive pressure by drainage is the appropriate treatment. In Dr. Minton's opinion, tuberculous meningitis is always fatal, also cases with infection of streptococcus or pneumococcus, but with meningococcus they sometimes get well. In cases of epidemic form showing leucocytosis and the diplococcus intercellularis, the use of the Flexner serum offers the best opportunity for control of the disease. 30 c.c. should be introduced into the cannula used in lumbar puncture, before its withdrawal. In severe cases the treatment is repeated in five days. Homœopathic remedies are best indicated before the disease reaches the pronounced type, especially if meningeal symptoms are ensuing in the course of any other acute disease. Dr. Minton gives the remedies indicated for separate symptoms rather than from an analysis of the whole, but suggests the latter as essential to choice of the remedy. For instance, in stiffness, rigidity and contraction of muscles, bryonia, actæa, cicuta, and others are indicated. Vomiting points to ant. tart., sulph., chloral, and cuprum acet. Irregularity of pulse and respiration, camphor, opium, ant. tart., bell., and ailanthus. Cerebral irritability, bell., acon., bry., apis, cuprum acet. Stupor, opium and cannabis ind. Convulsions, cannab. ind., hyos., ver. vir., and specially cicuta. Other symptoms might call for helleborus, gelsemium, or argent. nit. Cicuta,

cuprum acet., and kali iod., are specially to be considered in the cerebrospinal form. (*Hahnemannian Monthly*, May, 1910.)—ED.

Niccolum sulphuricum. *A Proving.*—In 1908, Dr. J. C. Fahnestock, of Piqua, proved sulphate of nickel on himself and others, using the 2x, 3x, and 6x trituration supplied by Boericke and Tafel. The following is a condensed report. Dr. Fahnestock began by taking the 3x trituration every two hours until symptoms were produced, then stopping it. He took 60 gr. The first night he dreamed of a bad taste and saliva in his mouth, and, on waking, his mouth was full of saliva with coppery taste, and he was obliged to spit. Next night pains in occiput at 2 a.m., urine +. Next morning shooting pains in hands and fingers. Soreness in cervical region, going down spine, followed with much heat of face, fulness of temples, pain in both zygomes and in teeth. Tongue red and sore, taste and salivation continue. Loss of appetite, dizziness, and general weakness ensued. The symptoms continued for ten days and gradually disappeared. In January and April, 1909, a similar proving was undertaken with the 3x and 2x triturations respectively. The result was similar, with the exception that in the latter case the symptoms lasted three weeks.

Miss F. began by taking 5 gr. of 6x trituration of nic. sulph. on July 27, 1908, and continued it for two days. On morning of July 30, bad, coppery taste in mouth; at noon, head felt big and heavy. Legs and arms heavy and weak, unsteady when walking. Face flushed and hot. Eyes began to burn and ache. Head heavy as if it needed a prop. Obligated to lie down. Next day was rather better. On fourth day felt well again. This experience was repeated in August.

Mrs. E. took 3 gr. of nic. sulph. 3x every two hours on January 25 and 26, 1909. At 2 p.m. began to have dull, aching pains in ovaries, then hot flushes, which came on every half to one hour. These continued, but she did not take cold. Needed to uncover and fan herself; followed by perspiration. This continued two days. On second day, pain in neck and occiput, extending to eyeballs. Pulling sensation eyeballs to occiput, < turning head side to side and lying on back at night. Spine became sore the entire length, > lying on side. Obligated to get up to urinate three or four times in night. Tongue white at first, afterwards brown. Nerves uneasy, could not settle. Perspiration occurred in parts of body in contact, then on exposure would dry immediately. Symptoms lasted six weeks, relieved by sepia and

picric acid. (*Journal of American Institute of Homœopathy*, April, p. 224.)—ED.

Thymol. *A Proving.*—A proving of thymol on two young men, students of the University, has been conducted at the Homœopathic Department of the University of Michigan, and reported by Dr. R. R. Mellon. Thymol occurs in colourless crystals, insoluble in water and in intestinal fluids, but readily in alcohol and then easily absorbed from the intestinal tract. It is extracted from the oil of thyme with cymene, and is closely chemically related to phenol and carbolic acid. The two provers were kept on a regular diet, and throughout the proving observed regular habits otherwise, as was their wont. The normal limits of their urinary output were estimated before the proving began. The provers knew nothing of the drug they were taking. An arbitrary tincture was made from 1 grain to ethyl alcohol 95 per cent. From this dilutions were run on the decimal scale. During the second week of observation the 3x was given in doses of 4 c.c. four times a day. During the third week 4 c.c. of 2x, and during the fourth week 4 c.c. of 1x, the latter five times a day. At the end of this week the stomachs of the provers became so irritable that the proving could not be carried on with impunity. Both provers were healthy energetic young men of exemplary habits. *Symptoms*: At end of second week, profuse seminal emissions for three or four nights in succession, then a night or two supervened and they recurred. Lascivious dreams of perverted sexual intercourse, at first realistic, subsequently phantasmal. Awoke tired and unrefreshed. Priapism during night and easily excited to lewd thoughts during the day in one prover. Mild burning in the urethra. Micturition followed by dribbling. Tired, aching feeling throughout lumbar region, much aggravated by mental or physical labour. Energy gone. Became irritable and arbitrary. Refused to be contradicted, and self-willed. Pursued by "blue devils." One prover craved company and could not bear to be alone. Normally seminal emissions occurred in these men every three or four weeks, followed by relief. *Analyses*: Some slight polyuria was noticed, urates showed slight progressive increase, chlorides and phosphates a decrease, while sulphates and urea remain normal or slightly decreased. If anything the drug would tend to retard metabolic change. The drug produces a typical sexual neurasthenia, and its application in this common condition naturally suggests itself. (*University Homœopathic Observer*, April, p. 49.)—ED.

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DR. GOLDSBROUGH, 82, Wimpole Street, London, W.*

RADIUM IN MODERN MEDICINE.¹

BY GEORGE BURFORD, M.B.

Senior Physician for Diseases of Women to the London Homœopathic Hospital.

ABSTRACT.

The renaissance of medicine.—The recent addition of new provinces to the territory of the “Law of Similars.” Radium, after revolutionizing physics and chemistry, enters the domain of medicine.

Joachimsthal in Bohemia, the main European source of radium: its present yield—except for Austria—*nil*. *L’Institut du Radium in Paris*: the richness of its equipment, the many-sided therapeutic activities there carried on. A description of some striking cures personally observed there.

The physical basis of this radiant energy new to therapeutics. Radium is the perpetual source of four separate and distinct discharges, each having a separate and distinct therapeutic value. The microcosmic *materia medica* of radium.

The therapeutics of radium:—

(a) Method of operation. Its action, *e.g.*, in cancer, is not “specific” or “selective”; it reinforces the protective mechanisms of the body against disease, and stimulates the reparative processes tending to restore the normal.

¹ Presented to the Section of General Medicine and Pathology, June 2, 1910.

Its therapeutics therefore are polyvalent ; its action is local on whatever diseased growth or tissue it can be brought into contact with.

(b) Sphere of operation. Its curative effects already demonstrated in malignant disease, benignant growths, cheloid cicatricial bands, nævi, tuberculosis of skin and mucosa, eczema, lupus, pruritus, neuralgia (*e.g.*, after herpes), port-wine stains, &c.

The practical use of radium:—In the solid form : dissolved or suspended in fluid. Ingestion : inhalation.

The necessary data for the external application of radium include :—

- The strength of the radium salt.
- The quantity employed.
- The area of application.
- The nature of the containing instrument.
- The available radiation leaving the apparatus (screening, &c.).

Further detail for calculating the result :—

- The duration of each application.
- The frequency of repetition.
- The repetition of courses.
- Single instrumentation, or “crossfires.”

Radium therapeutics, a striking instance of the applied “Law of Similars.”

(a) Radium cures in small doses similar conditions to those it causes in excess. The simpler morbid processes (dermatitis, ulceration, &c.), are *at once* caused by massive dosage. The more varied results of prolonged over-dosage are “unfavourable stimulation which may excite morbid evolution.” Such are the conditions which *dynamic* dosage cures.

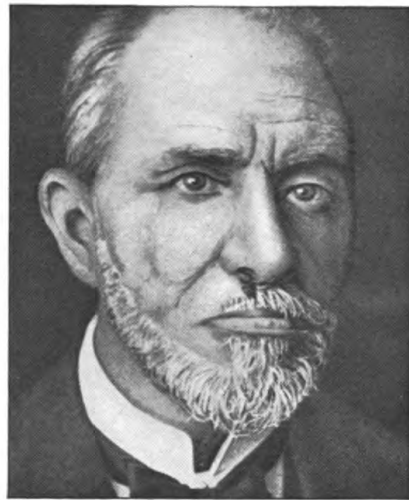
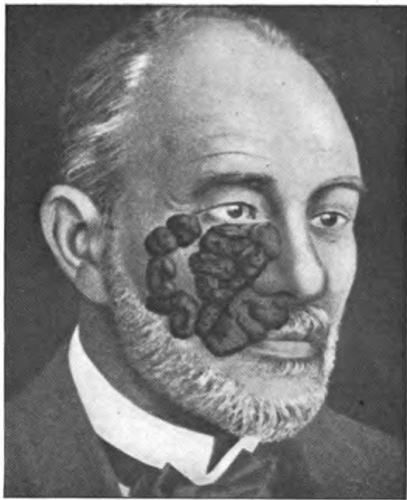
(b) Consequently in radium, as with other Homœopathic remedies, there is a “critical point,” below which its action is curative—above which it is pathogenic. This is an alternative cell-response peculiar to homœopathic action.

(c) The cure is effected, not by direct action on the diseased, but by heightening the protective mechanism of the normal tissues. Radium evokes the vital reaction of the healthy organism against the diseased processes. (Proved histologically in the case of cancer.)

(d) Attenuation over a considerable range of dosage is practically necessary and practicable in radium-therapy.

SECTION I.

DR. ALFRED RUSSEL WALLACE, reviewing the Georgio-Victorian Era, is moved to call it the “wonderful century” ; and in the very forefront of the achievements which warrant this laudation are placed anæsthetics and anti-septics in surgery. Medically the choice is unbalanced, for it omits to include the law of neutralization by similars. But the great biologist’s imagination had been fired by the



NÆVUS OF FACE, CURED BY RADIUM.

Patient, aged 55: growths formerly treated by Electrolysis.

“The tissues are smooth and even, rather lighter and more like mother of pearl than normal skin.”

“The improvement was so great that the patient was no longer recognisable.”



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Radium Therapeutics, a
Summary

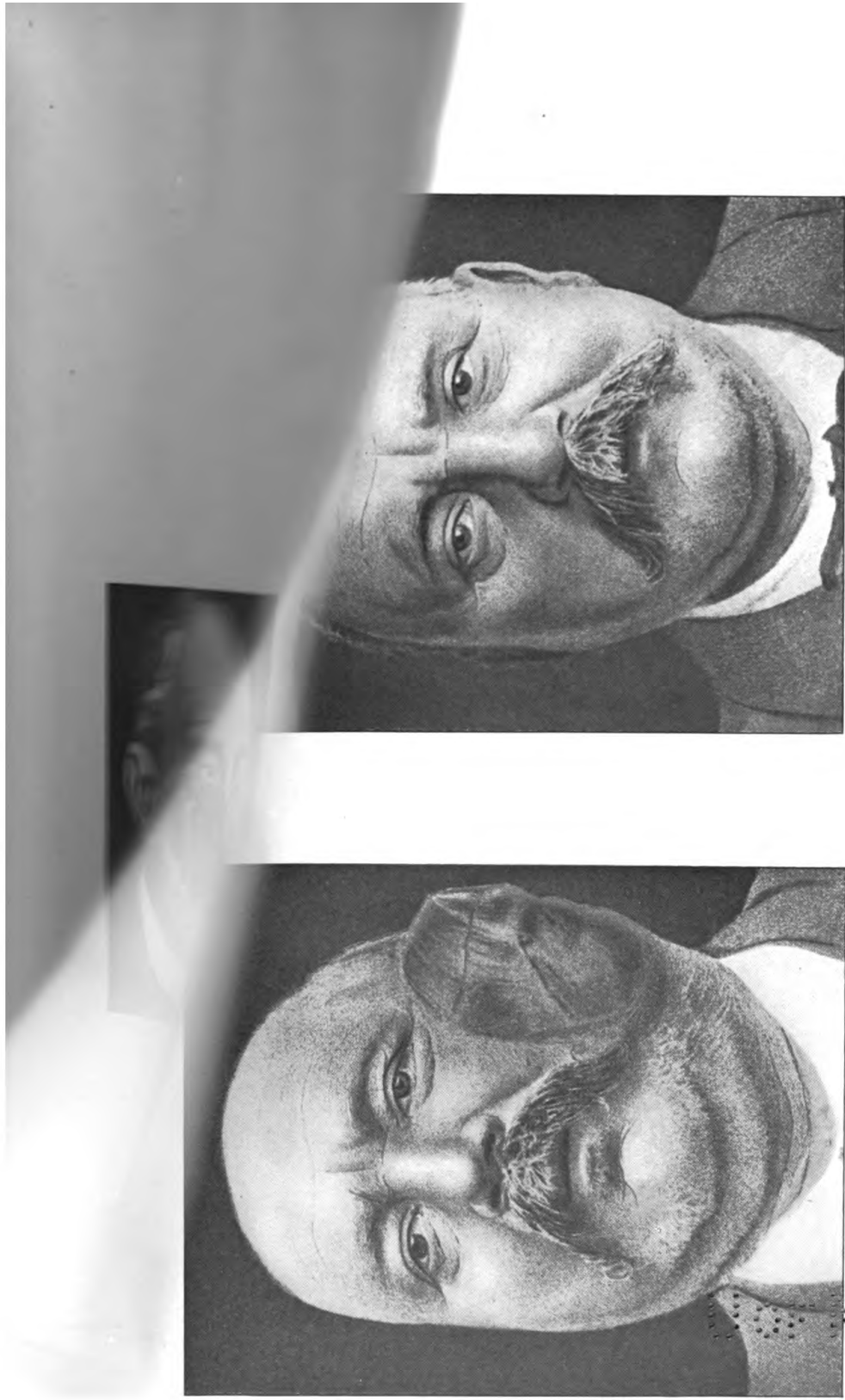
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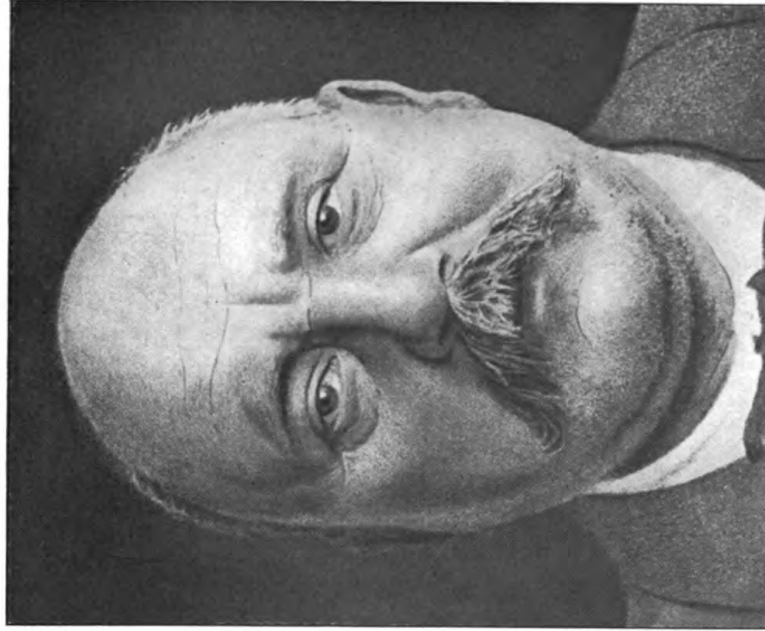
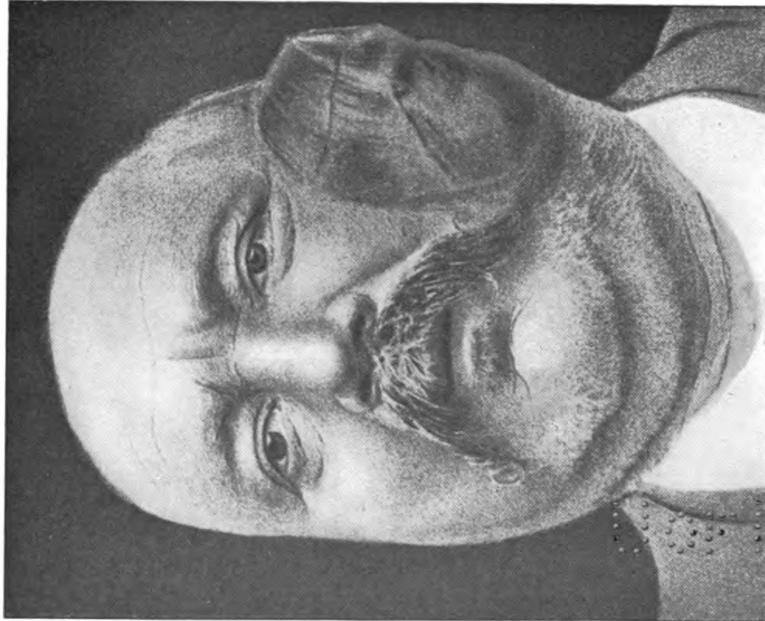
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CANCER OF FACE, CURED BY RADIUM.
TIME OCCUPIED IN CURE (WITH INTERVALS) FIVE MONTHS.

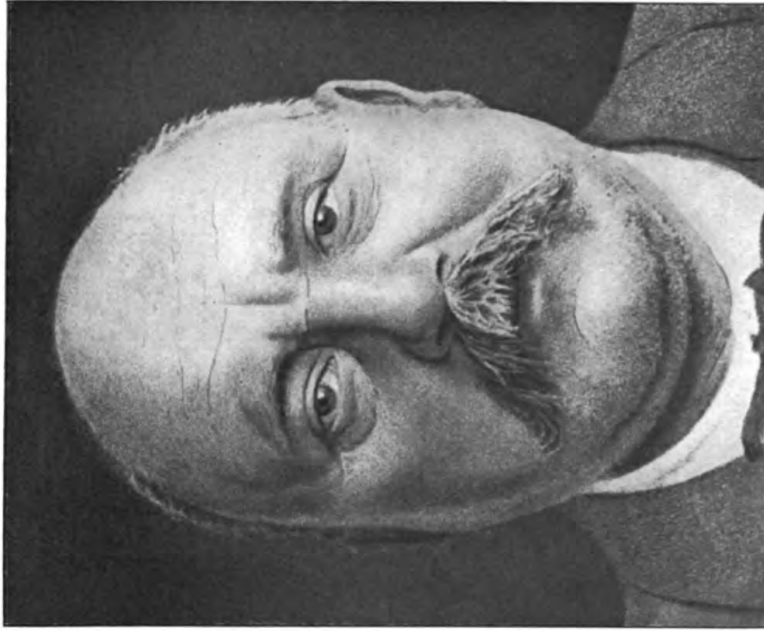
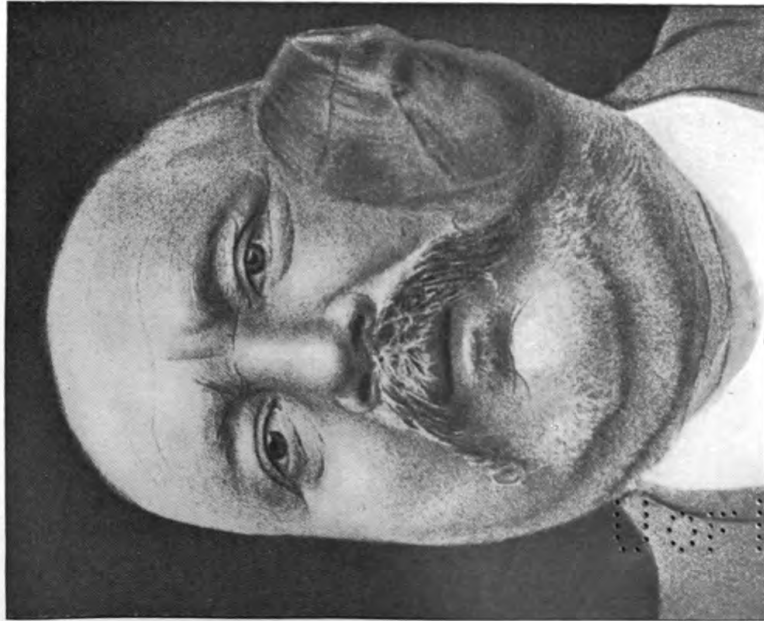
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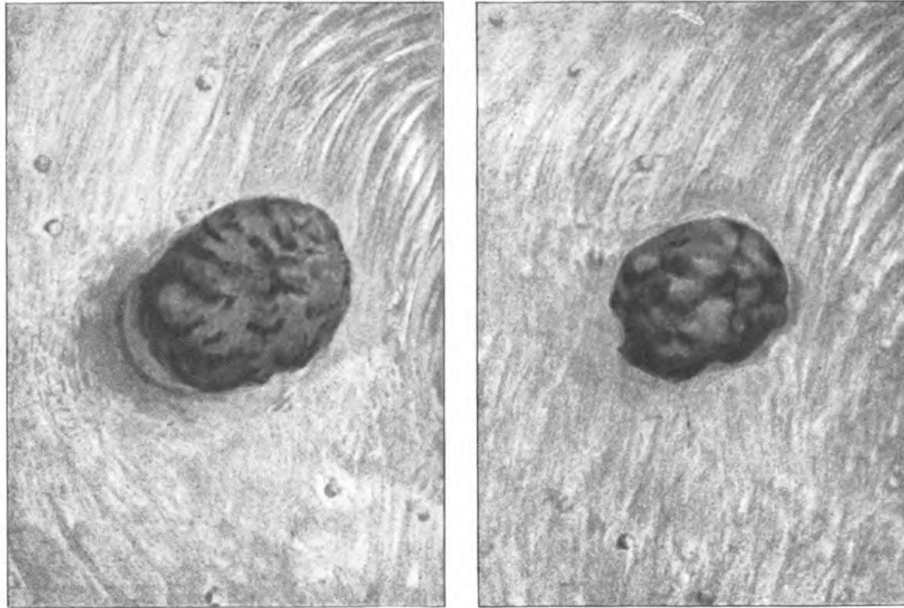




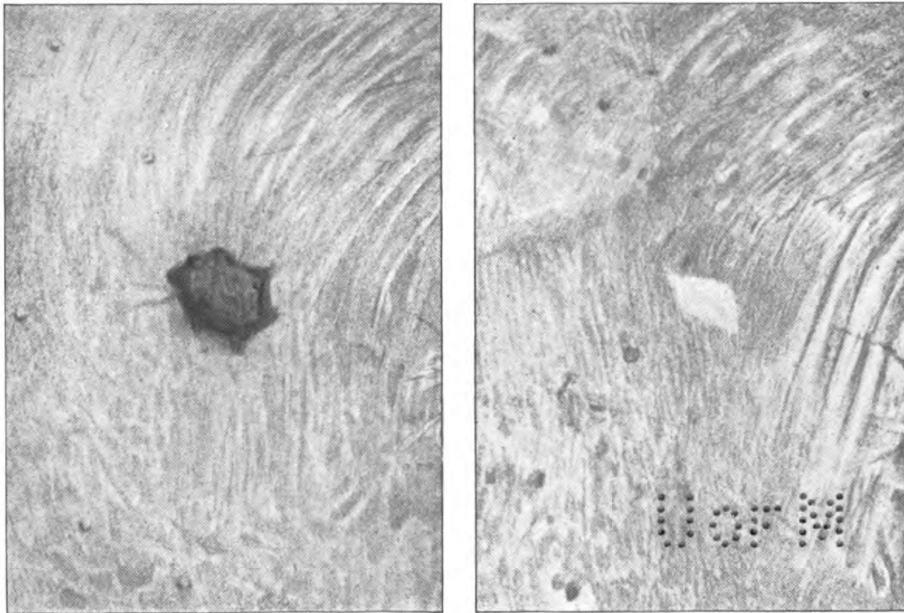
CANCER OF FACE, CURED BY RADIUM.
TIME OCCUPIED IN CURE (WITH INTERVALS) FIVE MONTHS.

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EPITHELIOMA OF SCALP:



FOUR STAGES IN CURE BY RADIUM.



TIME OCCUPIED IN CURE, THIRTY DAYS.

1700

yield of those new regions which surgery had fixed for ever in its domain, and which invests this wonderful century with the honour of the *Renaissance of Surgery*.

The coadjutor of Darwin, with that curious limitation of outlook which marks *patres conscripti*, taking that sexagenarian theory of values which made Huxley declare that every scientific man after 60 should be decapitated as an obstructionist—Dr. Alfred Russel Wallace regards the progress of medicine in the “wonderful century” as comparatively small, and limits its sphere of usefulness to fresh air, and other influences of Nature. But even while this was being said the heralds of an ampler day were already assembling. Von Behring was adding his great province of toxin and antitoxin to the continent of homœopathy, and had sufficient lucid insight to see it and say it. Almroth Wright, Arch-Homœopath, had evolved his vaccine therapy, and made *lux in tenebris* of the dose question by his opsonic indicator. Malaria and tubercle had been solved as problems of medicine, and their prevention merely a matter of State subsidies and the doctrines of the Fabian Society. Here, then, with the new century scarce begun, was the long-looked-for dawn of the *Renaissance of Medicine*.

The pendulum of the healing art is swinging out of the surgical into the therapeutic part of its arc. But not yet has it touched its highest ordinate. Radium, after revolutionizing chemistry and physics, has entered the domain of medicine. The limitations which beset the older therapeutics are swept aside, a stream of remedial influence is disclosed which sweeps right through the bodily mechanism of prevention and the bodily mechanism of repair. It has more power for the cure of malignancy than any therapeutic that has seen the light; it bids fair to despoil surgery of half its present and prospective spoils, and that these issues are well within the bounds of fact and probability any one can verify for himself who will see with his own eyes the daily work of the Radium Institute in Paris. Radium bids fair to add more trophies to the Renaissance of Medicine than any event since the discovery of the Law of Similars in the earlier part of the “wonderful century.”

The Discovery of Radio-activity and of Radium.

The history of radium is that of scientific topsy-turvydom, and might properly be taken from some scientific "Alice in Wonderland." Radium belongs to a wholly new type of physical substances and was isolated in a wholly new way. It has its Wallace-Darwin episode, and Becquerel played the Wallace to the Curie's Darwin. Becquerel accidentally discovered in 1896 that uranium emitted rays which could photograph in the dark. A hunt was straightway made for the bodies possessing this extraordinary property. Uranium was found to do this *in excelsis*. Now the principal uranium mines are at Joachimsthal in Austria; and Madame Curie being an Austrian, presumably knew something of the habitat of uranium-ore, commonly called pitchblende.

Uranium ores, after uranium had been removed, were found much more radio-active than the uranium itself; and after enormous labour, lasting over seven months, Madame Curie obtained, out of two tons of uranium-ore residues, three-quarters of a grain of a new radio-active body which was appropriately termed radium.

I have said that a new method was employed in the isolation of radium. The most delicate instrument hitherto available by the chemist, the spectroscope, would have been altogether useless for the discovery and isolation of radium. It was the electroscope that found itself 150,000 times more subtle than the infinitesimal requirements of the spectroscope in the detection of radium with its congeners, that enabled the Curies to discover that substance whose therapeutic values we consider to-night.

It was in Paris that the epoch-making discovery was made, and to Paris belongs the honour also of its discovery as a powerful therapeutic agent. Nor was this association a merely fortuitous one. The earlier physical investigations into radium were conducted in Paris, and drew the supplies thither. The therapeutists were supplied with radium by the physical investigators, and the original work of each was thus linked up in a scientific succession. Paris accordingly took and has maintained the lead in radium-

therapeutics, and accordingly in Paris is found the leading radium institute in the world for the cure of disease.

Joachimsthal—Paris.

The therapeutic powers of radium were disclosed in the first instance by pure accident. Becquerel in 1901 inadvertently placed a tube containing pure radium in his waist-coat pocket. A fortnight afterward a severe burn developed on the skin beneath. Curie, himself, made a similar experiment with like results. These hints were not lost on the alert intelligence of the radium circle. A small quantity of the wizard material was handed over by Professor Curie to the authorities of the St. Louis Hospital, and the therapeutic values of radium were now slowly and with much difficulty worked out. Foremost in the pursuit of this inquiry was Wickham, and to him, with his colleague, Degrais, we owe in the main the establishment of radium therapeutics on a scientific basis. Wickham pursued his inquiries in a definite manner, paying special attention from the first to measurements of ray-values, to filtration by screens, and to dosage. As the outcome of these labours, the Laboratoire Biologique du Radium was established, with a physical as well as a therapeutic department. On the therapeutic side, systematized observations have thus been made over a period of some four years, and embracing more than 900 cases, and the guiding principle deliberately laid down was this: "Assertions must be made with great caution, and always based on a sufficient length of time and number of cases."

In 1909 Dr. Wickham came over to England by invitation and delivered an epoch-making address before a section of the Royal Society of Medicine. That address was enthralling; it was comparable to the story of an explorer, in its wealth of new material, its quite unanticipated results, and its vividness and power. The élite of the medical profession were there; and the civic importance of the new revelation was typified by the presence of the chief civic personage in the country, the Lord Mayor of London. I heard this address, I saw the delineation of the cases before

and after treatment, I noted the variety and significance of the diseases dealt with ; and the issues staggered my powers of belief. If a half were true, radium held the potency and promise of a change as great in medicine as it had already effected in physics and chemistry.

I had already had some experience in the use of radium in private practice ; but my results, to the extraordinary successes depicted by Wickham in his London address were, to use a poetic simile, as moonlight unto sunlight and as water unto wine. Inspired by new zeal, I extended and amplified my radium therapeutics, and secured some passable results. Still they were not within a day's march of the brilliant records of the master hands in Paris. In particular I may record a case in which Dr. Eugène Cronin was interested, of combined peri-nephritic abscess with heavy pyuria, due to a mixed infection. Vaccine treatment, successful as a passing phase, had finally broken down, the patient was over 75 years of age ; and finally complete and permanent cure was effected by the use of gelatine styles, charged with radium.

During my visit to Vienna last autumn, I made it my business to ascertain what was being done with radium in that world-famous clinic. I was received with every courtesy by Professor Freund, the eminent dermatologist, but to my surprise and disappointment, I found that no systematic investigations were being made into the therapeutic powers of radium in Vienna. The Chancellery, said Professor Freund, was accumulating the available radium from their uranium mines before distribution to the Vienna clinics. Just before leaving England, I saw that our late King Edward had motored over from Marienbad to the uranium mines in Joachimsthal (whence nearly all the available radium had come) and had with *éclat* drunk a glass of natural radio-active water issuing from a local spring. I had also heard rumours of radium baths that were being administered in this radium territory ; and on leaving Marienbad I went, armed with a letter of introduction, into the hinterland, up the Joachimsthal valley, to make investigations at first hand. The uranium mines

here, which are Government property, are under the direction of Herr Josef Step. My first inquiry of this official was, Have you any radium to sell? "*Gar nichts*," he replied, "all we obtain we are under orders to keep." Next, as the valley must have been charged for countless years with radium emanation, I wondered if a state of chronic proving existed! and I asked, Is skin disease prevalent in this valley, especially among the workers in the mines? I gathered that there was no evidence of this, and I saw nothing to make me doubt the statement.

Further queries and responses passed: and finally inquired, Have you any bath establishments here, for the application of the natural radium spring water? "We have," replied he, "received medical orders for over 280 baths, administered this year"; and I further gathered that suitable bath buildings were in course of erection properly to meet the demands of the situation.

Thereafter, I was shown the process by which radium is extracted, and its potency measured; and I left Joachimsthal with the assurance that this, the chief source of radium hitherto discovered, was at present, as regards output, closed to the world at large.

My Continental inquiries hitherto had been sterile in result. Still, I could not forget the impression that a New Age had dawned in the therapeutics of the almost incurable—an impression derived from the variety of Wickham's cases and the verifying photographs. I continued my work with radium in selected cases; in *pruritus vulvæ* I secured results that were most gratifying, and in a case of large fungating cancer of the breast, seen with Dr. Cooper, the external application of radium brought about a most notable change for the better in the melting away of a considerable portion of the bulk without mass necrosis and with much lessened discharge—an eliminative process that is still continuing.

My successes, and my failures, convinced me that the effective therapeutic handling of radium was a far more complex problem than could be solved within the experience of a single personality. Once more the devouring thirst for

knowledge—a relic of academic days—led me to seek the fountain-head; and I determined I would see for myself the *modus operandi* of the semi-miraculous cases I had heard described.

A prior correspondence with Dr. Wickham brought a courteous invitation to visit the Radium Institute; and my friend Dr. Cash Reed and myself accordingly went over to Paris during the Easter vacation for this purpose.

L'Institut du Radium.

The Radium Institute provides for a private and public ambulatory clinic; there are no beds. This clinic is very well appointed; water-colour drawings have been made of the more striking cases, some of which we have had reproduced as lantern slides for this evening's address. The Directors of this clinic are Dr. Wickham and Dr. Degrais of the Hôpital St. Louis. Both are physicians of high repute and recognized scientific standing. I am informed, though I cannot vouch for the statement, that some £30,000 worth of radium is at the service of this Institute for the conduct of its work.

In the public clinic are to be seen persons of all ages and both sexes, simultaneously undergoing the prescribed treatment under the supervision of two skilled nurses. Each patient has a specified course as to duration, mode, and strength of application, which the nurses in charge deftly carry out. Babies with nævi, girls with port-wine stains, women and men with various superficial forms of malignant disease, *e.g.*, rodent ulcer and epithelioma, crowd the apartment. Each remains his or her specified time: one, two, or three hours, as may be, and in a book the nurses note the practical detail of the actual applications. The patients read, converse, and comport themselves with that good humour characteristic of a Parisian assembly.

Malignant Disease.—The first case I saw was sufficiently startling. A woman of mature years had been operated on for removal of a cancerous breast. In due course recurrence had taken place. I saw the water-colour drawing of the case at the commencement of the radium treatment.

At the inner extremity of the scar was a nodule 4 cm. in length and 3 cm. in height. It was about the bulk of a walnut. Its angry, livid, ulcerated appearance was most unprepossessing. I have no hesitation in saying that the poor woman was beyond help from any surgical measures,—it was an inoperable case—while I know no therapeutics that would have done what I am now about to tell you. The woman had daily applications of radium by the method of crossfires—five totally—during a period of six weeks. There were, I am told, rays from £1,500 worth of radium utilized in these daily applications. And now, gentlemen, after six weeks' treatment I could scarcely believe the testimony of my eyes. Side by side with the drawing of the original condition stood the patient, Dr. Degrais having kindly sent for her in order that I might see for myself. In place of the livid ulcerating mass was a smooth, supple, painless cicatrix, the sole remnant of a threatening state as one in recurrent cancer commonly sees. I looked on the picture and on the patient, and I think if this cure had been effected in the Middle Ages in the same way in six short weeks, both doctor and patient would certainly have been burnt as necromancer and as witch.

The next case was one of an English gentleman whose personal acquaintance I unfortunately missed. The first coloured drawing showed a mass of cancerous glands at the root of the neck, about the size of a small fist, ulcerating, livid, and immobile. The head was held on one side, the facial expression that of acute pain. The same plan of treatment was adopted, and the case was still under treatment when the second drawing was done. But already what a change! The head was now erect, the mass had diminished by about a half, the angry, red, ulcerous area was being replaced by cicatrix, and the case seemed to be making fair headway. This improvement, I believe, had been effected in about six months. Let those of you who may have a patient to treat in this parlous state, a mass of ulcerating carcinomatous glands at the base of the neck, feel how gloomy the outlook would have been with even

the most sublimated of modern scientific therapy prayed in aid; but here, not many leagues from London, potent therapeutic measures such as these are safely and pleasantly under weigh.

Now I think little of the heart and imagination of a man not fired by beholding such unique sights as these. It was to me like the discovery of a new world, and if I had seen no more, I should have felt amply repaid for my journey to Paris. But the rooms are thronged with patients undergoing radium treatment, and you are bidden to move about, see for yourself, ask questions, take notes, and given every opportunity for personal investigation.

These cases I relate were demonstrated out of a large general assemblage by Dr. Degrais personally.

The next striking case was that of a man with epithelioma of the left cheek. The original area was apparently that of a sixpence. This was cured in four applications of three hours, two hours, one hour, and one hour, respectively. Over the site of the aforesaid epithelioma my notes state that the skin appeared soft and supple.

I am informed by Dr. Degrais that tumours below the surface, so far below as not to be visible, are proper conditions for the effective application of radium. Such, for example, as growths deep in the substance of the breast with sound tissue intervening.

So much for malignant disease; but radium sweeps much more into its therapeutic net beside malignancy.

Rodent Ulcer.—There is its cousin-german, rodent ulcer. This is most effectively treated with radium of high potency, so applied that the rays are rigidly confined to the breach of surface only. Otherwise an avoidable dermatitis would be superadded to the disease. I need not quote any cases—they are legion—except one, which may interest you. A very exalted English personage, the victim of rodent ulcer, availed himself of the intermediation of one of the most eminent dermatologists of the day. This professional gentleman thus accredited, had the service and the experience of the Institute at his disposal. Radium treatment with this inspiration was carried out with striking success; and the

appreciation of the distinguished patient was manifested in a way and to a degree not often vouchsafed to the members of our liberal profession.

Lupus.—Lupus and its congeners come for treatment there thick as leaves in Vallombrosa. I saw a striking case of a girl approaching the end of her cure. Her nose at the commencement, said Dr. Degrais, was the lupoid nose of the voluminous bulbous kind. Now the whole lesion had been reduced to a single sore spot, scarcely attracting notice, and the nasal outline was well defined, the graceful contour restored.

Vascular Nævi and Port-wine Stains.—Even more numerous were the so-called port-wine stains and the vascular nævi of the adult and the child. For the former, the sole hope often lies in radium; for the latter, radium is the method of election of the mother, because of its painlessness, the entire freedom from contraction of the scar, and its uniform certainty of result. Two cases of facial port-wine stain cured by radium applications I saw side by side. One had been treated in the early days of the experience of the Institute; the area extended over one-quarter of the face; the result was obliteration of the unsightly stain, but the replacing tissue was thick and lumpy, and in spots faintly pigmented—a successful but not a good result. The second case was initially similar, but with how different a result! The replacing tissue was thin and pink, with the bloom of a healthy complexion. Why this difference in final result between these two cases? We were told that this was solely a question of dosage. The first was one of those earlier cases, before right experience as to dose-results had accumulated. The dosage had been strong, and the work quickly put through. The latter and ideal result had been brought about by a much weaker apparatus, corresponding to only 50,000 units, the full strength being 2,000,000.

Cheloids.—A case of cheloid mass in the neck attracted my attention. It was that of a young girl, and the area of involvement extended all along the side of the neck, parallel to a half of the lower jaw. This unsightly growth was under process of being dispelled by treatment with radium.

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And thus I could continue in the narration of cases in process of cure—cases observed at the clinic—cases allowing careful personal inspection and inquiry. Nævi of the vascular kind, port-wine stains, lupus, eczema, psoriasis, malignant disease of the breast, sarcoma of the inguinal glands, keloid, rodent ulcer, this is an epitome of the maladies I saw under treatment there.

The Physics of Radium.

What is the physical basis of the radiant energy thus pressed into the service of therapeutics ?

The discovery of radium was one of the finest intellectual achievements of the human mind in scientific history. The further analysis of the matter and force streaming from the physical substance constitute an intellectual discipline no less severe.

Radium is the perpetual source of four separate and distinct discharges each having a separate and distinct therapeutic value. These are Alpha rays, Beta rays, Gamma rays, Radium Emanation. These together constitute the crude totality of the microcosmic materia medica of the element radium.

Taking the percentage total of the rays: the Alpha constitute 90 per cent., the Beta 9 per cent., the Gamma 1 per cent., as emitted from naked radium. Let us mentally glance at these radium factors, *passim*.

(1) The *Alpha* rays are material particles, the positive corpuscles of Thomson, each about the size of a hydrogen atom, and are expelled from the radium mass at a speed of from 12 to 20,000 miles a second. Despite this initial velocity, they are but feebly penetrative, ceasing their course even in air at a distance varying from 3 to 7 in., and being unable to pass a thin sheet of rubber. They are also unable to penetrate the human skin. It is these rays when naked radium is applied that do most damage to the skin, readily causing radium dermatitis. As the radium increases in age, five different values of A rays make their appearance: they are no longer homogeneous.

(2) *Beta* rays are more sublimated products. They also

are material particles—the negative corpuscles of Thomson—and these are each 2,000 times smaller than the Alpha particles. But their powers of penetration are, on the other hand, 500 times greater; nor is this to be wondered at, since they are expelled with the velocity of light from the radium mass (200,000 miles per second). Some of them will penetrate human skin to the tissues underneath: I say some of them, since these rays are not homogeneous, but various in their powers of penetration, and are divided roughly into soft B, medium B, and hard B. The soft B rays are likest the A rays, and are stopped by the skin: it is the medium and hard B that penetrate somewhat more deeply.

(3) The *Gamma* rays are of a physical character totally different from their congeners, the A and B rays. They are not particulate matter at all, they are ethereal waves, caused probably by the flight of the A and B particles. Their velocity is immense, and their power of penetration much greater than the A and B rays. They easily penetrate the skin, and dive deep into the subjacent tissues. These are the rays that are potent in eliminating subcutaneous growths, the skin being unaffected.

There yet remains as a factor in the output of radium rays an extraordinary substance called radium emanation, a gas emitted by radium, diffused in definite quantities through the whole radium mass, and, like its source, possessing radio-active qualities. This emanation possesses the astonishing power of making substances with which it comes into contact also radio-active, and this without their containing a particle of radium themselves. In this way mineral waters, passing through a radium-bearing earth, become themselves radio-active from passing contact with the emanation. Like other new qualities this acquired radio-activity in waters soon vanishes unless perpetually renewed; and so mineral waters, radio-active at their source, rapidly deteriorate in this new quality when removed from constant renewing contact with the radium emanation in the earth. Radium emanation, then, is the medium through which certain of the qualities of radium are

temporarily conferred on recipient solids and fluids without any direct participation or loss of radium itself.

The microcosm of radium then contains four separate and distinct factors; each, like the alkaloids of bark or opium, having a separate therapeutic value. These four have as their physical basis the element itself, *fons et origo* of rays and emanation alike, and having the physical qualities of weight and mass. The rays cannot for therapeutic purposes be completely isolated; the emanation may be isolated, but the A and B rays actually constitute a whole gamut of radiations, an ascending sense of powers, in which the extremes are characteristically different, but where means insensibly merge.

SECTION II.—RADIUM: ITS PROCESSES OF CURE.

It would be strange indeed if such a new revelation as radium only enlarged our therapeutic powers of action. Quite as interesting as the wider range given to treatment is the *modus operandi* by which radium effects its cures. It gives intellectual completeness to our knowledge to know not only the issue, but also the method.

"I am never tired," said Huxley, "of telling Spencer that *a priori* men are mostly wrong." *A priori* men, unable to divest themselves of the dominant idea that remedies must be "specific" or "selective," have boldly waded in, and claimed for radium a "specific" or "selective" action on certain diseased tissues. This is set forth with all due gravity in this otherwise impeccable work of Wickham and Degrais. But the Imperial Cancer Research Fund, in their

second scientific Report, have dissipated this fallacy effectively. "This view," says Dr. Bashford, "has even been maintained by authors, whose own observations were opposed to it."

Take the leading case of cancer. The biological processes by which radium cures cancer have been experimentally demonstrated with extreme care by the Imperial Cancer Research authorities. And what is the upshot? Briefly that the curative action of radium on cancer is not exerted on the cancer tissues themselves, but on the healthy tissues in the proximity; that there is no evidence, experimental or histological, that radium has any direct selective or specific action on the cells of cancer. *The evidence is definite that radium cures cancerous growths by direct action on the healthy tissues and not on the diseased.*

What is this evidence? After radium has been applied the cancer cells remain for some time quite unaltered; these cells retain their normal activity.

But other changes are in full blast. The local healthy connective tissue cells at once respond to the stimulus; they undergo enormous hypertrophy, break up the new growth by their proliferation, invade the lobules of the tumour, and split it into smaller alveoli; and in due course, partly by altering the nutritive conditions of the cancerous growth, and partly by phagocytosis, the cancer cells undergo retrograde change, become vacuolated, and are finally absorbed.

All these changes may be expressed in terms of *the heightened activity of the cells normal to the body*. The cure proceeds by working the normal powers of bodily resistance, by stimulating the protective mechanism of Nature.

Now this is the method by which radium works for the cure of cancer, heightening the powers of bodily resistance.

A German observer named Orth has adduced some striking observations which link up with this view. In some of those all too rare cases, where spontaneous healing of epithelioma was going on, what did he find? Why, just

a parallel process to that I have described as proceeding under the influence of radium. The same series of changes was developing, a heightened natural resistance was eliminating the invading growth. In natural and in radium therapy alike the biological process of cure is one and the same; not specific action on the diseased, but stimulating action on the healthy tissues. Nor in cancer is the curative process merely local. It links up with constitutional protection in a very definite way.

One of the findings of Inaugural Cancer Research is that when unplanted cancer is cured by absorption, that such absorption considerably heightens the bodily resistance *against recurrence*, makes the animal immune in fact. In other words, the organism thus immunized is better protected against recurrence than if it had had no cancer phase at all; the resistance is higher than in the normal organism. This immunity is in a high degree specific for the special form of cancer absorbed; in a lower degree for malignant growths in general; and its time limit is not permanent. Yet, such as it is, just such an immunity is produced by absorption under radium. This is proof positive of the generalized issues of radium therapy in cancer.

I am not aware of the radium-curative process having been histologically followed up in any other lesion. The usual gross idea has been adopted that radium somehow cures disease by acting on the diseased elements in tissues. It is far more probable that it does not so act directly, but only by stimulating the regenerative forces to healthy replacement. This is precisely Hahnemann's idea that disease was cured by stimulating the normal vital process, healthy bodily reaction; and not by violently bundling diseased structures directly out of doors, the healthy tissues standing by with the interested detachment of referees.

We may take it then as a good working hypothesis that radium has no specific and selective action on disease, other than reinforcing the *protective* mechanism of the body against morbidity, stimulating the *reparative* mechanism of the body to regain the normal. Spontaneously, it cease-

lessly imparts that energy which many remedial measures can only evoke, and links up with the *vis medicatrix naturæ* wherever it can be fitly applied. Already it has shown us how to attack such a problem as cancer, in its ultimate issues the despair alike of medicine and of surgery; and by its own polyvalency substitutes the single for the thousand multiplied adjustments in which old-time therapeutics still luxuriate. To neglect to rise to the new plane of work of which radium is the portal, would be to repeat the scene in Bunyan's immortal allegory, and miss the crown in the upper air for the unconsidered trifles below.

SECTION III.—THE THERAPEUTICS OF RADIUM.

Its Generalized Results in Attenuation.

The first authority in this country to deal with the therapeutics of this wizard material from the dynamic aspect was Dr. Clarke. He, in a paper read before this Society, described from provings in the higher dilution the sphere of action of radium when potentized. It is pioneer work, and I cannot but hope that some of the new enthusiasm for potencies as expressed not in figures, but in consonants, will not content itself with the labours of others, but take up original research on its own account. Radium has not yet found its way between those widespread portals, the covers of Kent. Here is a fine opportunity for one anxious to add something to the world's knowledge to carry on Dr. Clarke's opening work, and investigate radium as thoroughly as

lycopodium, or sulphur. Dr. Clarke has brought radium within the homœopathic materia medica by his verification of its curative powers as already observed, and by his recount of provings. To his work I must refer you for the latest and most up-to-date account of radium among the attenuations.

The Therapeutics of Local Application.

Quite other and purely local influences issue from radium which are of the very highest value in delimited maladies; it is of such localized workings I propose now to speak. These are respectively destructive and dynamic.

It was the biological destructiveness of radium that first directed the attention of investigators to its therapeutic powers. I have detailed how Becquerel suffered severely from inadvertently leaving a tube of unscreened radium in his waistcoat pocket. Professor Curie deliberately applied it to his arm, and history repeated itself in the form of a localized ulcer in the propinquity of the radium application. This pathological action of radium occurs when the critical or indifferent point is passed, which separates it from the dynamic curative action. This pathological or destructive action is utilized when morbid tissues require to be melted away by molecular destruction, such as sprouting carcinoma, pigmentary nævi, &c. In this way any grade of pathological action can be produced at will—from simple inflammation of the skin to inflammation and destruction of the skin and tissues underneath. It is solely and wholly a matter of dosage.

But on the other side of the critical point, where the dosage is never strong enough to produce pathological action, the dynamic or curative properties of radium assert themselves. There is no inflammation, no visible radium reaction of any kind; cure is proceeding with no surplusage of effect.

In radium radiations to be used as a remedial measure there is one *sine qua non*; the lesion must be localized and accessible. "Radium only acts locally; it plays no part in generalized infections." The lesion must be sufficiently

accessible for radium rays to be directly driven into the diseased structure. This limitation, however, must not be taken broadly; it does not exclude deep-seated growths as those of the uterus, the pylorus, the prostate; all these are accessible from the point of view of radium therapy. So also are tumours of the anterior mediastinum, and deeply placed mammary growths. Naturally, most experience has been had with those lesions which are most accessible and most delimited. The list is a very varied one.

(1) *External Malignant Growths*.—Here, in recurrent growths and in inoperable states, the results have been equally good, as in cases of primary growths surgically manageable. I show you here a series of slides photographed from a recent work of Drs. Wickham and Degrais, and published by Messrs. Cassell in this country. By the courtesy of this firm I am allowed to reproduce these pictures in lantern-slide form specially for this meeting.

(A) *Fungating Epithelioma of Temporal Region*.—Case of an old man; growth 3 cm. in height and 3 cm. in width. On the thirty-fifth day a complete cicatrix had formed, and cure was complete. A year afterwards the cicatrix was scarcely detectable.

(B) *Rodent Ulcer showing Malignant Characters*.—It was 2 cm. long, 1 cm. broad. Had resisted other forms of treatment; base of ulcer of "alarming appearance." Case occupied from December 6 to February 12. Sound cicatrix two and a half years after recovery.

(C) *Epithelioma of Ear*.—About the size of a shilling; the growth projected about 3 to 4 mm. Cure by thirty-fifth day. A year later there was no sign by which the repaired tissues could be distinguished from those around them.

(D) *Epithelioma of Parotid Region*.—Patient aged 55, presenting on left cheek an enormous projecting tumour; it was solidly rooted in the tissues, and could not be moved without at the same time moving the head. "It was as hard as plaster." The growth was ulcerated at the top. There was a slight glandular swelling in the submaxillary region.

The histology was that of an epithelioma. Treatment occupied twenty-seven weeks; the skin had almost recovered its normal colour; the ulcer was cicatrized. Resolution is nearly complete; only two small hard movable projections being left, which appear to be fibro-sclerotic remains.

So much for cancer cases. We next come to the radium treatment of DISFIGURING SCARS and CHELOIDS.

CHELOIDS.

Cheloids seem most amenable to the remedial action of radium. Wickham and Degrais speak of fifty cases successfully treated without relapse.

(1) Girl, aged 12, cheloid indurated and deep, 6 or 8 mm. above the surface; there was severe pruritus. Radium treatment was applied in series, first for three days then an interval of six weeks; then for ten days, followed by another interval of six weeks, and so on. In about six or eight months what remained of the growth was scarcely visible; the tissues were supple, the skin was a little whiter than normal.

(2) Pre-sternal cheloid; relapse after surgical removal to three times its original dimensions. The growth was prominent, reddish violet, 4 to 5 cm. long by 1 to 5 cm. wide; hard to the touch. After about twenty-five weeks, with prolonged intervals between treatment, the skin took on an almost normal appearance, scarcely to be distinguished from surrounding healthy skin.

DISFIGURING SCARS.

Patient, aged 32, showing scars following seven years' suppuration of glands in the neck. The projections consisted of cheloidal hard thick bands. Two applications of radium at intervals of several months were made. The cheloids when last seen had melted away, the fibrous bands quite disappeared, the tissues being smooth, even, and whiter than the surrounding skin. The present state has existed for fourteen months.

But it is in the region of the angiomas—the vascular growths—that radium is most frequently utilized.

ANGIOMATA.

Case 1. Prominent Vascular Nævus.—Patient, aged 35. The two white streaks crossing the growth are the result of electrolyses, which the patient would not continue because of the pain they caused. The growth was of the papillated strawberry kind. The treatment occupied five hours, spread over nineteen days. Two years later, the tissues show no sign even of a scar. Comment is needless.

Case 2.—Patient, aged 28. Nævus dark red, like port wine: projection from 4 to 6 mm. The inequality of the surface was marked by hard yellowish streaks, and white depressed scars, the result of unsuccessful electrolysis. The nævus has now been healed for fifteen months: the surface is smooth and even, somewhat spoiled by the old electrolytic scars.

Case 3. Angiomatous Tumour.—An infant, aged 18 months, with enormous angiomatous tumour. The aspect of the child was “positively hideous.” Various operations had only exaggerated the unsightliness of the lesions, covering them with disfiguring scars. The lids of the right eye were drawn and retracted.

Photograph taken during the course of treatment. In comparison with the parts not yet subjected to radium, a rounded, rose-coloured surface is seen, scarcely showing any difference from the healthy skin around it: the scars had disappeared.

The radium was afterwards used for other parts of the nævus with the same result.

Case 4. Angiomatous Tumour in Adult.—A man, aged 55, with serpentine bands of angiomatous growth on the face. These bands were hard and prominent: and such angiomata are much more refractory in adults than in children. Repeated applications produced the result exhibited. The spot under the nose still remains to be treated.

Vascular Nævus covering the Left Half of the Face and infiltrating the Whole Cheek.

This was a nævus of such size and depth that no permanently successful treatment seemed possible. It was deeply coloured, of enormous size, and all this half of the face seemed swollen or thickened. The lesions were of a kind that hitherto had been refused treatment.

Radium was variously applied, and over a period covering some months. Considering the extremely forbidding nature of the case, the results were eminently satisfactory. The swelling disappeared; a pinkish tint now remains, indicating the area of the aforesaid disfiguring lesion. “From an æsthetic point of view the results are not complete, but they have given entire satisfaction to the patient. This young work-girl considers herself saved from a frightful and humiliating infirmity, which caused her to be dismissed

from workshops and deprived her of the means of livelihood."

Pigmentary Tumour.

In a child aged 11. The mass not only filled the entire nasal cavity, but also overhung the nose. Three months after the completion of treatment, the tumour had completely disappeared, the left nostril had gradually recovered its former size. The tissues are perfectly supple and there is no retraction

SECTION IV.—THE PRACTICAL USE OF RADIUM.—
THE TECHNIQUE.

To secure the therapeutic virtues of radium as a radio-active body, we may employ it as emanation, or dissolved, or suspended in various fluids, or finally and usually, in the solid form.

Radium Emanation.

This, a radio-active gas given off by radium, but separate and apart from this, has been as yet but little used. Nevertheless, Wickham and Degrais consider that a future is in store for it, from the encouraging and definite results they have obtained. It may be used—

(a) *By inhalation*, mixed with air. The emanation, given off by a solution of radium, is aspirated with a large volume of air into an exhausted receiver, and thence respired.

(b) *By solution*. Insoluble radium salts placed in fluids, continue to give off emanation, which is taken up by the fluid, this becoming radio-active with no loss of the radium

salt. Unfortunately, the duration of this radio-activity in the fluid, removed from its source, is very brief. At its best, it declines to half value in four days.

The best natural example of this is in mineral waters. Many of these are radio-active from the radium emanation caught up in their course through radiferous earth. On coming to the surface they at once begin to lose their borrowed radio-activity. This doubtless accounts in some measure for the difference in action between mineral waters on the spot, and when imbibed at a distance and after a time.

Next, fluids like water, or oil, or glycerine can be artificially charged with the emanation by sufficient exposure to radium, or by pumping emanation-laden air through. The fluid may be swallowed, or injected into cavities, sinuses, various tissues, and tumours.

I believe Mr. Ambrecht will demonstrate to us a new method for condensing radium emanation so as to ensure the retention of its power for three weeks—a great gain on any plan hitherto adopted.

Far and away in point of importance—past, present, or future—in winning from radium its best therapeutic results is the method of direct application.

Yet a study of the higher mathematics is almost holiday exercise compared with the complexities of radium dosage when the remedy is properly adjusted to the patient's condition. Futile persons of the happy-go-lucky order have brought much discredit already on radium treatment, regarding themselves as fully equipped by the light of Nature, and not taking the all-necessary trouble to sit at the feet of the masters in technique.

The main practical questions are :—

How to obtain the maximum satisfactory result ?

How to ensure the elimination of risk due to faulty adjustment ?

I have already drawn your attention to the cases of port-wine stain—in one of which the issue was perfect, in the other imperfect—owing to inexperience as regards dosage.

The following data enter into the composition of a radium prescription.

Strength of the Radium Salt Employed.

The varied strengths of the radium for therapeutic use are expressed in terms of units of uranium. Uranium radio-activity is styled 1.

Pure radium being two million times more radio-active than uranium, has the value of two million units. Many different strengths of radium are employed, such as 2,000,000—that is pure—1,000,000, 500,000, 100,000, 50,000, 20,000, 10,000 units, and others. Thus radium of approximately 2,000,000 units is used in malignant disease; radium of 10,000 units for marks on a baby's face. *Experientia docet* is the only prescription I can give you.

The Quantity of Radium Employed.

Obviously the more radium salt is employed, the more total radio-activation from the utilized dilution you will get. Yet if radium particles overlie each other, much of their radiation is confused and lost in the substance of the salt. Wickham and Degrais make an ingenious distinction between the value of the radium used in any instrument and the actual value of the radiation that leaves it. This latter they call the available radiation. Two instruments were compared, each of the same dimensions, and charged with radium-bromide of the same potency (quarter full strength), each emitting the same proportion of α , β , and γ rays. One, however, was loaded with twice as much weight of salt as the other; one contained 2 decigrammes, the other only 1 decigramme. Were the available radiations from the larger quantity approximately doubled? Not at all. From the lesser mass the total available radiations leaving the instrument were 17,000 per cm. What from the larger? Only 20,500. A doubled weight of radium—an increase in available energy of only one-seventh!

Size and Surface of Apparatus Used.

Here another complication enters. Given a lesion of a certain size, more available energy can be got from an

instrument of larger area with dilute radium than from one of smaller size with pure radium. This, of course, within limits; but, *ceteris paribus*, the larger the area of application on one level, the more do the various rays reinforce each other; and a dilute salt spread over a wider area may bring about a stronger and more rapid reaction than a more powerful salt, more limited in its area of application.

The Nature of the Containing Instrument.

It is now obvious that a prescription based on considerations of weight, of dilution, and of area may be confused unless the surface is a homogeneous surface, each part emitting the same radiant values; if not, the radio-activity will be patchy, and the result patchy, too. The thin layer of radium particles must be fixed; the particles kept *in situ*. How is this effected? A skilled French chemist has prepared a varnish, with which the radium dust is incorporated; this varnish on setting remains hard, smooth, and durable. It fixes the radium particles permanently *in situ*; it allows the easy passage of most of the radium rays. The maximum available radiation from a thin radium layer is thus secured, and kept permanent. The safe treatment of lesions of a surface was impossible until this method, or an equivalent, was adopted. In lesions of a surface it has altogether replaced the earlier cruder methods of tubes, or ebonite containers and so forth, for in these accuracy was impossible. If radium particles were movable there was great inequality of action, and much difference in the total radiation emitted, according as the radium was heaped up, or distributed.

The fixation of the radium particles on a celluloid or metal plate by a varnish allows all kinds of shapes and sizes to be constructed as instruments of application.

So much for flat surfaces. But for cavities, sinuses, passages, and so on, cylindrical, or spherical, or conical, or specially shaped skeleton structures are used, coated with radium varnish like the flat applicators.

Glass tubes containing radium salt in prescribed strengths are used to insert into the middle of tumours, or placed in

catheters for introduction into the urethra, œsophagus, artificial anus, and so on.

A very useful form of radium application is the "toile" or linen, covered with radium varnish. These "toiles" are flexible, are radio-active back and front, can be made convex or concave, or fitted on to irregular surfaces, and are very advantageous where flexibility is required over a large surface, *e.g.*, the arm of a child.

Now I come to by far the most important factor in the radium prescription.

It is the sifting out of the rays that are not wanted for the treatment of the case in hand. This filtration is effected by the interposition of materials of different kinds called screens.

For protective purposes the radium plate is enwrapped with a fine sheet of rubber. This virtually is a screen, for it stops many of the α rays. The varnish itself is also a screen—absorbing more α rays. What α rays do get through are immediately stopped by the skin. There remain the β and γ . Now by further screening, these—the total available radiations—may be varied in all quantities and all proportions.

When the destructive action of radium is required, no screening is used.

The γ -rays are the most deeply penetrating; there are not many of them in the total radiation, they have to be accumulated by long exposures. But during these long exposures, lasting twelve or twenty-four hours at a time, the skin and superficial tissues would be hopelessly ruined by the β -rays. These must then in whole or in part be intercepted. True, the total radiation—the strength of the radio-activation—is thereby much diminished. Therefore the quantity and strength of the radium salt has to be proportionately increased, or insufficient rays will get through to be of any service. In the minute quantities of radium with which we have to deal, defect in quantity is made up for by duration in application, where deep-seated action is required.

Now the screening is a very complicated and difficult

business. Lead screens will weed out all the irritating β -rays, so in lessening degree will gold, silver, aluminium, mica. Lead and aluminium are those most frequently used. Further, about ten to twelve folds of paper are required in heavy screening. The whole combination is termed a "cache."

Now, like Mrs. Glasse's famous hare, you have caught your radium, diluted him with barium, varnished him on a plate, and screened him. Is the radium-therapeutic novice now fully armed, cap-à-pie? Not a bit of it. Other rocks ahead remain to be carefully in turn navigated.

How long in point of minutes or hours shall each radium application be made? When I say that the time-limit of applications ranges from half a minute to twenty-four hours consecutively, you will appreciate the importance of making a careful choice. "An error of some hours," says Wickham and Degrais, "in the technique of 'surpenetrant' rays will be of comparatively little importance. If, however, a mistake of a few minutes in excess be made with regard to the use of slightly penetrating rays, a very different reaction will be produced. The shorter applications are made with unscreened apparatus, the longer applications require pure radium and heavy screening."

The Frequency of Repetition.—This is controlled in part by the intensity of the applications, in part by the susceptibility of the morbid tissues operated on. The object of application is to accumulate sufficient rays in the tissues to ensure permanent reaction. Usually the applications are so graded as to require daily repetition, for more or fewer days at a time.

The Spacing of Applications into Series.—Not infrequently it is desirable to make breaks in the repetition of the applications; and these breaks or intervals between this series may last days, or weeks, or months.

"*Crossfires.*"—As the "surpenetrant" rays are relatively few in number and their effective presence is necessary to secure deep curative reaction, a means has been devised to control the dose. This consists of the multiplication of the radium foci diametrically arranged. The rays,

then, are all diverted to the deepest part of a growth; the skin is safely passed by distributed multiplicity of entrance, and curative diffusion is obtained. This system is known as "crossfire"; it is absolutely necessary for the cure of growths of bulk. Without this plan screening would so attenuate the rays reaching the deeper parts as to render any curative action patchy and superficial, and therefore ineffective.

I am sure that you will concur in the weighty remark of Wickham and Degrais, "The correct and effective application of radium requires a long and thorough experience."

SECTION V.—THE HOMŒOPATHICITY OF RADIUM THERAPEUTICS.

I scarcely need in this company of experts to dilate upon the frank and patent homœopathy of the external use of radium for cure.

(1) Radium *at once* occasions certain simpler morbid processes in the skin, such as those forms of dermatitis which it is pre-eminently successful in curing. *A more deferred issue* is described by Wickham and Degrais as "unfavourable stimulation which may excite morbid evolution." And morbid evolution, as we have seen, comes well within the sphere of radium therapy. While I was in Paris, a British journal published a warning against the use of radium on the ground that it may actually cause malignant disease, for which by some strange perversion it is used to cure. And this is the so-called twentieth century!

(2) In the use of radium there is an indifferent or critical point, below which its action is curative, above which its action is disturbing, or destructive. Here is an instance of that alternative cell response to increasing stimuli which Dr. Moir worked out so thoroughly in his Leicester address, and which is a homœopathic canon of the first importance.

(3) Captain and chief of all the homœopathic characteristics of radium therapy is its *modus operandi* of cure.

This corresponds to Hahnemann's conception of homœopathic cures being effected by the vital reaction of the sound structures and powers of the patient. "The living organism," says he, "employs . . . only so much reaction as is necessary for the restoration of the normal condition." Such a reaction of the living healthy organism, and not of the diseased elements therein, is histologically proved in the case of radium treatment in cancer.

(4) In the dynamic external cure by radium therapy, the range of dosage is considerable, the values differing some 200 times between maximum and minimum potencies as hitherto employed. The dilution is effected not only by attenuation with an indifferent substance, but also by screening. Dilution is the dominant note in practical radium therapy.

(5) *Over-doses* produce a totally different kind of action from that caused by dosage within the curative limit—not mere riotous excess of the dynamic process producing cure, but another kind of action altogether—a destructive action on the other side of the critical point.

It needs not to develop these homœopathic lineaments further. He who runs may read. Radium is one of those radii from the centre of the similar law of which vaccine therapy is another and equally striking instance.

Mr. President and Gentlemen,—I trust I have proved to your satisfaction the thesis with which I commenced—that the introduction of radium into therapeutics is the most revolutionary force in the Renaissance of Medicine. The first decade of this century is but the portal to a period more splendid and more fertile than ever in the domain of therapeutics. Much of surgery is but an apology for the failure of medicine, a brilliant apology, but a phase in the evolution of the art of healing. And in radio-therapy we see another radiation from the law of similars from which, as a centre, all scientific therapeutics gain there potency and their promise.

IMPRESSIONS OF A VISIT TO THE RADIUM
INSTITUTE, PARIS.—I.¹

BY WILLIAM CASH REED, M.D. EDIN.

Joint Gynæcologist to the Hahnemann Hospital, Liverpool.

It was my good fortune to obtain an introduction to Dr. Wickham, and thus a few days ago to visit his "clinic" in the Rue St. Philippe de Roule in Paris. Dr. Wickham's writings are more or less known to us all, either through the *Journal of the Royal Society of Medicine* or other medical current literature. I do not propose to enter upon the scientific aspects of radium—it is not within the limits of the short sketch now presented—but I should like to bring you into touch with some of those cases which I have had the privilege to see and handle. I am sorry I have no photographs, but am hoping to secure some; in the meantime let me show a few prints which, though they are not actually representations of the cases I saw, yet resemble them in most details.

Dr. Wickham himself was not well, and thus the duty of demonstrator devolved upon one of his three collaborators. This gentleman is a born demonstrator, and he dealt with the cases in a masterly manner. His grasp of surgical subjects is obviously general and wide, and the reverse of a man of preconceived opinion and narrow outlook. Moreover, the conspicuous sincerity of the man in dealing with his work was very refreshing. The testimony of photographs, as I have implied, was called forth repeatedly for purposes of comparison of past with present states. The prints, however, were not good, and the work of some of our members would put the French Exhibition into the shade in this particular.

I have described the demonstrator, now a word as to the personnel of the *attendance*. Conspicuous was the figure of Dr. Hall Edwards, whose pathetic history as a martyr to

¹ Presented to the Liverpool Branch, April 14, 1910.

science is so well known. There were also several well-known representatives of the X-ray departments of various hospitals this side the Channel, London and Edinburgh conspicuously.

There is no hospital where the demonstration is held, that is, there are no beds. Some fifty patients pass in review before one, and range in age from a few months old baby to the nonagenarian. The scope may be said to embrace everything suitable to radium treatment from a small "port-wine mark" to a sloughing sarcoma—*e.g.*, angiomata, epulis, keloid, lupus, tubercular glands, eczema, and syphilis; and of the malignant diseases, epithelioma, scirrhus, and sarcoma.

The apparatus brought into requisition varies, I believe, in value from a few pounds to several hundred. The discs of radium are of course fastened over the area it is intended to influence, and remain attached for a longer or shorter period according to the concentration or attenuation of the radium.

I understand that some of the patients can be sufficiently trusted to leave the institution for a time wearing the plate, but this would not apply to all in Paris, any more than to all in any other city.

As to the treatment with regard to its *painfulness* or otherwise, I was greatly struck by the fact that even the little children showed no fear whatever of it, although many must have been treated over and over again. No stronger testimony as to the painlessness of the process could have been obtained. Some patients with severe neuritic affections as an accompaniment of some local lesion testified to the analgesic properties of radium.

Some of us interviewed patients from time to time who were waiting, and there was no exception to the expression not only of gratitude for, but of deep appreciation of, the remedy as a curative agent, either in their own cases or in that of their children.

Now a few words as to the specific effect of radium in certain well-known conditions. I will begin by a note of that produced on *cicatricial tissue*—*e.g.*, upon scars produced by the treatment of *nævi* by the galvano-

cautery. The unsightly tissue is, as it were, flattened out or smoothed down. The same result was very obvious in the case of a keloid produced by sulphuric acid upon the face and neck of a young woman. I saw also tubercular glands in the neck disappearing, also glands in a similar situation secondary to carcinoma of the tongue. The most remarkable case, however, which was exhibited was that of malignant disease in the neighbourhood of the shoulder. It had been removed no less than eight times by a well-known Paris surgeon, but had each time recurred after a short interval of immunity. The brawny hardness was replaced by a soft, yielding, contracting tissue, and all that remained was a small, superficial ulcer about the size of a shilling, whether the lingering evidence of the original disease or the result of a radium burn I did not gather. To all intents and purposes this patient appears to have entered upon a new lease of life.

But there are *limitations* which no one could have admitted more readily than the demonstrator himself—*e.g.*, a lupus may apparently be entirely cured by radium, as it may by other means, but by and by it reappears at a part remote from the original site, which remains healthy.

Another limitation is found in the case of secondary carcinomatous glands, which do not yield so readily to the action of radium as the primary lesion. In some cases it is advisable, as in malignant disease of the breast, to operate first and then to bring radium into requisition. There is a third limitation to be mentioned, though this has the great advantage that it is utilitarian. For example, a large facial angioma was brought to our notice in the case of a man whose side face presented the appearance of a turkey's wattle. We were assured, and the evidence of the photographs was indeed sufficiently convincing, that at one time this case was quite outside the domain of surgery. It had, however, become so modified under treatment by the diffusion of fibrous material throughout the telangiectasis, that it was now histologically rather a fibroma than an angioma, and thus it had been brought within the scope of the surgeon's skill.

I have merely to add, in conclusion, that I am deeply impressed by the honesty of conviction on the part of the personnel of this clinic, apart from the fact that the treatment itself was eminently convincing. I should still look forward in the near future to another visit. I have seen enough to believe that the therapeutic effects of this inscrutable substance are at present in their earliest inception.

II.¹

Introduction.

All who have, through the courtesy of Dr. Wickham, enjoyed the opportunity to visit the Radium Institute in Paris, must have been impressed especially by *two* outstanding features which characterize the place and the work. These are the thoroughly scientific basis upon which the work is done, and the free and unstinted "open door" policy which welcomes all and sundry who can present a claim to admission.

A truly scientific mind investigating a new substance with vast possibilities and limitless potentiality knows no hidebound limitations, and recognizes no exclusive rights. Nevertheless, we must see to it that priority in investigation and discovery receive its just recognition, all the more so when the exponents make everything so clear to the inquiring onlooker that "he who runs may read." It may be that here and there amongst the audience is one who "came to scoff," but I can vouch for it, if so, that he will "remain to pray."

I write as a general practitioner, not as a specialist, and hope to show, based upon what I have seen, the great possibilities which exist in radium for the benefit of suffering humanity, when in the hands of one qualified to deal with it.

The hindrances to the more universal adoption of radium in general practice seem to me to be threefold:—

(1) Cost.

¹ Presented to the Section of General Medicine and Pathology, June 2, 1910.

(2) Certain qualifications on the part of the practitioner which are not to be acquired by mere reading.

(3) The tardy acceptance of the fact that radium possesses a place in therapeutics which is not occupied by any other remedial agent whatever.

(1) *The Cost.*

Considering that up to the present hour there are but a few grains of a salt of radium available, it stands to reason that a market thus restricted can dictate its own terms. It has not been slow to do so, nor do the indications point to a cheaper market, but very much the reverse.

To the general practitioner, fettered already as he is by a growing tendency to the authoritative turning over of his clientele to the tender mercies of "taxed charity" the price of radium is very serious. Especially is this the case if the medical man chance to hold a hospital appointment, and thus to number amongst his patients a great many poor, the percentage of whom needing radium is far from inconsiderable.

It is not my province to indicate the remedy. Various schemes are on foot, and I can conceive no better present or posthumous charity than the provision of a supply of radium for the needy. That the solution of the difficulty will, by and by, be forthcoming, I have no manner of doubt. The question of cost has never yet completely baffled the efforts of the profession, and it never will. My apology, if apology be needed, for dwelling upon the commercial aspect of radium to such an extent, is that I recognize in it a substance which the profession cannot possibly do without, for it is absolutely indispensable to the well-being of the race. It is, of course, possible that an equally potent radio-active substance may yet be discovered which shall displace radium, but of this there exists no indication.

I do not speak as an unreasoning enthusiast, but simply state what all who know radium with anything more than merely a nodding acquaintance accept as a truism.

(2) *Certain Qualifications on the part of the Practitioner which are not to be acquired by mere reading.*

The question of dosage—*e.g.*, the length of application, the proper screening off or modification of ultra-penetrating rays, are all so important, that one may well hesitate to rush in “where angels fear to tread.” Otherwise, one’s ill-timed assurance may eventuate in a radium burn, which has the cynical propensity to delay its advent for perhaps weeks after the application. Having once appeared, however, it may occupy the patient’s time for months of exposure to solar rays to get rid of. Thus all who know radium must woo her delicately.

(3) *The Tardy Acceptance of the Fact that Radium possesses in Therapeutics a Place which is not occupied by any other Remedial Agent whatever.*

If radium can illuminate the vitreous in the apparently blind, and thus demonstrate that the retina has not lost all its function, but that an operation is likely to benefit, surely this is no small achievement. If radium can disperse nævoid growths and leave but an inconspicuous and slight opalescence of the skin, it is a great gain. When one has seen a face rendered most repulsive by scattered angiomas show in their place flattened, healthy, inconspicuous scars, making the expression (especially noticeable in the child) a pleasing one to look upon, it is obvious that a new era in cutaneous therapeutics has commenced.

Hitherto I have but generalized, and have omitted to refer to some unique, specific properties of radium from a therapeutic standpoint. In using the word “unique” it must be understood that I refer to the present state of knowledge, or, at any rate, to the writer’s acquaintance with it. Other radio-active bodies possess therapeutic properties akin to those of radium, but less intense. In speaking of *specific* properties I mean such as are not shared by any other remedial agent, having a like sphere of action—*e.g.*, the painless destruction of aberrant forms of cutaneous cell proliferation and neoplastic cell growth.

It may be said, of course, that the X-rays and the Finzen light and the galvano-cautery are powerful agents for good in the above conditions, and so they are, but radium occupies the premier position.

Its unique characteristics may thus be summed up :—

- (1) Completeness.
- (2) Painlessness.
- (3) Permanence.

As regards the first, viz. :—

(1) *Completeness,*

I do not, of course, make an all-embracing statement, but refer especially to angiomata, neuro-dermatitis, eczema, and keloid. All these we have seen completely removed, or in rapid process of becoming so.

(2) *Painlessness.*

If testimony were wanting on this point, it was abundantly supplied at the Paris Clinic (refer to Paper I.); but this characteristic of radium, however, is not merely a negation, it has a *positive* side, for radium is shown to be in a marked degree analgesic. How otherwise could be accounted for the soothing effect in a severe neuritis associated with malignant disease, or its quieting of the torture of a pruritus, or its anodyne effect in an itching eczema?

(3) *Permanence.*

Here I admit we are on debatable, if not shifty, ground, for what may be true of examples of a type may not be true of the type as a whole.

That lupus and tubercular glands are cured by radium is perfectly true, but to assert that the system is immunized so that a recurrence is in the highest degree improbable is altogether another matter.

I believe that no one recognizes the limitations of radium more than the workers with it at the Paris Institute, and the impression I received was that its powers were rather under- than over-estimated.

However that may be, I gathered, amongst many, one inference of such extreme significance that, should it prove true, it surpasses in importance all the rest put together.

It appears that when radium is used to dissipate secondary glandular deposits, occurring as a sequel of malignant growths which have been removed, the obliteration of the former is not only accomplished, but the emanations in some way immunize the patient, and thus act as a direct deterrent to the "return" of the disease. If this be so the gain is consummate, and the possibilities for the race unspeakably hopeful. The question of the *origin* of cancer becomes a secondary one, whether, for example, it be due to the aberrant functionizing of the pituitary gland or some other equally occult cause, sinks into the background.

That permanence of cure is obtained in angiomata, eczema, keloid, and other conditions is certain. That permanence is attained in lupus, rodent ulcer, tubercle, and syphilis is probable. That radium is permanently curative in cancer, taken as a whole, is conjectural, yet that cure has been attained in some cases is certain. Probably some years must elapse before a completely comprehensive answer, free from a tinge of equivocation, can be given to this question of permanence.

Gentlemen, I have said enough to show that I believe profoundly in the potentiality of radium in the region of therapeutics, and that there is a future before it of the greatest beneficence to the race, and that the study of radium is thus worthy the time and the highest intelligence of the profession.

(At the conclusion of the reading of the papers of Dr. Burford and Dr. Cash Reed, Mr. E. L. Ambrecht demonstrated the methods in use for the practical application of radium to various diseased states. He handed round a specimen which was the purest known, namely, 95 per cent., and the action of it could be very quickly demonstrated. The pitchblende was originally treated with sulphuric acid or hydrochloric acid, to extract the uranium. The residue was treated by boiling with carbonate of soda,

extracting the iron, copper, lead, and the other substances and then with hydrochloric acid to form a further solution, and ultimately everything was separated except the barium, which held all the radium. The process occupied eight or nine months. The effect produced by radium on the electroscope was extraordinary, and on sapphires it produced a remarkable change in colour. The chief constituent of sapphires was pure aluminium sulphide. Those stones were subject to the influence of the sun's rays, particularly in March. Charcoal absorbed radium, and remained charged three weeks, so that it was a valuable means of administration in the form of radium-charged charcoal.)

CASES AND SPECIMENS EXHIBITED AT
VARIOUS MEETINGS.

CASES.

*Rodent Ulcer.*¹

M. T., a male, aged 52, married, ten healthy children, always enjoyed good health. First noticed a sore place in front of ear fifteen years ago. This was cut out and skin grafted, which succeeded for two or three years, when the sore broke out again. Nothing was done for two or three more years, and there was no pain; the sore then spread into the ear and was treated by X-rays five years ago, which stayed any extension for a time and it healed over. About a year later it broke out again; the patient went to London, where he was treated by X-rays for twelve months. As this was not successful he went to St. Bartholomew's Hospital, where X-rays and some other electrical treatment was employed, which was very painful. The face has been paralyzed about two years. He has pain in the ear and in the teeth of the lower jaw and cannot masticate properly.

Dr. Vincent Green said the interesting point about this case was as to whether the man was suffering from rodent ulcer or X-ray burn. He had paralysis on the left side of his face, and there was some limitation in the movement of the jaw. He was suffering a good deal of pain inside the ear, but he could still hear.

¹ Exhibited by Dr. VINCENT GREEN at a Clinical Evening, June 28, 1910.

Mr. Knox Shaw said he felt no doubt that this case was one of rodent ulcer. It was extraordinary how far such cases would progress without resulting in death. He had once under his care an elderly man, in whom the disease commenced in his cheek, then destroyed an eye, afterwards attacking the mouth, so that he had an open cavity in the face. Half the upper lip and lower lip were also destroyed, and he had to wear a mask. Yet he lived to be an old man. With regard to treatment, rodent ulcer in the early stage offered an excellent field for all the newest remedies. Such a case was successfully treated with X-rays, ionization, radium, &c. Early cases would also yield to simple surgical measures, but in the end in most cases the disease returned. He had seen a case of a woman who was in the hospital who had rodent ulcer on the forehead; it had destroyed her upper eyelid, exposed the skull and the dura mater beneath. He saw her because she suffered from ulceration of the cornea from exposure. By utilizing skin from her temple he was able to make her a new eyelid, so that she did not suffer so much as she would otherwise have done. The disease was arrested for a time by X-rays.

Dr. Roberson Day said that Mr. Knox Shaw's case reminded him of a similar one in a man who used to come up to see the late Mr. Christopher Heath, who specialized on tumours and diseases of the jaw. The man had an enormous cavity on the left side of the face, commencing in the eyelid, the disease had proceeded to destroy the eyeball. When he saw the case the orbit was gone, the superior maxilla was gone, half the nose, the malar bone, and there was a huge cavity left in the face. It was the most gruesome sight one could expect to see. The man used to be shown at surgical lectures. A short time ago he (Dr. Roberson Day) had a case of ulcer of the upper eyelid which was satisfactorily cured by zinc ions, and it had not recurred. Judging by the results of radium treatment in Paris, he would advise the man to make every effort to go there.

Dr. Wynne Thomas said he could bear out what Mr. Shaw said with regard to radium. He had a patient, now aged 69, who for the last ten years had had rodent ulcer of the nose. She was under Dr. Ashton for some time for treatment by X-rays, and she got better, but never quite well. She had had all sorts of lotions and treatment, but he found radium kept it in check better than anything. Radium seemed to heal up some parts, but did not quite cure the disease, for though on several occasions the ulcer healed over it broke down again before many weeks were past.

Dr. Granville Hey suggested that Dr. Green should have the Wassermann reaction done, to see if there was any syphilitic taint about the man. He had ten healthy children, so syphilis was not likely. Still he (Dr. Hey) believed syphilis was often at the bottom of obstinate cases of ulceration. Cases of rodent ulcer which he had seen treated by zinc ionization had healed up quickly and firmly. A Wassermann reaction would simplify the matter.

*Basic Meningitis.*¹

F. W., female, aged 9 months, was admitted on April 14, 1910, to Barton Ward, under Dr. Roberson Day.

She was breast-fed till 6 months, then with cow's milk and Robbs' biscuits.

"Had fits ever since birth," worse last two months. Last two or three days, whining, rolling head about.

Temperature on admission, 104.8° F.; pulse, 140. Convergent strabismus and nystagmus. Mouth wide open and tongue protruding. Whining cry, with clenched fists and all limbs rigid. Given bell. 200, four-hourly. Rigidity has gradually increased, and child has seemed less and less conscious, choking on swallowing every mouthful. Respiration has been as slow as six a minute. Lycopodium, helleborus, cuprum, injections of meningococcus vaccine made from organism isolated from child's own spinal fluid, injections of sea-water plasma, all tried with no permanent good result. The last drug tried has been karaka ϕ , of which two doses have been given. Distinct improvement has followed, the limbs being less rigid, mouth less widely open, and expression more conscious.

Dr. Roberson Day said most of the proved and known homœopathic remedies had been tried in this case, but without effect. In addition there had been tried a culture from the cerebro-spinal fluid. He did a lumbar puncture, and drew off some fluid, and that fluid was found to contain a diplococcus. From that Dr. Hare made a so-called vaccine, or, more correctly, an emulsion, and on two or three occasions some of that was injected, as much as a cubic centimetre at a time. It appeared, however, to have very little effect, for either good or ill. The first question was as to the distinction of the case from tubercular meningitis, which was easy, as the latter ran a rapid course, whereas the present case had a chronic course. Posterior basic meningitis occurs in children under one year old. (This patient was nine months on

¹ Exhibited by Dr. ROBERSON DAY on June 28, 1910.

admission.) Tubercular meningitis is met with in older children. The disease was, no doubt, a sporadic cerebro-spinal meningitis. The organism found seemed to be closely related to that of the epidemic disease.

Dr. Goldsbrough asked whether Dr. Day had considered cicuta and mercurius iodide. Those were the two medicines which occurred to him. He could not say that the indication for mercurius was very strong, but he had seen effects from it in such cases. He would be glad if Dr. Day could elucidate the causation more fully. In last week's *Lancet* seven cases of meningitis following influenza were published, and they constituted an interesting series. A considerable proportion died. The author of that paper recommended injections of urotropin.

Dr. Blackley asked whether Dr. Day had any experience of the use of iodoform in meningitis. It had been exploited a good deal of late years, both by inunction and by the mouth.

Dr. Edwards (Philadelphia) asked what the result of the use of tuberculinum had been in Dr. Day's experience. He (Dr. Edwards) had had a number of cases of meningitis, and always relied on bacillinum for pulling the patient through, and he had but few failures. He gave it once a week in the 30th or 200th.

Dr. Day, in reply, said iodoform was useful for tubercular cases, but this was not tubercular. Nothing he had tried had produced any result. There had been no ear trouble. He had not tried cicuta nor iodide of mercury. He would do so if the child survived long enough. A culture made by Dr. Hare from the cerebro-spinal fluid was injected 300 million bacilli to the cubic centimetre. He tried tuberculinum in the higher dilution first (200th), and afterwards in the lower (30th). Apis was not tried. No cause for the disease could be found; it was not secondary to otitis. He did not inquire about influenza, but that antecedent would not be important as influenza was so common.

*Myositis Ossificans.*¹

A. R., male, aged 43, farm labourer, was under the care of Dr. Washington Epps in the Hahnemann Ward. Admitted April 26, 1910. No family or personal history abnormal. No previous illness, except measles as a child. Vaccinated when a baby; not since. No bad effects that he knew of. General health always good.

¹ Exhibited by Dr. WASHINGTON EPPS and Mr. H. FERGIE WOODS, June 28, 1910.

The present disease commenced at 8 years of age, with pain and swelling of left shoulder, with stiffness in joint following. Then, at 16, pain and swelling in bottom of back. At 28, left leg and thigh became stiff, so that he could only walk with difficulty. Later the right arm was affected, so could not move shoulder or elbow. Gave up work at 31.

Most of the muscles of the body are infiltrated with hard, bony growths. Back perfectly rigid. Can just manage to shuffle along on his feet. The jaw is fixed, and only movable about a quarter of an inch. Has to pass his food into the mouth through apertures left by extracted front teeth. Double hallux valgus is present, and there are markedly stunted big toes. A portion of bony growth was removed from the right pectoralis major and examined, and found to be true bone.

Has been given three doses of thuja, a month apart, one the 10 m. and two of the 50 m. Distinct improvement has resulted, both in general appearance and in power of movement, the neck being looser, and some movement gained in right hip, which was quite rigid on admission. A wen on the head is also melting away.

Thuja was selected by repertorizing, and its suitability to the case rendered more certain by a remark on it made by Farrington in his "Materia Medica": "Thuja has the singular property of softening hard tissue."

The symptoms used in "working out" the case were: The peculiar shininess of the face, as if smeared with grease; induration after inflammation; disagreeable odour of perspiration; stiffness of limbs; nodules in skin; relief from open air and aggravation from heat; wen; dandruff; falling of hair.

Dr. Goldsbrough said that sea-water plasma contained various salts, and affected constitutional states. It was, he thought, worth keeping in reserve for the case under consideration. What it had done would be found in the Summary issued in the Journal of the Society (April, 1910, p. 208, and 1906, p. 386).

Dr. Macnish (in the chair) said he had watched the man carefully each time he went in the ward, and he believed his condition had distinctly improved recently. Dr. Woods was to be congratulated on his working out of the general symptoms. For a man who had been under so many treatments (he had been in twenty-six hospitals) it was interesting to watch the effect of one remedy, thuja.

Dr. Epps, in reply, said he had tried hecla lava in somewhat similar cases, but it had disappointed him. Thuja had not been given long enough yet for any very definite result to be obtained.

The surprising thing about the man was that he seemed remarkably healthy, and had good digestion. He had had nearly every form of treatment one could think of. At one place an attempt was made to dissolve out the irritant with acid and water; at another, massage was employed; at another, electric baths. The totality of the symptoms seemed to point to thuja.

SPECIMENS.

*Gall-bladder from Case of Cholecystitis.*¹

History.—Pain of indefinite character right side abdomen—several years. Sharp pain left side abdomen and vomiting of everything taken—two days. Vomit black. Swelling size turkey egg, right side of umbilicus; tender. No jaundice. Sent in as intestinal obstruction.

Operation.—Cholecystotomy. Single stone acting as ball-valve. Gall-bladder presented appearances due to phlegmonous inflammation.

*Ovarian Cyst adherent to Liver.*²

Mrs. S., aged 42. Seen with Dr. Croucher. A fortnight before Dr. Neatby saw the patient she was seized with pain in epigastrium and right hypochondrium, which became distended. Temperature rose to 102° F. for one day, then gradually dropped. After forty-eight hours, the patient became rather jaundiced; urine dark, but the stools were *not* clay-coloured. The abdomen was greatly and uniformly distended. The flanks were resonant, so also the epigastrium, the intestines being crowded up into the upper part of the belly. The rest of the abdomen was dull. The uterus did not appear to be connected with the tumour. A large ovarian cyst had been diagnosed by Dr. Croucher, with possibly rupture of some part of it. With this diagnosis Dr. Neatby was in agreement.

On October 23 the abdomen was opened in the middle line, and a pale, bluish ovarian cyst was displayed. It contained thin, brown fluid; 17½ pints were measured and much was lost. The cyst was adherent at its upper pole to right antero-lateral parietes, to under surface of liver, and to subjacent large and small intestines and omentum. The adhesions could not be separated through the original incision, a Mayo-Robson incision was therefore made, the tumour was bisected, and the lower

¹ Exhibited by Mr. JAMES EADIE, October 6, 1909.

² Exhibited by Dr. NEATBY, December 2, 1909.

portion, about four-fifths, removed through the lower opening; the adhesions were then with some difficulty separated through the upper incision.

Patient had intermittent saline injection the first two days, and made an uninterrupted recovery.

*Microscopic Slide of Diphtheria Bacillus obtained in almost pure culture from a pustular rash on the palms of the hands and the soles of the feet.*¹

J. M., aged 38, married, three children, youngest aged 5; no miscarriages. Came on May 13 to out-patient skin department with a rash in palms of both hands closely resembling so-called *psoriasis palmaris*, and stated that it first showed itself about the beginning of April. Patient had always enjoyed good health and husband and children were quite well. She did all her own washing and scrubbing and used "Life-buoy Soap" (a very strongly alkaline soap). The hands were slightly swollen, very painful, and inclined to crack here and there. Came again in the middle of June with the rash similar in character but more spread, involving the whole of the palms of the hands and palmar surface of the fingers, which were denuded of their ordinary epidermis, bright red in colour, weeping very slightly, and intensely painful. I offered to take her into the wards, but, owing to want of room, it was only on July 1 that she could be admitted. By that time the palms, hands, and palmar surface of forearms were red and inflamed and showed numerous purulent blebs even under the nails, which were very painful on pressure; some pustules were also found on the soles of the feet. The pus from one of these pustules, taken with elaborate precautions so as to avoid surface contamination, was examined by Dr. Hare and found to yield a pure culture of *Bacillus diphtheriæ*.

On being closely questioned, the patient stated that she had a cat in the house which she was accustomed to stroke, and that the animal had been suffering for some time from discharge from one ear with some scabbing. The cat was also accustomed to sleep amongst the soiled clothes which the patient had to wash, otherwise no cause was known.

During her stay in the hospital, under the care of Dr. Goldsbrough, the hands were dressed with ungt. hydrarg. ammon. at first, and subsequently with ungt. hydrarg. oxidi flav. 5 per cent. For medicine she received petroleum 30, one dose on

¹ Exhibited by Dr. BLACKLEY and Dr. HARE, December 2, 1909.

July 9; diphtherinum 200, one dose on July 20; and petroleum 200, one dose on August 3 and 20. She left the hospital cured.

*Enlarged Prostate Enucleated Supra-pubically.*¹

A man, aged 77, was admitted into Bayes Ward, October 2, 1909, with prostatic retention. He was cathetered with great difficulty until October 12, when his prostate was enucleated supra-pubically. No drainage tube was used. His wound was dry on October 25, and a catheter passed into bladder retained. He passed urine naturally on the sixteenth day. The specimen shows well the cause of the difficulty in catheterism: the enlarged middle lobe.

*Adeno-carcinoma of Cæcum.*¹

M. H., a single woman, aged 51, was admitted into Durning Ward, October 30, 1909. Seven years ago had a tumour in right breast and was recommended operation, but under medical treatment by Dr. Macnish and Dr. Margaret Tyler it disappeared. For two years has had attacks at intervals of abdominal pain and diarrhoea, alternating with constipation. There has been no blood in stool, but at times a sour-smelling, brown shiny material. Three weeks before admission a mass was found in right iliac fossa, about size of small egg, freely movable, and probably connected with the cæcum and ascending colon.

At an operation on November 9 the above specimen was removed, consisting of portion of ileum, cæcum, appendix and ascending colon, together with some enlarged mesenteric glands. The divided ends of colon and ileum were closed and reunited by lateral anastomosis. She had action of the bowels on November 11, and has been having good actions since. She was out of bed on November 19 and is going to a convalescent home on December 8.

*Portion of Quadrilateral Cartilage and Bone from Descending Plate of Ethmoid removed by Submucous Resection.*²

*Hypernephroma; Kidney Successfully Removed.
Microscopic Specimen.*³

*Enlarged Prostate Removed Perineally during Cystotomy for Foreign Body in Bladder.*⁴

¹ Exhibited by Mr. KNOX SHAW, December 2, 1909.

² Exhibited by Dr. A. SPEIRS ALEXANDER, February 3, 1910.

³ Exhibited by Mr. DUDLEY WRIGHT and Dr. HARE, May 5, 1910.

⁴ Exhibited by Mr. EADIE, May 6, 1910.

*Girl, aged 19, on whom Disarticulation at Wrist was performed for Periosteal Sarcoma of Fourth Metacarpal Bone, and Specimen of Sarcoma from above.*¹ (See p. 278.)

*An Appendix showing Perforation.*²

*An Ovarian Tumour (a Dermoid) from a Patient aged 21 or 22.*²

*A Prostate Gland showing False Passages.*²

*An Intussusception of the Small Intestine.*²

*Uterine Fibroid and Carcinoma of both Ovaries.*²

*Ganglion of Wrist showing Tuberculous Giant Cells.*²

BRITISH HOMŒOPATHIC SOCIETY.

REPORT OF THE COUNCIL.

THE Session which reaches its close to-morrow evening has been a memorable one. On May 5, 1910, we held our eighth ordinary meeting, and our members casually remarked one to another upon the bronchial attack from which His Majesty King Edward was that day announced to be suffering. We little thought that ere midnight of the following day His Majesty would have breathed his last. His unique personality as a man and a monarch had endeared him to all his subjects, and it was with a sense of personal loss that the Council proceeded, on May 10, to pass a resolution of condolence with His Majesty King George and Her Majesty Queen Alexandra, coupled with an expression of loyalty to the Throne. This was confirmed by the Society at its next ordinary meeting.

Owing to a serious illness while abroad, the President of the Society was unavoidably absent from the chair during the early part of the Session.

The usual number of meetings have been held, with the difference that the President's address is placed at the end instead of the beginning of the Session. The Section of *Materia Medica* and Therapeutics has once more had a preponderance of five

¹ Exhibited by Mr. EADIE, May 5, 1910.

² Exhibited by Dr. HARE, June 28, 1910.

meetings out of ten. The liberal-mindedness of the Society has been demonstrated in the subjects allotted to this Section.

The Session opened with a paper on "Phosphorus," representing what may be styled moderate views, and dealing with the drug from the sides of pathology, symptomatology, and therapeutics. Later in the Session papers were read indicating the revival of interest in treatment on the basis of subjective symptoms, with doses of extreme dilution at long intervals. Still later, papers on "Radium" and "Vaccine Therapeutics" were presented, which may be described as representing progressive views.

A largely attended ordinary meeting was held in January, when thirty members met to welcome the President and to hear a paper on "The Present Position of Prostatectomy."

On June 2, Drs. Burford and Cash Reed gave special addresses on "The Therapeutics of Radium," illustrated by lantern slides and specimens, which drew an overflowing audience.

During the Session the Council has met no fewer than ten times. This is quite a record number of meetings for one Session and was due to the Council having been appealed to by a contemporary body with respect to homœopathic journalism in the near future. After many meetings, at which the Council considered the question from all sides, it placed before all the members of the Society, and others believed to take an interest in homœopathy, the following alternatives: (a) The publishing of a new journal by an independent committee; (b) the publishing of the journal of the Society every month; (c) the "previous question." The first proposal was supported by a large majority of those replying to the special circular, on condition that in return for a subsidy, which the Society would be asked to vote, its members should receive the new journal at half price. On April 19, 1910, to a general meeting of all medical men known to be interested in homœopathy, the members of Council reported the work they had done concerning the starting of a new journal, and handed it over to a body chosen for the purpose of its development. That body appeals to the Society for a subsidy of £100 per annum for two years, as already announced.

Eight new members and two Fellows have been elected during the Session, two members have resigned (Dr. P. Cox and Dr. Greig, of Wakefield), and one member (Dr. Chapman) and two corresponding members have been lost to the Society by death (Dr. H. C. Allen, of Chicago, and Professor Lombroso, of Turin). The Council recommended the following Fellows for

THE BRITISH HOMOEOPATHIC SOCIETY.

DR. BALANCE SHEET—SESSION 1909-10.

(Cr.)

RECEIPTS.	£ s. d.	EXPENDITURE.	£ s. d.
To Balance in Hand ..	84 8 11	By Rent ..	25 0 0
„ Dividends on Consols ..	4 19 4	„ Printing Journal ..	213 4 2
„ Subscriptions ..	192 8 0	„ „ Miscellaneous ..	18 12 8
„ Sale of Publications ..	8 17 10	„ Reporting ..	16 16 0
„ Half cost of Plates ..	2 19 6	„ Honorarium to Editor ..	10 10 0
„ Advertisements ..	46 5 0	„ Library ..	2 12 0
„ Balance of Clifton Memorial Fund ..	2 8 6	„ Postage and Stationery ..	7 8 0
		„ Refreshments ..	5 10 0
		„ Petty Cash ..	1 18 6
		„ Balance ..	£301 6 4
	<u>£341 12 1</u>		40 5 9
			<u>£341 12 1</u>

JAMES EADIE, Auditor.

June 28, 1910.

JNO. G. BLACKLEY, Treasurer.

election at the Annual Assembly: Dr. Theophilus Ord as President, Dr. E. B. Roche and Dr. V. Green as Vice-Presidents, and Dr. Blackley as Treasurer.

At the last meeting of the Council, Dr. Edwin A. Neatby tendered his resignation of the Secretaryship of the Society, but agreed to act until the next meeting of the Council.

HOMŒOPATHY IN THE EAST AND THE BRITISH EMPIRE.

THE PRESIDENTIAL ADDRESS TO THE BRITISH HOMŒOPATHIC SOCIETY FOR THE SESSION 1909-10.

BY DAVID MACNISH, M.A., M.B.EDIN.

Physician to the London Homœopathic Hospital; President of the Society.

GENTLEMEN,—To-night concludes the session 1909-10. It may not be inappropriate that your President should deliver his farewell address at this meeting. It is rather unique that the introductory address and farewell address should be combined together and given at the same time. Circumstances have so decided, and it will be a relief to you that such is the case.

I wish to thank the members of the British Homœopathic Society for the high honour and distinction which they conferred on me during my absence by electing me as their President. I appreciate the honour, and especially so under the circumstances in which it was conferred, and now take this opportunity to thank the fellows and members of this Society, individually and collectively, for it. You have conferred on me the highest honour this Society can confer on any of its members. I regret that I have shown myself quite unworthy of the distinction. An unexpected illness on the other side of the world prevented my presence at the opening of the session. I now present my apologies and regrets.

You have had the good fortune to begin the session without my introductory address, and the brilliant and

successful session which terminates this evening proves conclusively how fortunate you have been.

I may be pardoned if I refer shortly to the work of session 1909-10, and first of all to those members who are no longer with us.

To Dr. Chapman, whose sad and untimely death early in the year was a great shock to all of us. As resident medical officer at the Hospital, and medical practitioner in London and Margate, he was well known, and highly esteemed by us all. The British Homœopathic Society mourns his loss.

Two corresponding members have died during the session, both of them men distinguished by great abilities and attainments. Dr. Allen, of Hering College, Chicago, a great bulwark of Homœopathy in America and over the world; and Professor Cæsare Lombroso, of Turin, the greatest authority on Criminology in the world. Homœopathy has reason to be proud of both of them, and the Society here mourns their death.

The work of the session is well known to you all, and requires only a passing reference in this paper. Last evening you had the pleasure of hearing our Honorary Secretary, Dr. Neatby, read the report of the Council and his most interesting comments on the work.

Materia medica has been exceptionally well represented in the debates, and rightly so. It is the basis of our practice and system. The other branches of medicine have been well and worthily discussed, and papers of exceptional interest read at the meetings. The Society owes a great debt of gratitude to Dr. Stonham for his paper on Phosphorus, Dr. Miller Neatby for his splendid treatise on General Tuberculosis in Children, and Dr. Bodman for that on Pneumonia in Children, Dr. Ridpath and Dr. Weir for their admirable papers on the Philosophy of our System, Mr. Knox Shaw and Dr. Pritchard for their most practical papers on surgical subjects, Prostatectomy and Appendicitis—two subjects of not only general but also personal interest to us all—and to our esteemed colleagues, Dr. Burford and Dr. Cash Reed for the addresses on Radium. It is very unfortunate that an unavoidable accident pre-

vented us enjoying and benefiting from the paper on Vaccine Therapy, which Dr. Hare had promised to give us.

It has ever been the custom of your Presidents to deliver to you addresses on the different phases of our system ; its many and different forms have been discussed ; its principles have been re-studied and enunciated ; its evolutions and modifications amplified. In this address, with your permission, I shall not debate on such themes, but give you a short and very imperfect paper on my visits to our brethren over the seas. During the last two years it has been my fate to travel over a part of the world and visit many portions of the Empire. I thought, therefore, it may be of some interest to you to hear something of homœopathy as it is represented in the East and our Colonies. The British Homœopathic Directory is a good index of the prevalence of homœopathy over the world. To the traveller in foreign parts it is an invaluable guide, and to its efficient Honorary Secretary, Dr. Roberson Day, my thanks are especially due for the valuable information it contains, and indirectly for the valuable acquaintances which it enabled me to make. To the travelling homœopath it is the A.B.C. of guides.

During my journeys I particularly visited Egypt and the Sudan ; here homœopathy is practically unrepresented. At Cairo there is a most excellent opening for a British homœopath, especially during the winter season. At Khartoum, so far, there is not any immediate opportunity, though later this may one day become one of the great cities of Africa.

The vast continent of China has very few representatives of our faith. In the large European centres, such as Hong Kong and Shanghai, there are splendid openings for any homœopath, as well as at the other centres, as Canton, Peking, Hankow, &c. At the different centres there is a fair number of allopathic practitioners, but homœopathy is usually represented by the chemists who keep a supply of homœopathic drugs, and occasionally by a medical missionary who has been trained in homœopathy. At Mingpo there is Dr. Swallow, the head of the College there, a skilled

homœopathic practitioner and organizer, an American graduate, and a man of national reputation in China. In Chicago I had the pleasure of meeting a lady practitioner, a graduate of Hahnemann College, Chicago. She is connected with a Mission near Foochoo, and gave a most interesting lecture at the fraternity there on medical work among the Chinese and the remarkable success of homœopathic practice. The Chinese make admirable patients, and I know, from personal intercourse, they have a great appreciation of our system of medicine.

Japan, the mighty empire of the East at present, is poorly represented on our list. There is a lady doctor at Nagasaki, Dr. M. A. Suganuma, an American lady, who is held there in high esteem. At Kobe, on the inland sea, the sudden death of Dr. Slade, a young and most popular American doctor, has been a great loss to the cause of homœopathy. All through Japan are dispensaries organized by Japanese doctors who have been trained in Europe, especially at the German schools, and it is a great regret that our cause is still unrepresented by any of those most skilful and scientific practitioners. One cannot but admire the keen scientific instinct of the Japanese race, coupled as it is with marvellous industry, skill, and artistic ability.

India I did not visit at this time. Ceylon I visited, but only Colombo, and there I was unable to find any homœopathic doctor.

Penang, Singapore, Java, Tonquin, &c.—different possessions under different European rule—as far as I could ascertain do not possess any registered homœopathic practitioners. Singapore would be a most suitable place for any homœopathic practitioner. So in the East there are many opportunities for the practice of our system, and from a pecuniary point of view medical work and skill are much more generously rewarded out in the East than in Europe. There is every choice of climate with all the subtle fascination of life in the East.

Now I shall ask you to turn with me to our own possession under the Southern Cross. Here are lands and peoples of which any country may justly be proud. In no

part of our Empire does the Imperial spirit flourish more than here. The instinct of nationality is stimulated by, and finds its outlet in, Imperial ideas. In Australia, homœopathy is well represented in Melbourne and Sydney. Sydney is exceptionally fortunate in possessing the Deck family—a family of brilliant and most enthusiastic homœopaths; their enthusiasm is well represented by the Homœopathic Hospital, which they have founded in Sydney. This hospital is admirably managed, both in the medical and nursing departments. Here one has the pleasure of seeing pure homœopathy practised most skilfully and successfully in all its departments. To me it was a great pleasure to accompany Dr. Leigh Deck to his out-patient and in-patient charges and witness the exceptional care, skill, and attention which all the staff exhibited in the hospital. The members of the Deck family are well known to us all. Dr. Leigh Deck, a former resident medical officer of our hospital, still manifests his wonderful activity, his keenness, his wondrous skill, in his medical duties. Dr. Deck, sen., who was with us a short time ago, and Dr. Baring Deck, a distinguished graduate of Sydney and pupil of Kent, compose the staff. I am sure this Society wishes them every success, and if skill, industry, and diligence in the performance of duties be of any value, success must be theirs.

I had the pleasure of visiting Dr. W. G. Watson Williams, who was a student here in London at University College over forty-five years ago, whom I found full of vigour and activity, and the founder and director of the Australian Medical Association.

Brisbane, unfortunately, had not during my visit any qualified homœopathic practitioner. There is a great demand for one in this beautiful city.

Melbourne, the capital of Victoria, at present the Federal capital of Australia, possesses a finely equipped and large homœopathic hospital, and the largest number of homœopathic practitioners in Australasia. Its hospital, beautifully situated opposite the Botanic Gardens, is one of the features of the city. The hospital is admirably managed, and

possesses a large medical and surgical staff. On its staff are also American graduates who exhibit the vitality and energy so characteristic of their nation. Melbourne is the great centre for homœopathy in Australasia—a great training ground for many of our practitioners now practising over there. Most of the homœopathic practitioners over there are well known to you. Most of them are British graduates. I may refer to Dr. Alleyne Cork, Dr. Gutteridge, Dr. Scott, Dr. Warren among others who are especially known by many of us here. It gives me exceptional pleasure to express my gratitude to them for the exceptional hospitality which I received, and also particularly to Mr. Bennett, the Secretary of the hospital. Drs. Bouton, Ray-Teague, Egglund, Seelenmayer, &c., are well-known graduates of American Universities, and Melbourne Homœopathic Hospital is to be congratulated in its possession of such splendid surgeons and physicians. Melbourne combines the best elements of British and American homœopathy.

Adelaide—the beautiful capital of South Australia—is represented on our list by Dr. Niesche, a graduate of Edinburgh, a former resident medical officer of this Hospital, a physician of great distinction in the city. I feel under a great debt of gratitude to Dr. Niesche and family for his hospitality and kindness. At Port Adelaide there are two practitioners—the Drs. Bollen—one of whom I had the pleasure of meeting in Melbourne.

Perth, the capital of Western Australia, is, unfortunately, not represented by a qualified homœopathic practitioner.

Tasmania, the beautiful little island south of Australia, and also one of the States in the Australian Federation, is proportionately better represented in homœopathy than any of the other States in Australasia. Hobart, the capital, is worthily represented by Dr. Gibson, who has organized and founded a finely equipped and beautiful homœopathic hospital in a beautiful part of the city, opposite Mount Wellington. Dr. Gibson, by his wonderful medical skill and knowledge, by his geniality and fine presence, has done very much to advance the cause of homœopathy in the island. Dr. Benjafield, whom I had not the pleasure of meeting, still practises there.

There are representatives at Launceston and Franklin, but these, unfortunately, I did not meet. My stay in Tasmania was too brief to find time to call on all the homœopathic practitioners. It was with great regret I left the beautiful and magnificent harbour of Hobart.

Next, New Zealand—the Elysium of the South, the epitome of every country in the world, and the native land of two of our esteemed colleagues—Dr. Johnstone and Dr. Cronin Lowe—possesses few representatives of homœopathy. Dr. R. S. Stephenson, a graduate of Edinburgh, is our worthy representative in Dunedin. He has founded a large homœopathic association over there, and by his skill and wondrous cures among his patients has furthered the cause of homœopathy greatly in New Zealand. His influence over the South Isle is powerful for good, and later we may hope to see at other centres representatives of our system.

Dr. Stopford, at Auckland, has established an extensive practice, and his name as a homœopathic practitioner is well known and honoured all over the North Isle.

Dr. Mackenzie, of Levin, I regret I was unable to call on. I believe he is an American graduate, and has a great reputation round that district as a most successful practitioner.

If my paper be not too long I would like to refer to my visit to America, and especially to the Homœopathic Colleges in Chicago. I had the good fortune, thanks to the Tyler Scholarship, to spend several months in attendance on their lectures and clinics. It may be of interest to you to hear my views on the matter. There are two Homœopathic Colleges in Chicago—the Hahnemann and Hering—and at these most of my time was spent.

The education given in the colleges is thorough and excellent. The comparatively small number of students makes their training more practical and personal. Over here we are trained in the recognized medical schools which are not homœopathic. We study the methods of allopathy, we follow its practice, and many of us have been allopathic practitioners. Both in theory and practice we are fully

cognizant of its advantages and disadvantages. We are not under any delusions about it. There is no glamour about it as far as we are concerned. If we be homœopathic and imbued with the spirit of homœopathy we are so after our experience of allopathy. Our faith is as a rule stronger and surer than that of those only trained in a homœopathic school.

We are more qualified to avail ourselves of the advantages of either system, and when homœopathy fails, as in the imperfect conditions of our materia medica it sometimes does, we can also give our patients the advantages which allopathy professes to give. Many of the graduates there personally testified to the advantages of our system of training in Europe.

Otherwise the training in homœopathic colleges is unique. In the study of the theory and principles of homœopathy, in their practical application in the philosophy of homœopathy, as it is termed, the American colleges stand supreme. Here in both colleges the spirit of homœopathy permeates the whole course of study; the students are imbued with the underlying principle of our system, from their first year of study they are initiated into the methods of study of the materia medica; and its practical application is disease. The result being that when their four years' course is completed, the graduates are splendid and accurate prescribers of these remedies, thoroughly acquainted with the methods of not only physical but also drug diagnosis, quick and reliable in the recognition of symptoms, both subjective and objective; in fact, sound and well-educated homœopathic practitioners.

The Organon—the bed-rock of homœopathy—is taught, expounded, and discussed in a manner unknown in Europe. The tripod of homœopathy, the law of similars, the single remedy, the minimum dose, form the basis of their practice. This is the essential test of homœopathy.

Naturally, in the great continent of America, where conditions are so diverse, where colleges are so numerous, there are different degrees of homœopathy, and different methods of practice are adopted. The low, the medium,

the high, and the simillissimum, if I may so term it, all have there, loyal supporters. The dilution which liberates the energy or soul of the drug is the dilution which appeals to all. Diseases are on different planes, different dilutions, attenuations, and potencies, act on different planes.

Here the skill and knowledge of the physician can be exhibited. The selection of the remedy is not a mechanical process by any means. As physical diagnosis is often a most difficult matter, so equally difficult and intricate is drug diagnosis.

In such matters there is naturally differences of opinion—wide difference of opinion. Each practitioner must decide for himself. Diseases are cured under all systems; at least, patients recover. Diseases are cured by all potencies. The cure of disease is not the special privilege of any one class of potencies. The totality of the potencies is as necessary for treatment as the totality of the symptoms for the selection of the remedy. The first and only duty of the physician is to cure the patient.

The philosophy of homœopathy so skilfully and wonderfully expounded by our great teacher and master, Dr. J. Tyler Kent, of Chicago, has given to us a means of developing our special system of treatment, and placing it on a rational and scientific basis. It is unnecessary for me to discuss the subject of the methods of recognizing when Nature and when the drug cures—a most fascinating subject—or our means of giving a rational prognosis from the results of our drug actions on the patient, apart from the physical condition of the patient, and the many other points of great and vital interest to the physician.

This year is the centenary of the *Organon*. In 1810 Hahnemann published his famous work—the basis of our faith and practice. In the 100 years which have since elapsed homœopathy has had both a direct and indirect effect on the other system of medicine. To-day the truth of the system shines brighter and clearer. As Hahnemann said, our art needs no political lever, no worldly badges of honour, in order to become something. Only have patience.

In 1844 was founded the British Homœopathic Society; it now embraces over 200 members.

During the sixteen years of my membership attendance at its meetings has ever been to me a source of pleasure and medical education, invaluable, and inspiring. The older I become, the more I appreciate the benefit which is derived from its meetings.

The British Homœopathic Society has ever been a kind and indulgent *alma mater* to her members—a bond of union for the homœopath of the British Empire—a guarantee of knowledge of the principles of homœopathy, a bond of sociality and fraternity to its adherents, and long may it flourish.

MINUTES OF THE SOCIETY MEETINGS.

THE TENTH MEETING of the Session, 1909-10, and first of the Annual Assembly of the British Homœopathic Society, was held at the London Homœopathic Hospital on Tuesday, June 28, 1910, at 8 o'clock, Dr. Macnish (President) in the chair. There were present also Dr. Blackley, Dr. Cronin, Dr. Roberson Day, Dr. Goldsbrough, Dr. Vincent Green, Dr. Granville Hey, Dr. Johnstone, Dr. Cronin Lowe, Dr. Byres Moir, Dr. F. Nankivell, Dr. Edwin Neatby, Dr. Miller Neatby, Dr. Norman, Dr. Spencer, Dr. Wynne Thomas, Dr. Weir, and Mr. Dudley Wright.

NEW MEMBER.

Jessie Margaret Murray, M.B., B.S.(Durh.), of 14, Endsleigh Street, London, W.C., was elected a member of the Society.

VISITOR.

Dr. Harold Edwards, of Pittsburg, U.S.A., was welcomed as a visitor to the Society.

ANNUAL REPORTS.

The reports of the Council and the Treasurer for 1909-10 were read and adopted (see p. 340).

SECTION OF GENERAL MEDICINE AND PATHOLOGY.

A paper for this Section had been promised by Dr. J. C. Hare on Vaccine Therapy, but owing to the destruction of the Pathological Laboratory of the London Homœopathic Hospital by the fall of a house, this paper was unavoidably postponed. In its place some interesting cases were shown and discussed by Dr. Vincent Green, Dr. Roberson Day and Dr. Epps, particulars of which appear on p. 332 of this issue of the JOURNAL.

ALTERATIONS OF LAWS.

Certain alterations of the Laws of the Society were agreed to (due notice having been given) as having been required in reference to alteration in the publication of the Society's transactions.

“*Law XII.*—The JOURNAL of the Society shall be published quarterly in London, and shall be under the direction of an Editor or Editors, who shall be responsible for its proper issue.

“Once in every year a list of the Officers, Fellows, Members and Corresponding Members, with their addresses, shall be published as a supplement to the JOURNAL.”

The following alteration was carried :—

In place of the *1st Clause.*—“A copy of the Transactions of the Society shall be sent to each Member whose subscriptions are not in arrear, and to Corresponding Members.”

Law XIV. (2) EXTRA-ORDINARY MEETINGS: An Extra-ordinary Meeting may be called by the President, or on the requisition of five Members.

An alteration was necessitated by the Society requiring to vote money at other meetings than the Annual Assembly, and therefore it was resolved that *Law XIV.* (which had previously read as above) henceforth read as follows :—

“*1st Clause.*—An Extra-ordinary Meeting may be called by the President, the Council, or on the requisition of any ten Members.

“*New Clause.*—“Questions of finance or of alteration of the Laws may be considered and voted upon by such Extra-ordinary Meeting provided such question or alteration have been previously announced by circular on two occasions at an interval of not less than one month.”

Consequently *Law XV.* required alteration as follows :—

“*Law XV.*—“An Annual Assembly of the Society shall be held in London, in the month of June or July, each year, for the purpose of taking into consideration matters pertaining to the interests of the Society, and of Homœopathy in general.”

The alteration to read :—

“That to *Law XV., 1st Clause,* be added before the word ‘interests’ the following words, ‘financial and other.’”

and the following :—

“*New Clause.*—“At an Extra-ordinary Meeting twelve shall form a quorum.”

“The procedure at these meetings shall be regulated by Bye-law VI.”

The ELEVENTH MEETING of the Session and SECOND OF THE ANNUAL ASSEMBLY was held on Wednesday, June 29, 1910, at the London Homœopathic Hospital at 8 o'clock, Dr. Macnish (President) in the chair. There were present also : Dr. Burford,

Dr. Roberson Day, Mr. Eadie, Dr. Epps, Dr. Gilbert, Dr. Goldsbrough, Dr. Granville Hey, Dr. Johnstone, Dr. E. A. Neatby, Dr. Sandberg, Mr. Knox Shaw, Dr. Spencer, Dr. Wynne Thomas, Dr. Wheeler, Mr. Wilkinson, and Mr. Dudley Wright.

NEW MEMBERS.

William Alexander Davidson, L.S.A.(Lond.), of 235, Uxbridge Road, London, W., and John Lang, M.B., Ch.B.(Glas.), of 31, St. Vincent Street, Glasgow, and the London Homœopathic Hospital were elected Members of the Society.

OFFICERS FOR 1910-11.

The following Fellows and Members were elected to fill the offices of the Society for 1910-11.

President.—Dr. W. T. Ord, of Bournemouth.

Vice-Presidents.—Dr. William Roche (Norwich), Dr. Vincent Green.

Treasurer.—Dr. Blackley.

Council.—Dr. Macnish (Retiring President, *ex officio*).

Fellows : Dr. Byres Moir, Dr. Edwin Neatby, Mr. Knox Shaw, Dr. Wheeler. *Members :* Mr. Eadie and Mr. Granville Hey.

PRESIDENTIAL ADDRESS.

The President then read his Annual Address, which owing to his absence abroad had been unavoidably postponed until the end of the Session.

The address appears on p. 343 of this issue of the JOURNAL. A very hearty vote of thanks was accorded to the President for his address, and thereupon the meeting adjourned to the Hotel Russell, where through the hospitality of the President, supper had been provided, and in the enjoyment of which the Session concluded.

SESSION 1910-11.

At a meeting of Council held on July 13, 1910, the following officers were elected for the ensuing Session. Honorary Secretaries : Dr. Edward Neatby and Dr. Macnish. Editor : Dr. Goldsbrough. Librarian : Dr. R. M. Le H. Cooper.

Hon. Secretaries of Sections : *Materia Medica and Therapeutics*, Dr. Cooper. *General Medicine and Pathology*, Dr. Miller Neatby. *Surgery and Gynæcology*, Mr. Eadie.

MEETINGS.

The following evenings were allotted to the different Sections:—

- 1910—October 6, Presidential Address.
 November 3, *Materia Medica and Therapeutics*.
 December 1, *General Medicine and Pathology*.
 1911—January 5, *Materia Medica and Therapeutics*.
 February 2, *Surgery and Gynæcology*.
 March 2, *Materia Medica and Therapeutics*.
 April 6, *General Medicine and Pathology*.
 May 4, *Materia Medica and Therapeutics*.
 June 1, *Clinical Evening*.
 June 28, *General Medicine and Pathology (Annual Assembly)*.
 June 29, *Election of Officers and other business (Annual Assembly)*.

PROCEEDINGS OF THE LIVERPOOL BRANCH.

APRIL MEETING. SESSION, 1909-10.

THE seventh meeting of the Session was held at the Hahnemann Hospital, Liverpool, on Thursday, April 14. In the absence of the President (Dr. J. D. Hayward), Dr. Ellis took the chair. The following members were also present: Drs. A. E. Hawkes, Cash Reed, Chas. Hayward, Gordon, Proctor, Watson, and Bryan.

The minutes of the previous meeting were read and approved.

The election of officers for the next Session was next proceeded with, and resulted as follows: *President*, Dr. A. E. Hawkes; *Vice-President*, Dr. J. Hawkes; *Hon. Treasurer and Secretary*, Dr. Bryan; *Representative on Council*, Dr. A. E. Hawkes.

Drs. A. E. Hawkes and Cash Reed were nominated by the Society to serve on the Executive Committee of the International Homœopathic Congress to be held next year.

The President next called upon Dr. Gordon to read his paper entitled "Mainly about Ourselves." This was followed by a short paper read by Dr. Cash Reed, entitled "Impressions of a Visit to the Radium Institute at Paris," (which appears on p. 324 of this issue of the JOURNAL).

Dr. Cash Reed was thanked by the members present for his paper, which was keenly discussed.

The proceedings of the Session then terminated.

THE PROPOSED NEW HOMŒOPATHIC JOURNAL.

The present is the last issue of the JOURNAL of the BRITISH HOMŒOPATHIC SOCIETY. In future the Transactions of the Society will be issued annually to the Fellows and Members, but as reprints from a JOURNAL to be conducted independently of the Council of the Society : At the recent Annual Assembly it was reported the Committee who were appointed to consider the foundation of the new JOURNAL had met, and they had elected an Executive to carry out arrangements. Dr. Miller Neatby had been appointed the Secretary to the Committee, and the business arrangements of the JOURNAL would fall upon Dr. Miller Neatby. Dr. Goldsbrough and Dr. Stonham had been asked to undertake the editorial part of the work. The arrangements so far were that the new JOURNAL would be issued in January next, and thenceforward monthly, price one shilling, but it would be supplied to members of the Society at half price. The JOURNAL would consist of forty-eight pages per month, octavo size, and of similar type to that in the present JOURNAL. It would contain the papers read at the Society, and the discussions ; the papers read at the Liverpool Branch, the papers of the Western Counties Therapeutic Society ; the papers of the Annual Homœopathic Congress ; original articles by members of the profession, notably on Materia Medica and therapeutics, and on other matters of medical experience and knowledge, such as cases for diagnosis and treatment ; also on surgery and on special branches. It would also contain reports of cases from hospital practice, not only in London, but in the country, as far as they could be obtained. In addition, it would contain excerpts from contemporary literature from varied points of view : first from the point of view of Homœopathy in the old school, books, papers or cases published indicating the adoption of Homœopathy ; those would be taken from the old school journals and referred to in the new JOURNAL with their relation to Homœopathy pointed out. Criticisms of Homœopathy in the old school would be met by facts from the new. It was not proposed to introduce medical politics of any kind, or personalities apart from records of work, and discussions relevant thereto. Another point of view from which it was hoped to get excerpts from contemporary literature would be in the realm of pharmaco-dynamics

and therapeutics ; and for that purpose journals from the Continent of Europe and America would be read every month. The medical work of the British Homœopathic Association would also find a place in the JOURNAL, for example lectures would be noticed and announced beforehand, and research work and selected lectures would be published from time to time. In addition, two or three pages would be devoted to news, *i.e.*, news of meetings, and those announcements would be cut down to the minimum length. The present publishers of the JOURNAL of the Society, Messrs. John Bale, Sons and Danielsson, Ltd., would be the publishers of the new JOURNAL.

SUMMARY OF PHARMACODYNAMICS AND THERAPEUTICS.

Extracted from Exchange and other Journals by the Editor, in collaboration with J. Galley Blackley, M.B.

Æsculus Hippocastanum. *Characteristics.*—Dr. G. B. Stearns, of New York City, contributes a paper on frequently overlooked symptoms of æsculus, allium cepa (see below), antimonium crudum, and cannabis sativa. Of æsculus he draws special attention to the throat symptoms, which consist of burning, constriction, and rawness, accompanied by hoarseness, also a short cough induced by a deep breath, swallowing, and particularly by speaking. Other characteristics are pain in chest, < on inspiration, tightness and rawness of the chest. The nasal symptoms are dryness, burning and rawness, with supervening coryza, also burning pain and smarting in the eyes and round the orbits. Inspired air feels cold. Sensitiveness to inspired air is the leading modality, next to that a sacral backache. (*North American Journal of Homœopathy*, June, 1910, p. 390.)—ED.

Allium Cepa. *Characteristics.*—The most prominent characteristics of allium cepa are as follows: Desire for and relief in the open air; sensation of glowing heat or warmth on different parts of the body surface, and on the stomach and rectum; great hunger, often reappearing soon after eating; indigestion and colicky pains, with bad-tasting eructations and offensive flatus; pain in the ears and mastoids; toothache, > by holding cold water in mouth; shivering and burning in rectum similar to pains of fissure of anus; frequent micturition a general evening aggravation. (*Ibid.*)—ED.

Antimonium Crudum. *Characteristics.*—The eruption produced by antimonium crudum is pustular or scaly, with itching and burning, < night and from warmth of bed. In cases of workers with the ore, eruption appears on scrotum and about

genitals more than any other part. Pustules resemble small-pox. Sexual desire is first increased, then diminished, and finally becomes extinct, with accompanying atrophy of penis and testicles. Two workers developed painful and difficult urination with a urethral discharge. (*Ibid.*)—ED.

Arsenicum.—Dr. W. J. Hawkes, of Los Angeles, publishes in "Cases from my Note-book" one case which illustrates vividly the "sphere" of arsenicum. A strongly built man, aged 45, employed on the railway, had suffered for years with violent facial neuralgia and headache. The attacks were so severe at times as to make him delirious and confine him to the house and bed for days at a time. The neuralgia had followed an attack of intermittent fever under allopathic treatment. When Dr. Hawkes first saw him he could not describe the pain, he was suffering so much. It was located chiefly in the right side of the face and head, the right eye was drawn out of shape by it; < night, when very restless and nervous, > hot applications, < cold. Arsenicum given. He soon recovered from the neuralgia, but was attacked by well-defined intermittent fever, with irregular paroxysms, rebellious stomach, having much mucus, thirst for cold water which aggravated the nausea. Ipecacuanha and arsenicum, each as indicated, caused disappearance of the ague, but a violent dysentery set in immediately. Arsenicum was continued, but not often repeated, and finally cured the dysentery, and at the time of the report six months later he had no sign of either dysentery, intermittent fever, or neuralgia. The cure occupied a week. The attenuation of arsenicum is not stated. (*Pacific Coast Journal of Homœopathy*, June, 1910, p. 223.)—ED.

Arsenicum. *Poisoning by 3x Trituration Tablets.*—Dr. A. G. Howard, of Boston, reports the following case: C., aged 22, medical student, in good health otherwise, complained of coryza, for which arsenicum alb. 3x was prescribed, 1 gr. every two hours. The patient thought he would cure his condition more quickly by repeating his medicine more frequently, so he swallowed a tablet every twenty or thirty minutes. This was at 10 p.m., and he took four before retiring. On the following morning, Tuesday, he began again to take a tablet every twenty to thirty minutes until 3 p.m. He secured more tablets and commenced again at 11 p.m. During the early part of the evening he felt bright and active, with his mind clear and never

felt so good in his life. At 8.30 p.m. had an uncontrollable desire to go to sleep. He was awakened at 10 with difficulty, as he had to get home, to which he staggered half asleep. Slept soundly until 2 a.m. Woke (Wednesday) with severe muscular cramps in the abdomen, nausea, and an irresistible desire for stool, which was watery, yellowish-green, and shiny, fæces gushed out as of water from a hydrant. Vomited while at stool; afraid to leave for fear of involuntary passing of fæces. Cramps in calves and thighs, < bending forward. 2.50 a.m.: Stercoraceous vomiting with stool. Vertigo on returning to bed, could not see bed. Very weak, could not see bed, everything moving. Profuse cold sweat while vomiting, and at same time felt cold. Condition continued until 6.30. Vomiting and stools now at longer intervals, face pale, eyes dull, tongue bluish, tremulous, and cold tip. Disagreeable taste. Anxious, thinks he will die. Great thirst, > by holding water in mouth. Sore, raw feeling mouth to anus, in which burning, biting pain at stool. Pulse 60, temperature 96.6° F. Frontal headache pushing eyes out. Eyes feel heavy. Lumbar backache. Verat. alb. 3x given. 10 p.m.: pulse 86, temperature 98.2° F. Throbbing headache in temples like toothache. Slight epistaxis in afternoon, no stool since noon. Passes a great amount of flatus and belches, some nausea. Occasional cramps in calves of legs and soles of feet. Thirst as before. Very weak. Queer puckering feeling round umbilicus. Feels hot and desires to be uncovered. (Thursday, a.m.): Very weak, slept well. (Friday, a.m.): Ditto, vertigo and nausea. (Saturday): Root of tongue and throat very dry. Is greatly improved. A twenty-four-hour specimen of urine showed traces of arsenic. (*New England Medical Gazette*, July, 1910, p. 318.)

Cannabis Sativa. *Characteristics.*—*Cannabis indica* and *sativa* are alike in their symptomatology except that mental symptoms predominate in the former and urethral in the latter. Both produce chest symptoms. Oppressive constriction, suffocative feeling, a great effort being required to inspire deeply. Tough mucus accumulation in the lower part of the trachea which has to be swallowed; rawness and soreness follows tardy expectoration. Heavy feeling and mental cloudiness are continuous, muscular inertia, stretching of the limbs, and yawning. Thoughts run riot, with illusion on lapse of time. (Stearns in *North American Journal of Homœopathy*, June, 1910, p. 390.)—Ed.

Causticum. *A Study.*—Dr. Chase, of Utica, presents an interesting paper on *Causticum*, of which the following are the chief

points. More especially causticum has a profound effect on the nervous system, with tendency to paralytic conditions varying from a gradual and general decrease of muscular and nervous strength to actual paralysis, as of the œsophagus and throat after diphtheria. In facial paralysis from cold exposure it follows aconite. It is a principle remedy in ptosis, also in aphonia from overtaxed voice, accompanied with hoarseness and weakness. Weakness of bladder. Spurting of urine when coughing, sneezing, and straining. Constipation, with strong urging and straining. Stool passes better when standing and may be involuntary from a full rectum. Paralytic weakness of lower limbs, great fatigue and lassitude. Other less pronounced features are dimness of vision, black specks, choreic movements from fright. Neuralgic pains from exposure. Convulsions at puberty. Contractions and pains in joints and tendons, also in back, with restlessness at nights. A hard, racking cough, not deep enough for expectoration, > by swallowing cold water. Catarrh of nose and middle ear. The causticum patient is pessimistic and melancholic, sallow, dark hair, and weak. (*North American Journal of Homœopathy*, June, 1910, p. 394).—ED.

Exophthalmic Goitre and Belladonna.—In a paper read before the annual assembly of the American Institute of Homœopathy, in response to a question previously put to him, “How clearly was the applicability of belladonna to the treatment of exophthalmic goitre indicated by the test proving of the drug conducted by the O. O. and L. Society,” Dr. Howard Bellows draws attention to the correspondence of drug effects with disease symptoms under the following heads: (1) Heart symptoms; (2) thyroid enlargement; (3) eye symptoms; (4) general symptoms. Under heart symptoms the correspondence is shown under palpitation increased by exercise, increased frequency, pulsation of arteries increased and felt, irritability of heart as indicated by irregularities, intermissions, and dirotic waves. Feeling of enlarged or full heart. A rapid, weakened pulse is the ultimate characteristic effect of belladonna as distinguished from the full bounding pulse produced by large doses in cases of poisoning. Under thyroid enlargement such a condition has not been actually produced by belladonna, the effect of the drug on glands being of the salivary and lymphatics which were enlarged, painful, and engorged. Under eye symptoms, the subjective correspondence is very marked, and the objective consisted in a staring, suffused and wild look as produced by belladonna. Insufficient closing of

eyes is a belladonna symptom, also the occurrence of œdema. Fullness and tortuosity of the veins of the retina occur as both a disease and drug effect. Under general symptoms the correspondence is seen in mental irritability and excitability, depression with tendency to melancholy, mental processes fragmentary, no fixity of attention, impaired memory, hysterics, fright with hallucinations of sight and sometimes hearing, delirium, occasional mania, restlessness, tremor, local cramps and spasms, choreiform twitchings, weakness of legs, paroxysms of vertigo, tinnitus, vasomotor dilatation, especially in areas, sensations of warmth, epistaxis, paroxysms of dyspnœa, distressing thirst, diarrhœa, albuminuria, depressed sexual desire, dryness of the skin. The parallelism is thus almost complete, and Dr. Bellows points the homœopathic moral, but he says nothing about dosage and frequency of administration, which surely in exophthalmic goitre as related to the varying symptoms of belladonna from different doses would be of almost as much importance as correspondence of symptoms. (*North American Journal of Homœopathy*, August, p. 507.)—ED.

Narcissus. *Lily Rash.*—In a paper contributed to the Section of Dermatology at the recent Annual Meeting of the British Medical Association, Dr. David Walsh describes a dermatitis occurring in the “pickers” of daffodils and narcissi in the Scilly Islands. Many workers are employed in the picking, but only a proportion are attacked, and it appears that traumatism of the skin strongly predisposes to a development of the rash. The rash usually attacks the hands and arms, and not uncommonly the face, to which the irritant may be conveyed by infected hands. At times, especially where there are cuts or cracks in the skin, it takes the form of severe local inflammation and ulcers. It may become chronic or the eruption may become general. One of the patients seen had an erythematous eruption of hands and arms, in another the hands showed a condition resembling chronic eczema with rhagades and nail excoriations. Some workers escape the rash altogether. Some are attacked once only. Some are so susceptible that they dare not touch the flowers. The most severe effects are from infected cuts or sores on hands. Some varieties of daffodil and narcissi are more poisonous than others, the worst being the *Campernelle*, a small variety with dark yellow flowers. One worker was attacked once only in very wet weather. Others mentioned a similar experience as regards wet weather. As to the varying degrees of virulence of different varieties the following appears to be the order

(1) *D. campanell*, (2) *N. ornatus*, (3) *N. gloriosa*, (4) Scilly white, (5) *N. grand monarque*, (6) all other kinds now and then. Similar results to the rash seen among the workers were obtained by inoculation of a succus obtained from several varieties of the plants.

The rash may be described as an erythema of a papular, vesicular, or pustular type, of varying degrees of severity, at times chronic, and in rare instances generalized. The most interesting points brought out in the investigation were the importance of broken skin, individual susceptibility, and (homœopaths would add) aggravation from wet weather. (*British Medical Journal*, September 24, 1910, p. 854.)—ED.

Tuberculin in Pulmonary Tuberculosis.—Published experience in the treatment of pulmonary tuberculosis by tuberculinum has hitherto been scanty, and the results uncertain or unsatisfactory. A report of its use in twenty-three cases is accordingly noteworthy. Dr. Rankin, of New York, publishes such a report, the form of tuberculin employed being that known as Deny's Bouillon Filtrate. This preparation contains all the soluble products which the bacillus elaborates when cultivated in bouillon, no heat being employed in the preparation. It is prepared in a decimal series of five dilutions, and is administered hypodermically, the quantity of tuberculin in each 2 minims to the several dilutions is as follows: 1st, $\frac{1}{10000}$ mg.; 2nd, $\frac{1}{1000}$; 3rd, $\frac{1}{100}$; 4th, 1; 5th, 10. The first dose of each series is 2 minims. Each subsequent dose is increased by 2 minims until twenty is reached; then the next series is commenced and run up to 20 minims, then the third series, and so on until the five are administered. Between November 12 and 19, twenty-three cases were placed under this treatment in the Metropolitan Hospital, N.Y. The pulse, respiration and temperature were all taken three times a day for one week before treatment was instituted, and a careful physical examination was made, together with radiographs of the thorax. With one exception all cases showed advanced changes in the lung. Two left the hospital shortly after commencing treatment, the others were divided into two classes, those who were subsequently withdrawn from treatment, and those who continued and were still under treatment. The first class numbered ten, all having a similar history. At first there was some slight improvement, but at periods varying from eight to twelve weeks, they seemed to lose ground sometimes, with increase of temperature. Of the remaining thirteen cases

(of which details of each case are given) nine showed very decided improvement, three much improvement but less decided, and one no improvement. In six cases it was thought most likely the disease would be arrested, and nearly so in others. Dr. Rankin regards his observations as corroborating the following indications for the use of the remedy. (1) That the initial dose should not be more than $\frac{1}{1000}$ of a milligramme; (2) that the doses should not be raised too rapidly, the range for the series consisting from three days to seven; (3) when a reaction has followed, the next dose should be postponed until evidences of such had subsided; (4) after a reaction the last dose should be repeated before increasing; (5) malaise, headache, loss of appetite, increase of cough, raising blood, are evidences of limitation of the patient's tolerance and call for a suspension of treatment or limitation of doses; (6) cases suited to treatment are those without fever, or at least not above 100°, fair nutrition, and chronic in type. (*Journal of the American Institute of Homœopathy*, June, 1910, p. 342.)—ED.

Veratrum Viride.—A short investigation has been conducted at the pathogenetic laboratory of the Homœopathic Department of the University of Michigan, of which Dr. R. R. Mellon is director, with a view to inquire whether veratrum viride has the power of raising the opsonic index of the human subject against the coccus of Fraenkel. The experiments were conducted on six persons, extending over about two weeks each, and full attention was given to method and possible defects. The doses given were ten drops of the 1x dilution (supplied by Boericke and Tafel) three times a day. The following is a summary of results: (1) It was shown that veratrum viride will raise a person's opsonic index against the *Diplococcus pneumoniae* 70 to 100 per cent.; (2) that its action is more profound than has been inferred from the proving; (3) there is a probability that physiological doses may depress the index, while sub-physiological doses raise the resistance. (*University Homœopathic Observer*, July, 1910, p. 78.)—ED.

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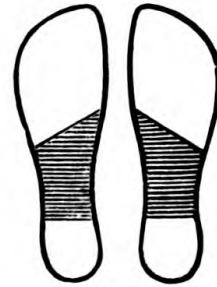
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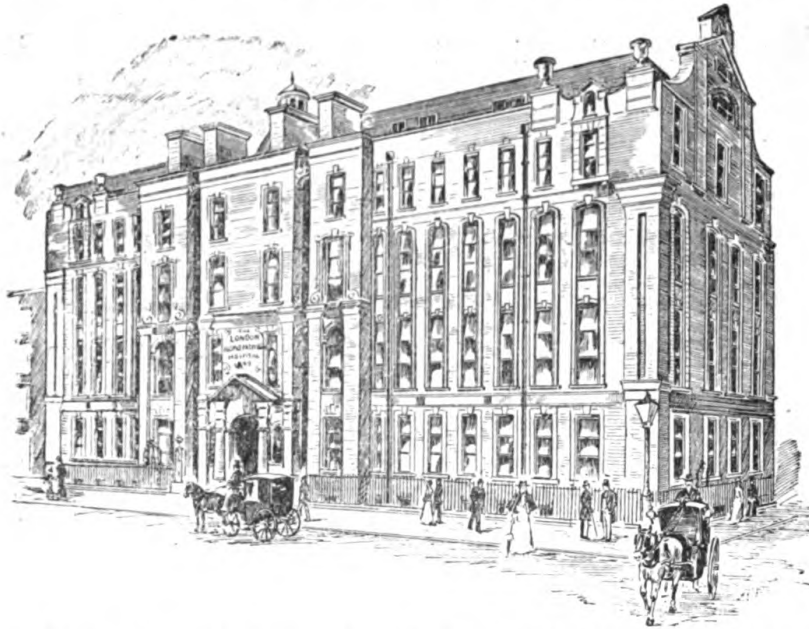
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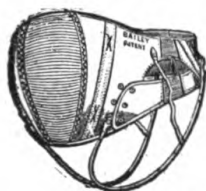
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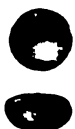


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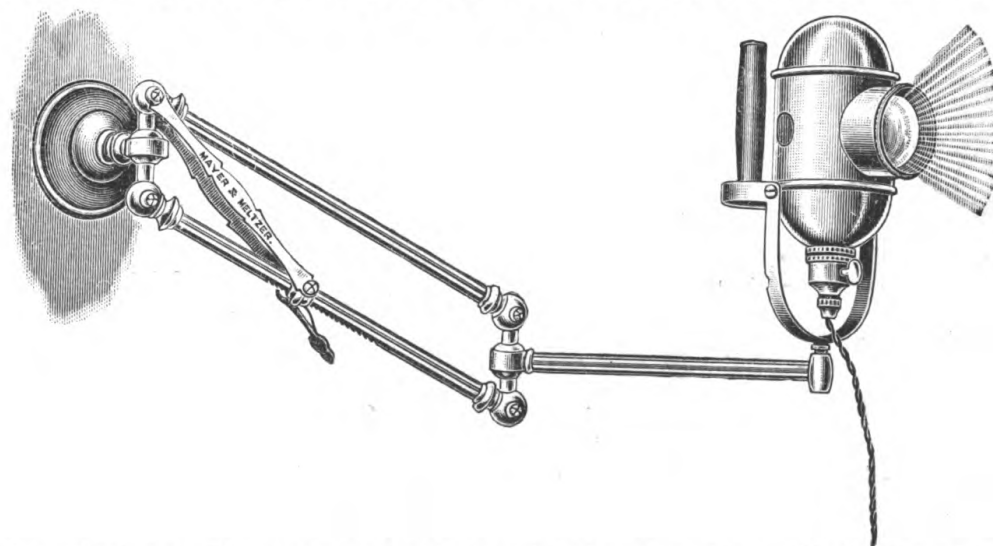
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The Journal

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British Homœopathic Society.

No. 4.

OCTOBER, 1910.

Vol. 18.

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WE desire to draw your attention to the fact that from January next the transactions of the British Homœopathic Society will appear in a new *Journal*, which will be published independently of the Council of the Society. The title of the new publication will be

“*The British Homœopathic Journal*,”

and it will be under the Editorial Management of Dr. GOLDSBROUGH and Dr. STONHAM. It will be published monthly, price One Shilling, but will be issued to Members of the Society at half price, namely, post free for Six Shillings per annum payable in advance. On page 357 of the issue of the Journal herewith you will find a short account of the aims and proposed contents of the new Journal. A subscription form is enclosed, which should be filled up and returned with remittance to the publishers, Messrs. JOHN BALE, SONS & DANIELSSON, LTD., 83, Great Titchfield Street, London, W. The Council of the Society trust that “The British Homœopathic Journal” will receive the cordial support of all its Fellows and Members.

We are,

Yours fraternally,

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