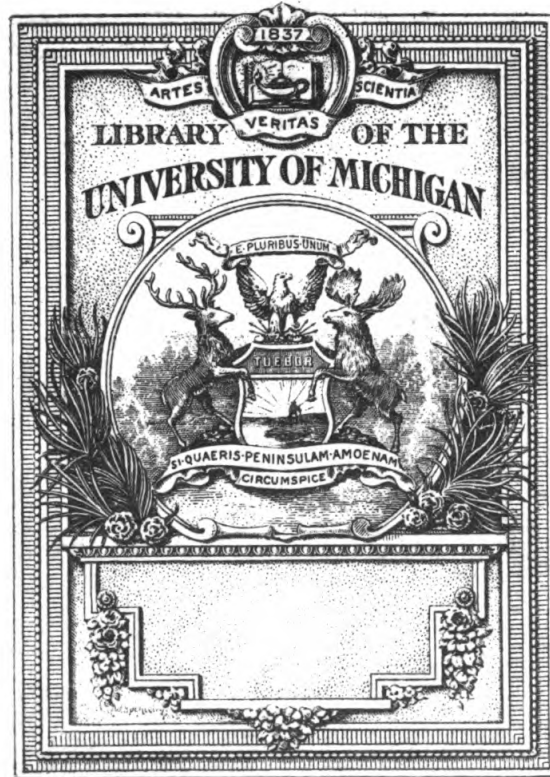


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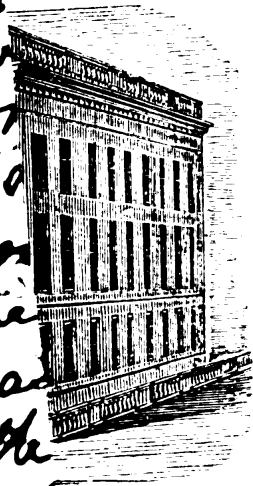
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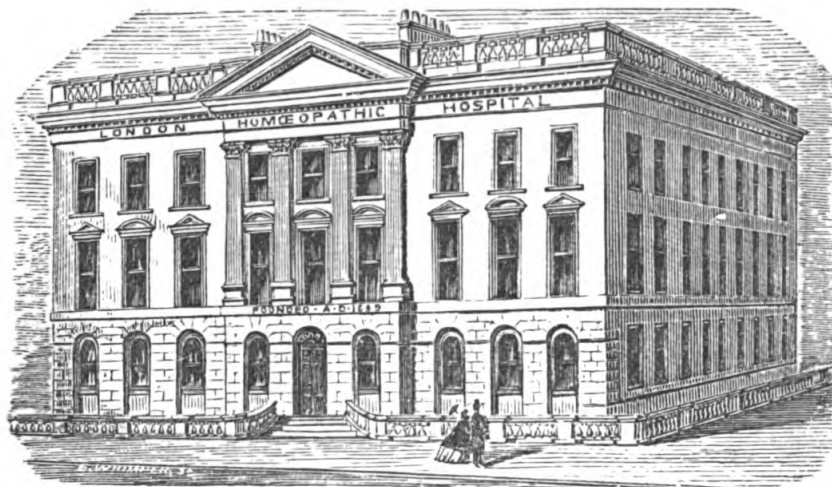
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A CONTRIBUTION TO THE STUDY OF REMEDIES FOR DISEASES OF THE NERVOUS SYSTEM.

BY E. A. NEATBY, M.D.

Assistant Physician to the London Homœopathic Hospital.

INTENSELY interesting as is the study of diseases of the nervous system for its own sake, it must be acknowledged, even by the enthusiast in neurology, that to the therapist it is one of the most depressing in the whole range of medicine. Of preventive measures we know little or nothing, for we are ignorant of the conditions which lead up to and precede the fully developed disease. Of curative agents and means we are almost equally in the dark, as far at least, as organic lesions and corresponding drug remedies are concerned.

The main object of my paper will be to bring into juxtaposition the correlated effects of drug and disease on the nervous system. That our accurate knowledge of these relationships is small will, I fear, be demonstrated. But if I am able to remind you what are the lines upon which we should work with a view to increasing our positive knowledge and to filling up gaps, of which so many unfortunately exist, I shall be abundantly gratified. In the words of another:* “The localisation of the action of drugs on the different tracts of the spinal cord appears to be a field of research in which, as yet, little has been done, and is one that gives promise of very interesting and useful results. The importance of being able to localise the action of a drug to a special tract of tissue cannot be over-estimated, and if further work should prove this to be possible it will go far to render the use of drugs in diseases of the nervous system a more rational proceeding.” Not only so, but we must make it our object to ascertain the nature of the lesion produced

* *Internat. Jnl. Med. Sci.*, Aug., 1889.

by a drug in the particular tract of tissue which is the subject of its "elective affinity." We shall not overlook, however, in our eagerness to localise with accuracy, the fact that while our knowledge is still imperfect in this direction we may obtain valuable aid from drugs having no primary relation to the nervous system. Diseases commonly called of the nervous system are, as we all know, not always, or perhaps even most frequently, due to lesions of nerve tissue. Consequently, we may hope for help from agents which influence the vascular and connective tissues, even though we are not certain that they have as yet shown their power over these tissues in the nervous system. Before the audience I have the honour to address it is almost unnecessary to remark that we shall not neglect the guides which symptoms afford us, though I feel sure you will agree with me that here this guide is more liable to fallacies than in other situations, and that to have a real and reliable "totality" we must include objective conditions as well as subjective symptoms.

The following is a *résumé* of the facts I have been able to collect illustrating the precise and localised action (as far as hitherto ascertained) of various substances on the nervous system and especially on the spinal cord.

Alcohol.—The chief lesion of the nervous system (apart from delirium and tremors), is a multiple neuritis. Three varieties of alcoholic neuritis are described: 1, the paralytic (with predominating motor symptoms); 2, the ataxic; and 3, the hyperæsthetic or neuralgic (the last two with predominating sensory symptoms). The ataxic form can resemble tabes dorsalis very closely, exhibiting at times double vision, inequality, sluggish reaction, or even immobility of the pupils, Romberg's and Westphal's symptoms, and nevertheless is due to a neuritis, and can be recognised as a neuritis only by its ætiology (alcoholism), and by its favourable course ending in recovery.

The symptoms of multiple neuritis are doubtless familiar to most of you; they may be summarised as follows, although any individual case may present wide departures from a typical description: Tenderness of nerves and muscles, subjective hyperæsthesiæ (cutting, burning, shooting pain, worse from every movement), numbness of fingers and toes, trophic and vasomotor

disturbances (often including extensive painful œdema). General weakness shows itself early, soon developing into an evident bilateral paralysis, followed by atrophy; or the paralysis may be less general and be limited to isolated muscles or groups of muscles. Eye symptoms and disturbances of the organic reflexes may be present, with or without delirium, mental excitement, insomnia, rapid pulse and signs of cardiac weakness.*

Alcohol may produce all these symptoms and lesions, but it may apparently go further. Sharkey reports a case† in which constant rapidity of heart's action, dyspnoea (paroxysmal), dysphagia, and weakness during life, was found to be associated *post mortem*, with intense inflammation of phrenic, vagus, and popliteal nerves, and with inflammatory softening of the spinal cord in the lower cervical and dorsal regions, and in the lumbar enlargement of the cord. Degeneration of cells of anterior cornua at level of fourth and fifth cervical nerves has been found. Retinitis indistinguishable from albuminuric retinitis, was present in another case‡ and was associated with increased arterial tension and enlargement of the left ventricle. No signs of nephritis were present and the symptoms all passed away. Double optic neuritis has been more than once reported, with or without strabismus. Widespread paralysis may exist without any sensory phenomena. Contracture of the flexor muscles of the leg has also occurred.

In some cases the nerve terminations may be damaged and the trunk escape, while such spinal cord lesions as the following may exist, recent hæmorrhages in the gray matter with thickening of the blood vessels. The neuritis fascians of Eichorst, is caused by alcohol as well as by other agents. Sclerosis of the posterior or postero-lateral columns has also been found to be due to alcohol.

Antipyrin.—This drug appears to act § on all parts of the nervous system; mainly on the cord, but also on the brain and motor nerves. If the symptoms produced by a drug may be compared with those the result of disease, the localisation of *antipyrin* is fairly obvious. The symptoms in question bear a very strong resemblance to

* Ann. Univ. Med. Sci., 2 B—5.

† *Lancet*, April 21, 1888.

‡ *Lancet*, 1888, vol. 1, p. 273.

§ *Brit. Med. Journ.* June, 1889, p. 222.

those of lateral sclerosis. For instance, in guinea-pigs and a cat, spastic rigidity of the hind limbs has been found, and, in all animals experimented upon, rigidity formed a marked symptom. Further, in the first-mentioned animals this symptom appeared to come on with any attempt to use the limbs, just as is the case with a patient with lateral sclerosis.

The excess of myotatic irritability is also very marked, the slightest tap being sufficient to evoke violent muscular contractions, and in extreme cases to cause clonic spasms of the whole body. In one experiment phenomena exactly similar to those of ankle-clonus were obtained. In all cases the contrast between the effect of painful stimuli and stimuli such as the slightest taps, or even the vibrations produced by walking about the room, was most marked, the former producing less effect than in a normal animal, while the latter caused the violent spasmodic movements already mentioned.

The effects of *antipyrin* are so transient, seldom extending over more than a few hours, and the recovery is so complete, that pathological results demonstrable by the microscope are hardly to be expected. Further, doses sufficient to cause death produce other symptoms not referable to the lateral columns alone.

As regards the action of *antipyrin* on the brain of mammals but little can be said at present. From the rapid rhythmic movements noticed in many cases, and from the circus-movements sometimes observed, it may be concluded that either the motor centres themselves are involved or that their inhibitory power is abolished.

In further illustration of the power of *antipyrin* to influence the motor centres of the brain is a case reported by Tucek, and reproduced in the English journals. A healthy boy of four years of age had taken daily 18 grs. for three weeks. He fell into a condition of somnolence, passing into sopor. While in this state, "paroxysmal epileptic attacks" set in, some of them complete, with general convulsions following in regular order; others incomplete, with partial unilateral twitching. The pupils were dilated.

Arnica produces some ill-defined paralytic symptoms; *argentum nit.* also.

Arsenic.—The paralytic symptoms of *arsenic* are so well-known that I need not dwell upon them. Suffice it

to say, that they are chiefly due to neuritis. An excellent assemblage of cases, illustrating both the motor symptoms and the various paræsthesiæ, is to be found in the *Cyclopædia of Drug Pathogenesis*, vol. i., pp. 431—434. I would refer you also to an important case by Dr. M'Clure, reproduced in the *Monthly Homœopathic Review* for August. The condition of the reflexes and of the electrical reactions is fully described.

Although, as I have said, *arsenic* most commonly induces inflammation of the nerves (both nerve-trunks and nerve-endings) three cases are reported in *L'Art Médical*, vol. 43, p. 48, in which the symptoms pointed to a myelitis, acute, sub-acute or chronic. What these symptoms were or what lesion of the cord they suggested is not stated. Of more certainty is the record by Vulpian of an acute myelitis produced by *arsenic* poisoning, and demonstrated apparently after death. I have not met with any recent information on this subject.

Subnitrate of Bismuth.—In some experiments on a dog by Dalché and Villejean, the left hind leg became gradually weaker and weaker, and would not support the weight of the animal, and undoubted atrophy of the thigh accompanied this. The sensibility was difficult to estimate. Then the left fore-leg was affected, and, finally, the right hind extremity. Thus the whole of the hind quarters were paralysed, and hemiplegia and paraplegia were together present. Slight power of movement was present throughout, but only in the muscles of the thigh and shoulder. The tendon reflexes were present and the pupils remained active. At the autopsy no nerve lesions were found, but the cord was not examined. (*M. H. R.*, Feb., 1889.) The paralysis of *bismuth* appears to be of spinal origin, although it must be confessed that the case quoted does not furnish proof of this. The records of *post mortem* examinations are, unfortunately, often incomplete, especially in regard to the condition of the cord. In another case, related in the *Cyclopædia*, a kind of general paralysis occurred, and the *post mortem* showed the brain to be not very full of blood, with a gelatinous deposit between the convolutions, and some fluid in the cavities. The spinal vessels were full of blood, especially about the cauda equina. Spasms of the limbs are not uncommon.

Cocaine.—This drug has so wide and powerful an action on the nervous system that it should be capable of being turned to good therapeutic use. Richet* pointed out that the convulsions produced thereby were identical with those of true cortical epilepsy. Great weakness of legs in life is associated, *post mortem*, with degenerative changes in the central nervous system.† Marked hyperæmia, albuminoid degeneration in ganglion cells of spinal cord and of heart, and fatty degeneration of heart-muscle and nerve cells of heart. The vascular system of the cord was much affected, there being cellular proliferation and hyaline degeneration of the coats. Extravasation of blood into fourth ventricle and anterior part of medulla; grey substance of cord over-filled with blood, resembling a bloody sponge.‡ Allen's *Handbook* gives, under *coca*, "involuntary rapid walking, with head bent forward." This symptom, together with the tremor it causes, and its effect on the motor centres of cerebrum, suggest the possible usefulness of cocaine in paralysis agitans.

Copper produces cramps, choreiform and convulsive movements, and a paralytic condition resembling amyotrophic spinal sclerosis, as pointed out by Dr. Hughes. The *Cyclopædia* gives no case where a lesion of the cord was demonstrated after death.

Iodoform.—In 1887 I made a collection of a few illustrative cases of *iodoform* poisoning; these were printed in the *Homœopathic World* for January, 1888. This substance causes local anæsthesia, staggering gait, diminution or exaltation of both superficial and deep reflexes, spasmodic paraplegia, with tremor on voluntary movement, permanent priapism, dilated pupils, convulsions, &c., mostly of spinal origin. There were found *post mortem* intense hyperæmia of cerebro-spinal nervous system, especially in the grey matter, accompanied with changes in the nerve cells. *Chorea* has been produced.§

Lead.—An admirable summary of our knowledge of the action of lead on the nervous system is to be found in Dr. Hughes' *Pharmacodynamics*. There is little to add to his account. Neuritis is unquestionably produced,

* *Ann. Univ. Med. Sci.*, vol. v., p. 9.

† *Ibid.*, vol. ii., p. 22.

‡ *Cyclo. of Drug Pathogenesis*, vol. ii., p. 278.

§ *Lancet*, Sept. 21, 1889.

but there can be little doubt that the spinal cord is affected both by acute and chronic inflammation. Vulpian has demonstrated its power to induce acute myelitis in a dog,* and many authors have concluded from the similarity of the muscular atrophy of lead poisoning to that of affections of the anterior horns from other causes, that an anterior polio-myelitis was the cause of lead palsy. Recent studies of peripheral neuritis show these deductions to have less value than they formerly were supposed to possess.

Wood, in the third edition of his *Treatise on Therapeutics* (1881), says, that no definite spinal lesions have been recorded, and Brunton has no additional information to give.

Braun† relates a case in which lead appeared to be an important ætiological factor. The following is a summary of the symptoms and of the lesions found after death. Pains and paræsthesia in right arm and hand and in both legs; muscles of hand, forearm (extensors), and of shoulder became painful on pressure, atrophic and showed fibillary contractions. Electrical excitability was diminished, and a partial reaction of degeneration present. Deep arm reflexes abolished; those of leg present. Sensibility normal. Autopsy showed absence and atrophy of ganglion cells of anterior horns, and of anterior nerve roots on right side at the level of origin of sixth and seventh cervical nerves; bilateral atrophy of posterior nerve roots of cervical and lumbar enlargements, and also a degeneration of the posterior columns (atrophy of nerve-fibres and increase of connective tissue). Nerves and muscle of paralysed parts were degenerated, Braun regarded the central changes as secondary and due to a continuation upwards of the inflammation of the nerves.

In a case of sciatica, probably due to lead and alcohol, in addition to neuritis a lepto-myelitis of the lumbar enlargement was found.‡

These are the only cases I have found where the spinal lesions have been localised.

Other neuroses of plumbism are optic neuritis proceeding to atrophy; strabismus due to paralysis of exter-

* *Nouveau Dict. de Méd. et de Chir. Prat.*, t. xxii.

† *Ann. Univ. Med., Sci.*, v, B—14.

‡ *Ibid.*

nal rectus or other muscles; hemiplegia, hemianæsthesia, violent and intractable chorea; and the *encephalopathia saturnina* (including epileptic convulsions).

Lathyrus.—This agent appears to cause two classes of symptoms, according to the part of the cord affected; if more than one tract of the cord be affected at the same time, however, as is sometimes the case, the symptoms necessarily become less clearly defined. In one class of cases impairment of power of locomotion goes with rigidity, tremor of extremities worse on exertion, increase of the deep reflexes. Tactile, thermic, dolorific, and electric sensation are perfect, the special senses are unaffected and the muscles are not wasted. The lateral columns of the cord are evidently affected, though strangely enough there are no post-mortem proofs on record of this probability. In the second class of cases the impaired power was associated post-mortem with atrophy of the ganglion cells of the anterior horns of the cord and of the medulla, also of the vagal and spinal accessory nuclei. These conditions occurred chiefly in horses poisoned accidentally or experimentally. They were accompanied with fatty degeneration of the intrinsic muscles of the larynx (especially of the left side) and of the heart. The neuroglia was increased in one case concurrently with the atrophy of cells. In still other cases sensory phenomena exist and the organic reflexes are interfered with. These symptoms tend to improve and perfect recovery may ensue. Proust, who observed these cases, attributed the condition to a transverse myelitis due to hæmorrhage and followed or not by degenerative changes.

Schuchardt believes the muscles below the knee to be largely affected.* Cantani † finds the abductors to be more affected than the adductors, sensibility of legs preserved and the “descending galvanic current produced slight contractions when the current was closed. The contractions were weaker in the flexors than in the extensors.” A fragment of muscle showed diminution of the transverse markings and some evidences of fatty degeneration. In a recent number of the *Revue des Sci. Med.*, I read of a very considerable muscular degeneration having occurred as the result of *lathyrus* poisoning.

* Ann. Univ. Med. Sci., vol. 5, B 19.

† Ibid.

The *oxytropis lamberti*, a "loco" weed of the western plains of America, is very poisonous to horses and is an ally of *lathyrus*. It is said to produce spinal congestion and paralysis (Allen's *Handbook of Materia Medica*).

Mercury.—Kussmaul's * picture of the tremor, the paresis, the affection of speech, the nystagmus, and the mental disposition, strikingly suggest disseminated sclerosis. At the autopsies there have occasionally been found traces of inflammation in the brain and spinal cord, but no localised lesions are recorded.

A transitory left hemiplegia with sensory phenomena has (apparently) resulted from the drug, † and Bartholow ‡ has "seen a well-marked case of locomotor ataxia," with pains, ocular disorders, spermatorrhœa, plantar anæsthesia and inco-ordination result from the inhalation of mercurial fumes. I may state here that two cases have come under my observation, which illustrate the depressing influence of *mercury* on the cord. One was a case of myelitis, and the other of tabes dorsalis in an early stage; both were doing well and gaining power under the use of electricity and rest, when a celebrated neurologist prescribed a course of *mercury*. From the time when they were under its influence they went back hopelessly and completely.

A condition resembling *petit mal* is induced by *mercury*.

Nitro-benzol.—The general effects of *nitro-benzol* § are anæmia, cyanosis, drowsiness, headache (temporal and vertical, and worse on lying down), vertigo, anorexia, nausea and vomiting, palpitation and dyspnœa on exertion, etc. The symptoms of the nervous system are as follows:—There is always present a feeling of tingling and itching in the fingers, both palms and the back of the hands, reaching as high as the wrists. The fingers feel numb and clumsy, as if the skin was thickened, and there is inability to hold or properly feel a small object such as a pin or needle. These sensations are observed in the tops of the feet, but never in the soles. The hands and feet are easily chilled, and the extremities become cold. Areas of hyperæsthesia are common. Drawing the finger very lightly over these sensitive areas sends shooting

* *Cyclopædia of Drug Path.*, sub. voc. p. 218.

† *Cyclo.*, iii., p. 229.

‡ *Ibid.*, p. 230.

§ *Practitioner*, July.

pains some distance up the limb. Tenderness when the muscles are pressed is usual, and is sometimes curiously limited. Muscular feebleness and general lassitude are very early and prominent symptoms. The power of grasping by the hand is greatly decreased, and that of walking almost fails in severe cases. When walking, the men are often twitted for being drunk: they say they do not know where their legs are, and if they fall, as they often do, they cannot pick themselves up. They are very unsteady when asked to close their eyes and walk backwards. Other symptoms of ataxia cannot be detected, neither does any special group of muscles seem to be affected. Muscular wasting may occur, and interference of the finer and more delicate movements of the hand. Sensations of touch and pain do not appear to be retarded. The hearing and taste are unaffected. The cremasteric and umbilical superficial reflexes I have nearly always been able to obtain; ankle-clonus I never found. Speaking generally, the tendon-reflex of the knee is weakened, especially in severe cases; in some cases it is lost. There is great loss of energy, and the sexual appetite is notoriously weakened or lost, and erection of the penis very rare. This array of symptoms implies such a profound and extensive affection of the spinal cord and its membranes as to suggest the probability that the central nervous system is not alone responsible for the symptoms. Another point is the absence of either vesical or rectal symptoms, and the non-implication of the ciliary sympathetic regions. It may eventually be found, as Dr. Lauder Brunton suggests, and has, I believe, to a certain extent proved, that both the central nervous system and also the peripheral nerves are affected.

Oxalic acid has many symptoms pointing to the belief that it has the power to damage the nerve centres and the meninges. They are weakness of the legs (extending over the whole body), stiff feeling in back on rising; toes of right foot spasmodically drawn downwards; and heaviness in left hand; fingers obey will only heavily and slowly, and draw inwards; sharp pains here and there, increased sexual desire. These symptoms were experienced by provers, and in poisoning cases they are much more pronounced—excruciating agony in lower part of back, extending down thighs, weight and powerlessness of

limbs, numbness and tingling of extremities and general numbness. In experiments on animals slight permanent stiffness of the hind legs, gradually increasing, stiff gait, insensibility, spasm giving place to paralysis, and general tetanic spasms, like those produced by *strychnia* are caused.

For spinal pain and spasm *oxalic acid* is deserving of confidence. The symptom "pains occupy a small area" suggest it for the severe pains of *tabes dorsalis*. I have myself relieved such pains in a woman with an ataxic gait but without any other sign of *tabes*.

An important case of poisoning by *oxalic acid* is recorded in the September number of the *Homœopathic Physician*. The nervous symptoms are as follows: Tonic and clonic spasms occurred in the upper and lower limbs; the patellar reflexes on both sides were exaggerated, also tendo Achillis and periosteal reflexes. When the left external malleolus was merely touched, the left tibialis posticus protruded. The triceps and periosteal reflexes of the forearm were also increased. The pupils were dilated but no note is made as to their activity; sensorium dull. Examination showed perfect anæsthesia of tips of fingers and toes, of ant. surface of hands, and of plantar surfaces of feet. While the prick of a pin is rightly localised in the upper arm and thigh, a deep prick is necessary in the leg to cause a dull pain; sensibility of other parts normal. Pains were felt in left lumbar region and in legs; feet and hands as if asleep. The drug also produced acute nephritis with hæmaturia.

Petroleum-ether (Benzene).—Poisoning by this substance, in the case of a workman using it, has shown it to have considerable effect on the nervous system, as indicated by the following symptoms: The pupils were widely dilated and did not act to light; there was nystagmus, conjunctivæ were barely sensitive to touch, and paralysis of lower extremities, with incontinence of urine and fæces, existed. The patient was entirely unconscious and had had a general convulsion. *Petroleum-ether* or *benzine* is a mixture of several organic compounds, which belong to the marsh-gas (CH) series. As it is not a definite organic compound the active factor in the mixture which gives rise to the above symptoms is not known.

The benzenes having haloid radials produce general tremor on movement resembling the tremor of disseminated sclerosis.*

Picric acid.—Under the influence of this drug the animals experimented upon displayed great weakness and lassitude, and suffered from entire anæsthesia and analgesia of posterior extremities. The gait, too, is peculiar, resembling somewhat that of locomotor ataxy. This is due to sudden spasms of single muscles during walking. General spasms exist. After death the cerebellum, medulla oblongata and upper part of the spinal cord were found to be completely disorganised, soft and pulpy.

The optic nerves have been found hyperæmic and the vessels, especially the veins, enlarged. Above the optic nerve “immense white patches of exudation, with some hæmorrhagic spots,” were found. On *post-mortem* and microscopical examination the nerve entrance was found much swollen and infiltrated; masses of yellowish white exudation are observed, extending from the nerve into the various portions of the retina; others are unconnected with the nerve-entrance. Whole retina infiltrated; small extravasations in optic nerve and retina.

The power of this drug to produce serious lesions of the nerve centres is very pronounced, but hitherto its effects have not been sufficiently localised to make it of much use in pathological prescribing. Weakness, heaviness, coldness and numbness are the symptoms the provers experienced in the lower limbs and of these the left appears to be sometimes more affected than the right. The sexual excitement caused by the acid is apparently of spinal origin. It has been used chiefly in functional disorders of the nervous system. Dr. Hughes suggests its use in so-called “white-softening” of the cord and in neuro-retinitis.

Spigelia.—Hare of Philadelphia found that this drug caused dilatation of the pupil and exophthalmos; this, together with its known effect on the heart confirm its use in Basedow’s disease. He also found that muscular weakness and lack of co-ordination were induced. The walk became staggering and uncertain in both fore and

* Proc. Royal Soc., vol. 42, p. 240.

hind legs. Muscular power was progressively lost, but sensation did not seem to be affected. The palsy was found to be spinal in origin.—*Ann. Univ. Med. Sci.*, vol. iv., p. 544, 1888.

Concerning some other remedies of interest, such as *agaricus*, *belladonna*, *ergot*, *phosphorus*, *rhus*, and *strychnine*, etc., etc., I have, unfortunately, no time to speak.

In conclusion, while acknowledging the smallness of the positive and accurate information I have been able to collect, I should like to anticipate criticism on one point. If my paper has been only or mainly pathological, it is not because I undervalue symptomatology. But I do wish to express my opinion that subjective states should, whenever possible, be associated with their objective conditions. Symptomatology alone has yielded but meagre results in these formidable diseases of the nervous system. Pathology alone would do as little, it is true; but the two together may, perhaps, in the future be more fruitful. In any case, however, it was outside the intention of this paper to go minutely into symptoms. In affections sufficiently definite to be localised—affections in which the lesion has gone beyond perversion of function—pathology will guide us to a number of drugs from which to choose the remedy, and symptomatology will enable us to determine which one of the number to select for the case before us.

TABLE I.—*Summary.*

<p>MYELITIS. (Lesion not localised.) Arsenic. Lead. Mercury. Nitro-benzol (?) Petroleum ether. Picric acid. Spigelia.</p>	<p>ANTERIOR HORNS. Alcohol. Cocaine. Lathyrus. Lead.</p>
<p>LATERAL COLUMNS. Antipyrin. Bismuth (?) Copper. Lathyrus. Mercury (?)</p>	<p>POSTERIOR HORNS AND POSTERO EXTERNAL COLUMNS. Alcohol. Lead. Oxalic acid. Spigelia (?)</p>
	<p>ANTERIOR AND POSTERIOR NERVE ROOTS. Lead.</p>

TABLE II.—*Clinical Suggestions.*

LATERAL SCLEROSIS.	TABES DORSALIS.
Antipyrin.	Alcohol.
Bismuth.	Lead (?)
Copper.	Oxalic acid.
Lathyrus.	Spigelia (?)
Mercury.	(Ergot).
(Belladonna).	(Strychnine ?)
	(Belladonna).
DISSEMINATED SCLEROSIS.	MENINGITIS
Mercury.	(spinal.)
Benzenes.	(Actæa rac.)
PARALYSIS AGITANS.	Arsenic.
Cocaine.	Lead.
Mercury (?)	Oxalic acid.
	Picric acid.
INFANTILE PARALYSIS AND PRO- GRESSIVE MUSCULAR ATROPHY.	OPTIC NEURITIS.
Alcohol.	Alcohol.
Cocaine.	Lead.
Lathyrus.	Picric acid.
Lead.	
MULTIPLE NEURITIS.	EPILEPSY.
Alcohol.	Antipyrin.
(Aniline).	Cocaine.
Arsenic.	Mercury (petit mal).
Copper.	
Lead.	
Nitro-benzol.	

DISCUSSION.

Dr. GOLDSBROUGH wished that Dr. Neatby could have given a series of demonstrations, as the subject of the paper was so large. He had lately devoted special attention to the symptomatic aspect of drug action in nerve diseases, and one conclusion was forcibly suggested to him. If we are to cope successfully with these lesions, we must study more carefully their early clinical history, before gross lesions have occurred. If we knew the earlier and minute changes occurring, we could the better adapt the drug to specific cases. Fuller knowledge was accordingly required of the commencing changes in nerve diseases.

Dr. HUGHES considered the conclusions of the previous speaker very important, but suggested that they be not made too absolute. For cure, the lesions must be taken in the stage

when they seem merely bundles of symptoms ; but we may be sure that the lesion is already there, that the pathological changes are already commencing. It was therefore improper to use drugs having only a fugitive action in diseases of structural alteration, and we required the study of drugs like *plumbum*, *phosphorus*, *secale*, &c., whose protracted action corresponded to the course of lesions.

Dr. DAY stated that drugs, in this class of lesions, were more likely to act on functional phenomena, and it was a question how far pathology aids the administration of drugs. Finding a definite lesion, are we to seek remedies which, if given long enough, will cause such a lesion ? A definite lesion, *e.g.*, *Tabes dorsalis*, presented sclerosed tissue for drugs to act on. If we could diagnose the lesion before sclerotic changes have occurred, should we give the indicated drug ? If, again, a drug could be found causing anterior poliomyelitis, should we administer that drug in such cases ? He alluded to a marked case of mercurial tremor seen in the out-patient department, and added that here, evidently, the stress of the poison had fallen on the nervous system.

Dr. MORR remarked that, as concerning the whole paper, the first question to be considered was the primary causation of these lesions. The causes at work were definite, and often these were protracted in action. In treatment, the best results were seen in specific lesions, but we required more details of the minute action of drugs in nerve lesions to prescribe more successfully.

Dr. DYCE BROWN agreed with the views of Dr. Hughes as to the relation of symptomatology and pathology. Pathology, he considered, held quite a secondary place when treatment had to be considered. By the time that pathological changes were discoverable, the mischief was done. If we could select the drug which would produce the early symptoms which are invariably, or frequently, followed by the pathological lesions, that would be the really successful medicine. Hence symptomatology is the only reliable guide. Treatment of the cause had been recommended by one speaker. It was, of course, common sense to remove a cause when possible ; but in nineteen out of twenty cases of nerve disease that came up for treatment, the cause had either ceased to operate, or its existence was only a matter of guess. Consequently, it was only in rare cases that treatment of the cause was likely to be of the least use.

Mr. KNOX SHAW said that Dr. Neatby's paper contained very much which required to be read quietly at home. He regarded the suggestion of paying attention to the earlier nervous symptoms as of great value. Very many of the best symptoms

were seen in trades, as from chronic poisoning. These cases must have early premonitory symptoms before the patients become so ill as to cause them to give up work. Nicotine might, for instance, have been added to the list as producing well-defined nerve symptoms.

Dr. BURFORD adduced a case of chronic alcohol poisoning in which the force of the poison was spent on the viscera, and no notable nerve symptoms were present. Renal degeneration, ovarian cirrhosis and commencing cardiac hypertrophy, were the obvious lesions, and attention was specially directed to the atrophic ovarian condition. The patient was only twenty-six years old.

Dr. MURRAY reviewed the statements made concerning the dynamic action of alcohol, and asserted that its dynamic action was on a par with that of *natrum mur.* He quoted a recently published case in support of this contention, and proceeded to state that although we were frequently blamed for not sufficiently regarding pathology, in to-night's paper and discussion this did certainly not obtain.

Dr. DUDGEON stated that when changes had gone on to gross lesions of the cord, no homœopathic treatment was longer available. He said the determination of pathological conditions on which nerve symptoms depend has exercised a great fascination over medical men during the last forty years, and proceeded to detail a case culled from American sources amusingly indicative of the uselessness of the agreement of eminent medical men as to diagnosis in determining rational treatment. The study of pathology had shown the greatest variations in pathological opinion, while symptoms remained the same.

Dr. BLAKE had listened with pleasure to the scholarly and scientific paper of Dr. Neatby. He considered that this was indeed work in the right direction. It was a praiseworthy effort to bring our antiquated neuro-pathology abreast with the more vigorous and accurate modes of thought obtaining in the present day. He thought, apropos of the therapeutic use of alcohol, that so many of the symptoms of chronic alcoholism being due to innutrition rather than to the actual alcohol, constituted a reason against its utility as a remedy. Regarding the capture of disease in its early stages, this could not always be done. Further, as concerning elaborate papers coming before the Society, a syllabus should be printed and furnished before each meeting. Much gratitude was due to our old school brethren for persistently furnishing us with cases of drug proving.

Dr. NEATBY replied. Concerning Dr. Day's observations, it was a question whether, if once the damage is done, any

medicines whatever will really remove the lesion. Nevertheless the rule *similia* is the only one which can be any guide to treatment. If we get a patient in the early stage of a condition which will develop into, say, a sclerosis, our best chance is to give one of the drugs which if long enough in acting, will itself develop a sclerosis. Symptomatology, not pathology, will teach us which of these drugs to decide upon. He believed the virtues of *arnica* were too much neglected in nerve lesions. He did not agree with Dr. Dyce-Brown concerning the relations of pathology and symptomatology in this sphere. They should be put on a par together. In chronic diseases of the nervous system symptomatology alone had proved very insufficient.

SOME UNUSUAL CASES IN OBSTETRIC PRACTICE, WITH REMARKS ON THE RELATION OF HOMŒOPATHY TO OBSTETRICS.

By J. ROBERSON DAY, M.D., Lond.

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WHEN asked to read a paper before this Society by our Secretary, the first subject which suggested itself to me was one which would treat on some branch of obstetrics.

When on searching through the *Annals of the British Homœopathic Society* I could find no paper that had any reference to this subject, I ventured to hope that from its novelty a paper on obstetrics might have an especial charm. But then, after further consideration, I found that such a subject, from its very nature depending only secondarily on medicines, would offer little opportunity for the consideration and discussion of homœopathic remedies, so I feel I must ask your kind indulgence for what is to follow.

In the practice of obstetrics we must ever bear in mind we are dealing with a normal physiological process, and by assisting nature in her efforts, and the observance of scrupulous cleanliness, the great majority of cases do well.

On the other hand, the conditions under which we live—the effects of civilisation—tend more and more to render these perfectly normal conditions exceptional.

It is no uncommon thing for the Hottentot mother, suddenly feeling the onset of labour, to retire into a corner of the hut, give birth to her child, and after a short time resume her usual occupations, much as if she had simply obeyed an ordinary call of nature. Such cases with us are rare, although not unknown.

I remember attending a Primipara who gave birth to her child before my arrival, and on being questioned said she felt no special pain during parturition, and but for my injunctions to remain in bed would probably have been up and about as usual.

But the penalty of civilisation is trouble during parturition, and diseased and ill-developed women have to suffer most.

The following cases, which have come under my notice, I trust will prove interesting and lead to a profitable discussion :—

CASE I.—*Arm Presentation and Turning.*

Mrs. B., the patient, it appears did not send for the nurse until the membranes had ruptured, and as soon as she arrived she observed the hand come down externally. This was about 6 p.m. I arrived about a quarter to 8, and immediately sent for a friend to give chloroform. By the time he arrived and I commenced to operate, the arm had been prolapsed fully two hours and a-half.

I found the right hand projecting through the vulva ; the dorsum of the hand was œdematous from pressure. By abdominal palpation I ascertained the head to be in the right iliac fossa, and therefore it was an abdomino-anterior position.

The patient being under chloroform I passed my right hand, previously carefully carbolised and greased, into the vagina, and tried to push up the right shoulder. I did not succeed in this so I passed my hand up into the uterus to seize the right leg. At last I succeeded in getting my fingers into the popliteal space, and drawing down the right leg.

There were then presenting through the vulva the right leg and arm. I then passed my hand into the uterus again and tried to pull down the other leg, but did not succeed at first, the uterus being firmly contracted on the child and all the liquor Amnii having drained away. I got the tip of my forefinger, however, into the child's anus, and hooking it round the ischial tuberosity managed to draw down the buttock. During these manœuvres I steadied the uterus from the outside, and tried to press up the head on the right side and the buttock down on the left.

In time I got hold of the left leg and drew it down. The rest of the delivery was readily accomplished. I prevented the arms from being extended and locking

over the head by drawing them down. When the umbilicus was born the cord pulsated feebly, but when the child was born completely it would not breathe, and all efforts at artificial respiration and plunging the child into hot and cold water proved futile. Considering the time the arm had been prolapsed before I commenced the operation, viz., two and a-half hours, and that all the liquor Amnii had drained away, so that the uterus was tightly clasped round the child, I think the result could not have been expected to be otherwise.

Statistics show that one-half the children are lost and the mortality of the mothers is 1 in 9 in turning operations.

The rule for bringing down the leg opposite to the arm presenting (namely, in this case the left leg) was quite impossible to carry out.

The mother made a good recovery.

CASE II.—*Shoulder Presentation and Turning.*

I was called to this case in consultation by the doctor in attendance, who informed me that it was a transverse presentation, but he was sure the child was dead, so there was not any need to hurry.

On my arrival I found the head was in the left iliac fossa, and the left shoulder was presenting, it being an abdomino-anterior position; so I passed in my right hand, previously cleansed, disinfected and lubricated, but though I got hold of a foot could not bring it down.

I then prepared my left hand in a similar way, and passed it in and succeeded in bringing down the left foot. I soon after got hold of the right foot, and the delivery was easy till the head came, when the arms extended over the head and had to be drawn down separately. Then, after a good pain, the head was born with the cord round the neck, and the placenta followed at the same time. The child was dead, as had been foretold, and was a seven-months' foetus.

There was no *post partum* hæmorrhage, the uterus contracted firmly. The patient took the chloroform well and made an excellent recovery.

The interesting thing about this case was that although an abdomino-anterior position, the right hand, which in

such cases is most easily passed along the child's abdomen, failed, and the left hand succeeded, showing that this rule is not always to be relied on.

In these two cases of transverse presentation could anything have been done by drugs? We read in the *Pharmacodynamics* that *pulsatilla* has the power in some cases to rectify mal-presentations, and Dr. Leadam even says it will sometimes restore a prolapsed cord.

If I get a case early enough before labour has set in, I will certainly try it. I trust we shall hear the experience of members on this subject.

CASE III.—*Turning for contracted pelvis.*

Mrs. C., who had previously given birth to several living children, although she had always had very bad times, sent for me. On May 3rd labour had commenced at 10 a.m., and I found the os dilating and high up. I called the next morning and found the head had made no descent, but the os was dilated. The patient was very restless, so I resolved to apply the forceps under chloroform. I got a friend to give the chloroform, and, after emptying the bladder and rectum, I passed in the forceps. It was a high forceps case, the head being freely movable at the brim. I found no difficulty in applying the forceps, but the head refused to engage in the pelvic brim, although I tried steady and continuous traction repeatedly. It was evident the vertex would not enter the brim, so the forceps had to be abandoned. The pelvis, although contracted and small, was not notably deformed, and with the previous history of several living children born at term, I hoped to be able to deliver by turning. Version was performed without any difficulty, but at the same time the head was found to be large, in fact so large that it caused serious delay in its delivery and, as a result, the death of the child.

Here the cause of the dystocia was an unusually large, ossified head, occurring in a woman with a slightly contracted pelvis.

Unfortunately—or, as she would say, fortunately—this lady is not likely to have any more children; but should she again become pregnant I should induce labour at the eighth month, and deliver with forceps if there was any delay.

CASE IV.—*A Generally Contracted Pelvis. Delivery by Craniotomy.*

Mrs. W. did not send until the membranes had ruptured, and on arriving the cord was prolapsed in the vagina. On vaginal examination the pelvis was found much contracted and the promontory of the sacrum easily felt. The two previous children she had given birth to were delivered by turning, and did not survive. I called in a friend in consultation, who carefully measured the pelvis, as follows:—

Between the ant. sup. iliac spines	...	...	9 $\frac{5}{8}$ in.
Between the crests	...	...	10 $\frac{7}{8}$ „
Inclined conjugate	...	...	3 $\frac{3}{8}$ „
Conjugata vera	...	...	3 $\frac{1}{2}$ „

After this deliberate examination under chloroform, we decided that a living child could not pass through such a pelvis, so it was determined to perforate.

The presentation of the head was peculiar; both fontanelles could be felt on about the same level, and the posterior was just behind the symphysis pubis. The head was freely movable at the brim.

Having emptied the bladder and rectum, I warmed and lubricated the perforator, passing it up the vagina and through the os, protected by my forefinger. I felt the right parietal bone, and on this I steadied the point of the perforator, while I gave it a rotatory boring movement with the right hand. At first it slipped off the bone into a suture, but the next time I got a firm hold for the point in the bone. Then by steady pressure on the instrument I passed it through the bone up to the shoulders. I then pressed the handles, thereby opening the blades, and then gave it a quarter-turn and did the same in the reverse direction, so as to make a crucial incision. I then passed the instrument boldly into the cranium and freely stirred up the brain. This done I withdrew the perforator and passed through the same opening into the cranium the crochet, and by its means endeavoured to rake out as much of the brain as possible.

Next I passed the cephalotribe in the same way as the forceps, having warmed and greased the blades. The blades passed very easily, but when I proceeded to screw

up the handles, they slipped the first time, so I withdrew both blades and re-introduced them. This time when I screwed up, the blades took a firm hold on the head, which when I had sufficiently compressed it, I proceeded to deliver by traction, using the cephalotribe in the same way as the forceps. Delivery was easily accomplished. The whole operation took I suppose from 20 to 30 minutes. The placenta came away quite easily a few minutes after. The uterus contracted firmly in spite of the chloroform, and there was no hæmorrhage. The patient made a tedious recovery.

As so often happens with our interesting cases, I have lost sight of this patient, but certainly this is just a case for the induction of premature labour in the event of her again becoming pregnant. Labour being induced at the seventh month a living child ought to be delivered by turning.

CASE V.—*Hydatid Degeneration of the Chorion.*

For the notes of this case I have to trust to my memory, but the details are such that I shall not easily forget them. The patient, whom I saw with a friend, suspected nothing unusual to be the matter. She imagined herself to be in labour. The only unusual feature in her case was that for some weeks previously she had been losing quantities of blood. I confess the case was most perplexing. Vaginal examination showed the os to be soft and patulous, as at the beginning of labour, but no head or any other part could be felt presenting.

Within the os there seemed to be a soft mass resembling the placenta, and we concluded it was a case of placenta prævia. The uterus was enlarged to about the usual size at term. The chief feature in the case was the large amount of hæmorrhage which was weakening and reducing the patient.

We decided to pass in a sponge tent, which was done, through a Fergusson's speculum, and left in the cervix, with a view to checking the hæmorrhage, and at the same time to dilate it for subsequent operation.

We called later in the day, again passed the speculum, and decided to remove the tent. This was no sooner done, than a large gush of blood followed, with shreds of membrane. On examining these carefully we saw the characteristic cysts; and here let me say, in passing,

that the cysts in the fresh state have only the very slightest resemblance to the blanched, ætiolated specimens we are accustomed to see in our museums. They were small, translucent little pellicles, about the size of peas, and containing a red, blood-stained fluid.

We now for the first time recognised the true nature of the case, and at once decided to empty the uterus as soon as possible as the only effectual means of stopping the hæmorrhage. This my friend did, passing in his right hand and with his fingers scraping out large quantities of the degenerated chorion.

The patient becoming very faint, I administered an enema of milk and brandy.

The hæmorrhage soon ceased after the uterus was emptied, and a full dose of *ergot* was administered.

The patient made a tedious recovery.

CASE VI.—*Vaginal Cystocele Complicating Labour.*

Mrs. X. first sent for me one week before true labour pains commenced. When I saw her she had much bearing down, and a large tense tumour, about the size of the two fists, bulged out from the vulva, a truly formidable sight.

I ascertained it to consist of the anterior wall of the vagina with the bladder.

Behind this tumour, high up, the cervix could be felt, soft, but not dilated at all.

I left her, giving directions that she was not to strain or bear down, as she was not in labour.

A week later I was again called to attend her, and, as before, the tense tumour came down. The os now was dilating, and true labour pains had set in. As soon as the head entered the pelvis I managed to press up the tumour above it, and as the head descended it kept up the tumour, which gave no more trouble, and labour followed naturally.

This condition appeared but an exaggeration of the one so commonly met with where the anterior lip of the cervix gets carried down in front the head, and jammed between it and the pubic arch. When this is pushed up above the head, labour, which had previously been tedious, rapidly advances.

CASE VII.—*Placenta Prævia.*

The patient, aged 34, had given birth to three living children, and had had one miscarriage. The labour came on at six and a half months, and was accompanied with much hæmorrhage. The os was found dilating and the soft placenta could be felt within. The finger was passed in and swept round the lower part of the uterus, so as to detach the placenta. This was done, and then it appeared that the placenta was only partially over the os—a case of marginal attachment—for when this detachment was accomplished, the fœtal head could be felt on one side presenting. The membranes were then ruptured. The result of doing this was that the pains increased in force, and the os dilated more, and the head descended, very much checking the hæmorrhage. The child being premature, was now easily delivered, and the placenta came away afterwards. The child was still-born.

The mother for some time after suffered from anæmia, and about a fortnight after was attacked with phlegmasia dolens, from which she made a tedious recovery.

And now, gentlemen, I come to the second part of my subject—What is the relation between homœopathy and obstetrics? What opportunities have we for the scientific study of drug action in the puerperal state?

I think the answer must be that we have very few. We have only such opportunities as are met with in private practice, and these are necessarily very limited. Indeed, it is a common belief amongst the public that physicians practising homœopathy do not undertake midwifery cases, and if they do, they understand very little about the subject. Only the other day there came to me in the out-patient department of this hospital, a woman who was a monthly nurse, and should have known better; describing to me how she had sprained her arm whilst applying the binder, she confided to me, “but perhaps, sir, you don’t understand what that is?”

In the same way it is very frequently heard that homœopaths are not surgeons, that we do not operate. It is a matter of almost daily experience at this hospital to have patients coming with abscesses requiring opening, or with growths that obviously must be removed;

patients who have been the round of the hospitals come here and ask us to perform miracles, saying, "Oh, we thought you could give us something to *disperse* it." That is the favourite expression. Disperse a tumour as big as an orange, that the patient has carefully cherished for years! The only pleasing feature in these cases is the simple faith of the public in the power of drugs. I wish sometimes I had half their faith.

But I am glad to say that at length we have given a public denial to these absurd notions by the appointment of a surgeon to our hospital, by which we shall prove that the surgeon's skill cannot be dispensed with in all cases, but is necessary and most useful when combined with the administration of drugs given homœopathically. Surely the time has come when obstetrics should have a recognised place also in the hospital.

"A staff of 42 nurses has been trained in the wards of the hospital to nurse medical and surgical cases, and several have been specially trained for accouchement cases." So reads the hospital report, and it sounds exceedingly well, until we come to criticise it. Let us proceed to do so:—In the first place, where have the surgical nurses been trained? Until quite recently we have only had a Consulting Surgeon.

In the next place, where are the nurses trained for accouchement cases? In the body of the report we read, "in suitable institutions." Naturally. Now as to the several nurses that have been specially trained for accouchement cases, I learn from the Lady Superintendent of nursing there are very few, as the demand for monthly nurses is not great, who, however, tells me if ever I want nurses for this work some can be specially trained for it! Unfortunately, it is not in our power to prolong gestation beyond the ninth month, whilst these nurses are being trained. With such a state of things existing, is it to be wondered at that "the average number of nurses employed in out-nursing duty has been less than that of last year," and that "the Board must again remark that the demand for nurses is largely dependent on the mindfulness of the medical profession, and would once more earnestly urge upon those practising homœopathy the great advantage the Nursing Institute offers to them of nurses trained in the wards of the Homœopathic Hospital." Such earnest urging on the part of the Board

would no longer be necessary had we better opportunities of training our nursing staff.

But what I wish most strongly to urge is, that we as members of the British Homœopathic Society, have a position to maintain in the medical world, that we must prove ourselves equal to our brethren in all the branches of our profession, and superior to them, because in addition to their knowledge we are acquainted with the New Therapeutics: that our hospital, which is now becoming a General Hospital, should be able to cope with all the diseases which flesh is heir to: that our Nursing Institute should really be what it lays claim to. There would then be no need for the Board to sing its praises. Why do not all medical men who practise homœopathy in and around London patronise our Nursing Institute? Partly, no doubt, because it is insufficiently known.

Now are we going the right way to work to obtain this foremost position in obstetrics? Listen to what a well-known text book says in speaking of obstetrics.

“Perhaps we have fields here yet to conquer, for indeed this is a department which has not been assiduously cultivated by homœopathic practitioners. The position in which most of us are placed, in this country at least, makes it impossible for us to attend confinements. The result is that we have little practical experience of the application of our remedies to the accidents of labour.”

For my own part I do not see why it is impossible for us to attend confinements, but I do most certainly agree that there are fields to conquer here. How much longer are we to hold back and be outstripped in the race? The Homœopathic Journal of Obstetrics tells us that gynæcology and obstetrics were rather poorly represented at the International Congress of Homœopathy held in Paris last August, and there seems to have been only one paper in obstetrics on “Homœopathic Therapeutics of Pregnancy,” and whilst preparing this paper I have been struck with the scanty literature on the subject, and what little I have read has somewhat astonished me. Croserio is reponsible for the following:—

“In the case of a woman, 26 years of age, in her first labour, in whom the sacro-pubic diameter of the superior strait did not offer more than two inches and a-half, I

had the patience to wait for 72 hours the natural efforts of labour. The head being in the first position at the end of the second day, it began to engage in the superior strait. At the end of the third day the pains slackened very much, the woman became very feeble, was pale, exhausted, and had lost all hope.

“ I put *secal. cor.* 30 into a glass of water, and gave her a teaspoonful at 11 o'clock in the evening. Some minutes after she fell asleep, and slept very quietly for three quarters of an hour, when awakened by a violent pain. She made a courageous effort, and two hours after gave birth to a child, pale, and in a state of asphyxia, but which was recalled to life by proper care. The recovery of the mother proceeded in a regular manner.”

With a sacro-pubic diameter of the superior strait, or as we should say the conjugate at the brim of $2\frac{1}{2}$ inches, I do not see how a foetal head at term could pass; since the smallest diameter of such a head, viz., the sub-occipito-bregmatic, is 3.25 inches.

With a conjugate diameter reduced to from $3\frac{1}{2}$ to $2\frac{1}{4}$ inches, Barnes says labour at term can only be accomplished by craniotomy.

Nevertheless, we are told that on the second day the head began to engage in the superior strait. At the end of the third day the woman had lost all hope—the only wonder is she did not lose it before. Then she was given a teaspoonful of *secale cor.* 30 and slept, and after two hours more suffering was delivered.

Now setting aside the question of measurements of the brim and head, we have here a case where there was some disproportion between the foetal head and the pelvic brim, such that the head, for two days after labour had commenced, refused to enter the brim, but at the end of that time was sufficiently compressed to do so. Is not this eminently a case where the forceps should have been used? As soon as the os was completely dilatable the forceps could have been passed, and by compressing the head brought it through the pelvis and accomplished the delivery days before-hand. Think of the suffering and exhaustion the mother would have been spared. But perhaps some one will say, all's well that ends well—agreed. But what is the use of the physician if he can only watch nature in her efforts and not assist her?

Now what is the remedy for this anomalous condition of things? Obviously the *most* suitable institution for training our monthly nurses would be one where homœopathy is recognised. Now there exists no such institution in England, although in America there are several. While other general hospitals have their maternity departments, *we* have none. And why should not one be established with a certain number of beds in the hospital for the more interesting cases? It has been abundantly proved that these cases do well in hospitals when strict antiseptic precautions are observed. We should then have the opportunities we need for studying these cases, and could train our own nurses and no longer be under the necessity of sending them to "suitable institutions" to acquire the knowledge.

Gentlemen, I fear you will think that I am taking a morbid view of things in general, that I have been spying out the nakedness of the land, and am now revealing things which should remain secret.

My reasons for doing so are, however, only to show what an unsatisfactory position Obstetrics is in, and by so doing to try and obtain a recognised position for this neglected branch of medicine. I hope we shall all leave this evening feeling thoroughly dissatisfied with what we have done for Obstetrics. This is the feeling which must first come; then we shall begin to ask one another why things are so, and after that will come the desire for reform, and an ardent wish to bring this about. If my paper produces this result it will not have missed its aim.

I am not unmindful of the progress homœopathy has recently made, but I think I have pointed out a really weak point, and one which needs reforming. No permanent good can be done by the issue of statements unsupported by facts; we must boldly face the situation, confess the deficiency, and seek the remedy.

I might say something about the Medical School of the London Homœopathic Hospital, but I will limit my remarks to such a possible case as this that might happen. A medical man comes, saying "I am convinced of the value of homœopathy in many acute diseases, I wish to learn more; especially I want to know its value in the puerperal state."

I have no doubt the Honorary Secretary to the Medical School would be equal to the occasion, and no doubt

would make a suitable reply ; perhaps he will tell us what he would say.

But let us not be unduly cast down by the contemplation of such an unsatisfactory state of things, but take courage from our recent triumphs at Margaret Street and in the *Times* controversy, and look forward confidently in the near future to the time when, with a new hospital and ample provision for the treatment of all manner of diseases, we shall see our doors thronged with eager enquirers after truth, and our Hospital and Medical School the glory of the metropolis.

DISCUSSION.

Dr. MADDEN agreed with Dr. Day that in obstetric operations we were not much helped by homœopathy, though he had observed much benefit from homœopathic medicines in preparing patients for confinements, and also in relieving after-pains, and preventing after accidents. He hoped Dr. Day's suggestion of the establishment of a maternity department in connection with the hospital, or, better still, in a separate building, would be carried out, so that our obstetric nurses might be trained in our own institution.

Dr. DYCE BROWN had hoped for observations on the action of homœopathic remedies from Dr. Day. There is comparatively little scope for medicines in the majority of obstetric cases, since, in ordinary cases, none are required, and when interference is needed, it is chiefly surgical, and common to both schools. The reason why so few cases in obstetrics, showing the action of medicines, as in promoting pains, relieving after-pains, &c., are published, is that they will not convince an opponent. We shall be told that nature was doing the work, and that there is no proof that the medicines made any difference. It therefore comes to be a matter of personal opinion and judgment, which, to one who has charge of the case, is satisfactory, but will not convince an opponent. He had great belief in the action of homœopathic remedies in obstetrics, when they were called for, but the publishing of results would be so much waste paper, as far as our opponents are concerned, for the reason already given. But the less we heard of malpositions being rectified by *pulsatilla* 30, the better. He deplored the advice given by such writers as Guernsay, to look out from a list of 20 or 30 remedies, when a patient had a uterus full of clots, and was dying of hæmorrhage. The only safe treatment was to empty the uterus with the hand. In the inflammatory fever following confinement,

homœopathic remedies acted like a charm. As to the proposal to have a maternity department, he thought it would divide our strength, while the hospital was so small as it is.

Dr. GOLDSBROUGH agreed with Dr. Day, and disagreed with Dr. Dyce Brown, in thinking that a separate maternity department should be established in connection with a new homœopathic hospital. He had attended upwards of 300 labour cases, and he considered that drugs were often of much service, especially in pregnancy. In the vomiting of the latter, *ipéc. kreasote* and *apomorphia* were of great value. In heartburn and other forms of dyspepsia, *nux vom.* was of service. During the fourth and fifth months a state of spinal irritation and nervous exhaustion was not infrequently met with, and here *sepia* or *achea rac.* act very satisfactorily. *Collinsonia* 1x was far preferable to aperients in the constipation of the latter months. During labour two medicines had served him well, viz: *ignatia* and *pulsatilla*. The former in exhausted states of the nervous system, and the latter in uterine inertia or fatigue. For this condition, where in former days it was customary to give a drachm of *ergot*, he now gave five drops of the mother tincture of *pulsatilla*. For after-pains he administered *gelsem. φ*, two or three drops after each severe pain, and found it of much benefit. If this did not relieve, and the pains were referred mostly to the back and thighs, *actea* was given instead. In febrile conditions following labour, if originating in the uterus, *verat. r. φ* was the first medicine he thought of; if in the mammæ, *aconite* or *belladonna*, or both. In inflammatory conditions, *aconite*, *merc. cor.*, *coloc.*, *bry.*, or *nux vom.* (in a high dilution) were called for according to different indications. Injections of hot water with antiseptics were always of service. He believed the internal use of *arsenic* to be homœopathic to septic conditions.

Dr. MOIR thoroughly agreed with Dr. Day that there was great room for developing this department in connection with the hospital. We must keep up the special departments. The development of this work would be much better carried out by specialists. One reason why he objected to do midwifery work was that he was constantly seeing infectious cases. A specialist could keep himself clear of them.

Dr. NEATBY said *calc.* and *salicia* were of great value in preventing premature births. *Arnica*, *secale*, *ignatia* and *gelsem* were very successful in relieving after-pains. In the vomiting of pregnancy he mentioned *coeculus*, in addition to those mentioned by Dr. Goldsbrough. *Collinsonia* had given him great satisfaction in relieving constipation. *Puls.* and *op.* had given him no results in promoting labour pains. He was

desirous of seeing a maternity department added to the hospital.

Dr. HUGHES thought it was a mistake for homœopaths to refuse obstetric work. He was glad to see the younger men were taking it. He was struck with the way in which Dr. Brown pushed aside the possibility of *pulsatilla* rectifying mal-presentations. It was possible for nature to rectify a mal-presentation, and, if so, it was possible for us to assist nature by medicines. If the evidence was satisfactory, that was no reason to deny it. He confirmed Dr. Goldsbrough's remarks about the medicines he had mentioned. In delayed labour he never needed to give *secale* in material doses. One medicine that had not been mentioned in this connection was *caulophyllum*. This is called for when the pains are irregular. *Pulsatilla* is best when the pains are weak from the first.

Dr. BURFORD said he could scarcely understand Dr. Brown's objection to having maternity beds in the hospital. It was true, as Dr. Brown said, that there was much common ground in obstetrics between the two schools. But if we are cast out from fellowship from the ordinary obstetric societies, where are we to look for fellowship if not to homœopathy and its special societies and institutions? He endorsed Dr. Goldsbrough's remarks on the vomiting of pregnancy, but he had obtained the most satisfaction from medicines chosen with respect to the totality of the patient's symptoms. Dr. Madden had spoken of the advisability of substituting Porro's operation for craniotomy. This he did not endorse, abdominal section being a very serious operation indeed. The question of the action of *pulsatilla* in rectifying mal-position is not so much a case of private opinion, as Dr. Dyce Brown had said, as of observation.

Dr. GALLEY BLACKLEY said he had found *arnica* given for a month or six weeks before labour of great advantage. *Apo-morpha* in the vomiting of pregnancy had given good results. This bit of practice we owe to Dr. Dyce Brown, who was the first to apply it, Dr. Blackley himself having been the first prover of the drug. With regard to establishing a maternity department, he could not think that feasible with the present institution. In the new hospital he hoped to see a separate obstetrical wing.

Dr. BLAKE (in the chair) said in China maternity was very fatal. It was not true that the women of uncivilised nations suffered less than those of civilised. The diminution of mortality was due largely to the spread of antiseptics. The substitution of vaseline for lard had done much good. Dr. Blake put on a binder before delivery, and tightened it after,

He ordered a hot rectal douche immediately he entered the house. He advised obstetricians to use a warm antiseptic vaginal douche before labour in all cases by way of preventing ophthalmia in the child. He approved of fomenting the perinæum before delivery. It not only tended to prevent laceration, but it also occupied the nurse. He had found homœopathy of enormous value in many of the side issues that crop up in every case. *Tabacum* relieved the vomiting of pregnancy, especially when associated with salivation. The heartburn of pregnancy was relieved by equal parts of *carbo veg.* 1x and *sodæ bicarb.* crude; dose, one teaspoonful.

Dr. DAY (in reply) thanked the members for the way in which his paper was received. He said he thought Dr. Dyce Brown's remarks were not consistent in condemning a separate obstetrical department which he (Dr. Dyce Brown) acknowledged to be in a large degree surgical, while at the same time approving of the appointment of a surgeon.

D

THE CARE OF THE EARS, WITH SPECIAL
REFERENCE TO THE ACTION OF CALENDULA
OFFICINALIS.

By ROBERT T. COOPER, M.A., M.D.

Physician Diseases of Ear, London Homœopathic Hospital.

DURING his holiday, however much rest is required, the general problem of the maintenance of health is ever before the physician, and his mind is ever on the alert concerning it. Nor could it be otherwise; for meditation upon the subject of health is necessarily for him an every day occupation. Absence from thought can never be rest to the healthy brain, just as absence from work can never be rest for the healthy body.

Perfect stillness, perfect freedom from movement would mean immediate disappearance by decay—by degeneration—of any part of the body; so also of the mind, and of its organ the brain; take away its stimulus, and it degenerates; the tissues change and we change with them. Nature makes every provision for keeping up internal movement, but the motion induced in the internal economy is in the long run subservient to external agency. Cosey Murphy, as he was nick-named in Dublin, went to bed for years and stayed there, but Cosey Murphy returned to active life, a “wusser” if not a wiser man than when he committed himself to the luxury of a feather bed.

I am prompted to make these remarks as the idea prevails among some portions of the community that periodical inaction is beneficial; periodical rest most certainly is enjoined, and is beneficial; periodical inaction, idleness, absence from work can benefit the diseased body but can only be injurious to the healthy. *Le bonheur, c'est le mouvement, le malheur c'est le repos.*

Two years ago I read a paper before this Society on the subject of *Baths and Remedial Agents in the treatment of Ear Disease*, and feel inclined to continue in much the same strain this evening. Our ears are little thought of until we suffer from them, as we are very likely to do during the holidays, and almost invariably from the

effects of bathing, hence it is not amiss to consider how this comes about. First, as regards *diving*; diving produces deafness in the most healthy ear, in consequence of the shock to the head occasioned by the forcible impress of the head against the water. This can easily be prevented by breaking the water with the hands and arms well in front of head; unless attention be paid to this deafness must be expected as an almost necessary consequence. Then, as regards bathing: deafness from this cause, strange as it might at first appear, is much more usual from sea-water than from fresh-water bathing. The reason is obvious; the comparatively smooth and tranquil surface of rivers and lakes does not contribute to the forcible entry of cold water into the ear, but the contrary effect ensues when water is thrown into agitation, and comes against the head in waves; then the constant succession of shocks of cold water against the tympanal membrane must in time be provocative of deafness. Consequently bathers ought to be warned against swimming lengthways with the shore when the waves are high, that is across the waves, but rather straight against them. When swimming straight against the waves, and precisely the same holds good when driving on land against an opposing wind, the natural conformation of the auricle protects the ear, for the tragus of each side slopes off, valve-like, from before backwards, over the orifice of the meatus, and thus diverts the stream—whether water or air—from directly entering the ear. If, however, we swim across the current, or drive sideways to a wind, there is no such provision, and the stream enters the ear unopposed, that is in a way that nature by the provision of a tragus sought to prevent.

A small india-rubber bag is now constructed by Messrs. Khronne and Sezemann, of Duke Street, for blocking up the ear while bathing, and thus preventing the entrance of water; these should be worn by all who have delicate ears.

Professional men ought to be warned against excessive exercise during the early part of their holidays. Nothing is more dangerous than the attempt to accomplish violent muscular exertion when debilitated by sedentary employment and town life. “For God’s sake, Sir, don’t run for that train; there have been no less than three

sudden deaths from this cause at this station within the last few months." Such was the warning given to a friend of mine by a railway porter a short time since; and it would be well to have every railway station in the Kingdom placarded with similar advice. No organ of the body more visibly manifests the effects of fatigue than the ear; if an ear has discharged and is imperfectly healed, it will almost certainly recommence discharging after a railway journey, or any great fatigue, while ear discharges as often disappear altogether in a bracing and highly oxygenated air.

When I addressed you two years ago, I advocated the adoption of auto-massage as a means of drying the body, especially after warm baths. When sea bathing during warm weather the risk of taking cold when dressing is reduced to a minimum, if instead of hurrying to dry the body with a towel we adopt this plan of auto-massage; then the kneading, fingering, tapping, thrusting, hacking, pinching, squeezing, rubbing, stroking and other performances peculiar to efficient massage may be adopted with, *mirabile dictu!* pleasure and comfort. There is nothing more dangerous to the sustenance of the race than the pursuance of luxuries that lead to diminished physical activity. Living in surroundings that increasingly contribute to human comfort, the tendency is for the viscera to become clogged with venous blood, effete products are not burned off, and the skin especially becomes inactive. By massage we lessen the pressure upon internal organs, but the skin has yet to be attended to.

Some of you who have travelled in Connemara may have witnessed the interesting sight of the old country-women with handfuls of sea-sand lustily scrubbing the backs of their lords and masters, the proverbial return compliment not being altogether usual. Now these Herculean women are philosophers of the truest stamp did they but know it; sea-sand is admirably adapted by reason of the rotundity of its angles for application to the surface of the body, and was, I believe, used for this purpose by a no less ancient authority than Mohammed himself; it not alone cleanses the skin, but softens it and renders it active—far more so than all the lotions and liniments in the world. No Amazonian caretaker having volunteered, I have employed this means myself, and with the most pleasurable after-effects. Let me

counsel any man, who, leaving town for the country, desires to exhaust his surplus energies in violent mountain climbing to fortify his body for some weeks beforehand by graduated and sustained muscular exertion such as auto-massage, aided it may be by sea-sand, or sea-sand and olive oil, supplies. In order to render auto-massage the more affective, I have had made for me of indiarubber a *fouet-dermatique*, by which we secure the great advantage of being able to act upon the supporting spinal muscles that would be otherwise out of reach of the hands.

Before hurrying on, let me say this, that as medical advisers we ought to explain clearly to the public that if they require to have a sea bath with full physiological effect, it is necessary to enter the water in a state of absolute nudity. The present system, of course it mostly applies to women, is physiologically wrong, supposing that a pleasurable and beneficial shock is sought for, while of course if the bath be partaken of only for the sake of the muscular exertion then there is no great harm in bathing dresses, provided no perniciously dyed materials are employed.

Out-door bathing supplies us with an air-bath as well as with a water-bath : the air bath is imperfect if, before and after the dip, we are caged up in an insufficiently ventilated bathing box ; the water-bath is imperfect if the skin be protected by clothing whilst bathing, and the entire salubrity of the operation is thus lessened by a too close adherence to fashionable requirements. These are facts : how far we can minimize the influence of the goddess, fashion, I am not prepared to say : it is enough for us to direct attention to defects and to allow a discriminating public to remedy them.

The young lady, who a few years ago divested herself of her superfluous garments on a hot summer's evening and plunged into the Serpentine, had more philosophy than modesty, more common sense than decency ; and in protest against police interference might have pleaded, *summum jus, summa injuria !*

We will now leave the subject of baths and of massage, and discuss the question of the influence of our old friend *calendula officinalis* upon the ear. This is a subject that I flatter myself is altogether new.

Last January there was attending my out-patient department, an engineer's apprentice, who had been under me for over two years, during which he had remained in a stationary condition, and before this had been a patient at an Ear and Throat Hospital, where he had decidedly got worse. He had been deaf since childhood, his body having after vaccination been covered with an eruption which was cured at this hospital, and the evidence of which he retains in the thickened hard, dry skin of his hands, and in constantly recurring sores about the body. There was a history of otorrhœa; but since being under me he has never had purulent discharge, but the ears are filled with a dirty-looking semi-liquid cerumen, which, when washed away, is shown to hide tympanal membranes with cicatrices as though perforations had existed.

The deafness is worst in a noise and best after being in open air. His hearing, on first coming, was about 4 in. on *right*, and 1 in. on the *left* side, and until last January, when I put him upon *calendula off.*, it had varied but very little.

It occurred to me to try *calendula*, and for this reason *calendula* as well as *saffron* have been used from the time of Culpepper* as "expulsive remedies." Both these are used now-a-days by the herbalists for developing eruptions when suppressed in the exanthemata. Now I had given this man *lobelia* with more benefit than any other remedy upon this metastatic principle, but it did not cure him, and naturally I asked myself if *calendula* might have an effect such as the herbalists claim for it. Five drops of *calendula* ϕ to go over two weeks, well diluted with water, and four drops of the same to ζij of *sacch. lact.*, a grain to be used three times a day as snuff was my prescription. The effect was unquestionable; steady and continued improvement at once set in, both in his general health and in his deafness, and he has gone on with it in varying dilutions up to the present time. On beginning with it, the hearing was, *right*, 5 in., *left*, $2\frac{1}{2}$ in.; now, *right* is 7 in., *left* 20 in.

* *English Physician*. Printed by John Streater, 1666. By Rich. Culpepper, Gent., Student in Physic and Astrology. Under Marigolds, p. 154, we are told, it is "an herb of the sun," and under Leo, "they strengthen the heart exceedingly, and are very expulsive and little less effectual in the small pox and measles than saffron."

All I wish to commit myself to in this case is the enormous benefit this man derived from *calendula*; as to the theory which suggested it, I have no opinion to offer.

Calendula is of great use in the local treatment of ulcerating and eczematous surfaces, and it may be that it effected a change in the epithelial lining of the nasopharynx, the influence extending to the middle ear.

Beyond the presence of dermic thickening of the dorsa of the hands and a disposition to sores on the body, this case gives us no presumable indication.

But there was then attending another very similar case in a girl of 21, where *calendula* exercised an equally beneficial effect, and in which the indication seemed plain enough:—"A great disposition to take cold, especially in damp weather."

Since then I have had an opportunity of putting very fully to the test of practical experience this key-note, and am well satisfied that we know of no remedy which can be resorted to for this particular symptom with such certainty as *calendula*.

In one very obstinate case, in a clergyman of about 33 years of age, where only the left ear was deaf, and where everything had been tried without success, the *calendula* brought back the hearing in a few days. In this case the deafness had come on after bathing, both membranes were normal in appearance, there was no discharge whatever, and there was an inability to distinguish with the left ear from whence sounds were coming, and which was always worse in damp weather. It had existed three years, during one year of which I had used every possible means without any real benefit until *calendula offic.* ϕ 7 drops to ζ ij. of *sacch. lact.* was given as a snuff. If a solitary case could be a crucial test of the powers of a drug this would be; for in no way can the action of *calendula* be explained except on the principle of specificity. Other medicated snuffs had proved useless.

The next case shows very plainly the action of *calendula* and of *calcareo phos.* A girl of 17 consulted me 14th October this year. Always dull of hearing, very much worse last three months from being exposed to draft in church. Was very deaf as a child "from her throat" but yielded to treatment.

Right ear : deaf since scarlet fever, fifteen years; watch-hearing, 15 inches.

Left ear : deaf three months; watch-hearing, 4 inches. Glairy hyaline discharge from both ears.

Hears best in a train or busy thoroughfare.

Hearing is worse when she takes cold, which she always does in damp weather; worse when fatigued.

Cannot hear two persons speaking together. Hears church bells and distant sounds fairly.

Has never been strong, liverish, appetite fair, bowels regular, sleeps heavily, not subject to cough, catamenia regular.

Prescription : *Calendula* 3x, 7 drops to go over a fortnight, and a grain of 3x trit. to be taken as snuff thrice daily.

October 27th.—Has been hearing very much better; the snuff restores hearing in an hour or two after each insufflation. Watch-hearing, right, 13 in.; left, 15 in. Glairy discharge continues. To continue.

November 11th.—In every way better; heard in church for first time for four months. R., 30 in.; L., 40 in.

Prescription : *Calcarea phos.* 1x 3 grs. dry on tongue three times a day.

November 25th.—Not hearing so well, but *calcarea phosphorica*, she states unasked, acts upon the tonsils and enables her to swallow easier, the fluids of mouth do not hang about the throat as used to be the case. General health better. Watch-hearing better—right, 50 in.; left, 45 in.

Prescription : To have *calend. off.* 3x as snuff and *calcarea phos.* 1x.

The case is still under treatment, but enough is shown by it to prove the effect of *calendula*.

It will be thought, perhaps, I am robbing *dulcamara* of its reputation; I do not think so, but any way what concerns me at present is not *dulcamara* but *calendula*.

What I claim to have done this evening is simply to have shown that there are good grounds for supposing *calendula* to be particularly useful in the treatment of certain varieties of deafness, namely, those where the deafness is worse in damp surroundings and especially where eczematous conditions are present.

It will be said that *calendula* is imperfectly proved; this certainly is a reason for proving it, but none for

withholding clinical observations regarding it. The point is this: we have many ear remedies, amongst the principal of which are *aconite nap.*, *pulsatilla*, *hydrastis*, *ferr. pic.*, and *quinine*; not one of these meets the symptoms for which I have found *calendula* so useful, and as this symptom is a very frequent one, the addition of *calendula* to our ear remedies is a decided gain.

There are many people who are constantly taking cold in damp weather; they require something to counteract this tendency, and as a help to their ears, we cannot do better than advise the sniffing up of a grain of the 3rd dec. trit. of *calend. off.*, the fresh plant being used in its preparation; while as far as the state of system generally goes, it ought to prove useful as there are few remedies which produce symptoms like those arising from damp and chill more obviously than *calendula*.

Lastly: what position is *calendula* to occupy among ear remedies? It is of course too soon to express a definite opinion; but it is not too soon to say that without excepting even *hydrastis canad.*, and which was first brought into prominence as an ear remedy by myself in this hospital, I have never handled a remedy with greater satisfaction than *calendula* in the treatment of the moist catarrhal manifestations of Vascular Deafness.

DISCUSSION.

Dr. BLACKLEY inquired as to the nature of the glairy hyaline discharge mentioned in the case. He also stated that he had ceased to use *calendula* externally, having given it up in favour of antiseptic dressings.

Dr. MOIR agreed with the preliminary remarks of Dr. Cooper as to the luxury of a sand bath, also as to the undesirability of too many clothes—both heavy bathing garments and in ordinary life. Some patients of his had been much benefited by the sun cure. Dr. Moir said *calendula* often caused an offensive discharge at first, but after a day or two the wound became sweet and healing progressed. He would like to know how Dr. Cooper mixed his *calendula* for external application.

Mr. WRIGHT asked Dr. Cooper what was the best method of getting water out of the ear.

Dr. NEATBY used *calendula* strong—1 in 4 to 1 in 8—and the dressing should be wet. For dry dressing he used other things. It answered the same purpose as an antiseptic.

Mr. KNOX SHAW referred to the action of *calendula*, though his experience in ear cases was limited. He was disappointed with his results in ear cases ; but *hydrastis* and *ferrum picricum* were of great value, and he will now look with great interest to *calendula*. He recommended his patients to dry out the ear with a little cotton wool before putting anything in. With regard to *calendula*, he had quite dropped its use, on account of the foul smell. When the *calendula* is used strong, the alcohol may act as an antiseptic. He had had a *calendula* oil made by extracting the *calendula* with hot oil. This oil has a fragrant smell, and he used it in dressing burns ; and though the burns do become offensive, they have good results.

Dr. MADDEN asked whether *calendula* has been found to produce eczematous eruptions? *Dulcamara* and *arnica* can produce eczema. Also he asked why it should not be applied to the ear by the meatus as well as by the Eustachian tube as a snuff? He asked Dr. Cooper if he recommended its use for deafness only from damp, or for colds generally from the same cause? His experience of the drug as a vulnerary was very satisfactory. In deep wounds he would use an antiseptic. Dr. Madden referred to the use of *salufer* as a dressing in discharge from the ear.

Dr. CLARKE had seen one of the cases referred to by Dr. Cooper, and could verify the remarkable effects of *calendula*. Dr. Cooper had given us a few indications in which we might prescribe the drug, but, though few, they were clear. He referred to a case, related by Dr. Ghosh in the October number of *The Homœopathic World*, of very inveterate eczema cured by the external use of *calendula*. This might have some bearing on Dr. Cooper's use of the drug. Dr. Clarke had seen a number of apparently hopelessly crushed fingers saved by the use of *calendula* ; and, for his part, he was not afraid of the smell it occasioned.

Dr. DUDGEON said that Dr. Cooper's papers were always interesting as they always gave us an agreeable surprise, for he brings forward remedies which no one would have divined from the pathogenesis. This showed the value of clinical observations. *Calendula* nearly always immediately removes the pain of superficial burns. He did not agree with Dr. Cooper's remarks about diving. He never found his hearing in the least degree affected by his diving. The water never gets into his ears. Those who got water into their ears could prevent it by putting a little oiled cotton wool into their ears. In some cases bathing in the sea is dangerous. One of the most severe cases of meningitis he had seen was in a gentleman who had gone into a rough sea with an ear discharge. It is

not the salt water that does harm—it is injurious neither to eyes nor ears.

Dr. HUGHES thought the value of *calendula* in these cases was due to its local effects, as in all the cases it was used locally as well as internally. In most cases of catarrhal deafness of any standing *iodine* 2x or 3x was very effective. He regretted to hear what Dr. Blackley and Mr. Knox Shaw said about antiseptics. The rule was *primum non nocere* ("Don't hurt your patients"), and that could hardly be said of the use of *perchloride of mercury* or *carbolic acid*.

Dr. COOPER, replying, expressed great satisfaction at the interesting discussion his paper had elicited, and at the complimentary way in which it had been received. He would endeavour to reply to the several points raised by the various speakers.

First of all, Dr. Blackley had raised a very important question as to the nature of the glairy fluid discharged from the ears in one of his (Dr. Cooper's) cases. This fluid Dr. Cooper looks upon as almost confirmatory of the presence of post-nasal growths, and he is inclined to think it arises from pressure upon the Eustachian tubes and the parts adjoining, as the tubes pass below the *foramen lacerum medium* of the base of the skull, and that this fluid is the discharged *liquor sanguinis*, mixed with the mucus of the middle ear. Dr. Cooper was glad to find his observations regarding the beneficial and pleasurable influence of sea sand to the skin confirmed by Dr. Moir, and to hear from him how much he valued *calendula* as a local application. As to the unpleasant odour assumed by wounds after some applications of *calendula*, the fact reminded him that he (Dr. Cooper) has found patients complain bitterly of the taste of mixtures of *glycerol of calendula* and water, used as gargles, after they have been some days in keeping, and this, although the taste was particularly pleasant—in fact, *vinous*—at first. From this, as well as from the fact, that he has never noticed any really curative effect from the *glycerol of calendula*, he would specially insist upon the *calendula* being given in the usual way by the mouth and in the dry state by the nose. Glycerine is well known to modify very seriously the action of some substances. Dr. Wright asked as to drying out the ears after bathing; a roll of absorbent cotton wool allowed to remain a minute or two in the meatus effectually accomplishes this.

Mr. Knox-Shaw's testimony as to the influence of a calendulated oil in burns ought to secure serious attention; its property of removing pain from a burn (subsequently confirmed by Dr. Dudgeon) is noteworthy.

Dr. Madden mentioned *salufer* as a substance about which he (Dr. Cooper) had written, and from which he (Dr. Madden) had obtained beneficial effects in otorrhœa. Quite so, but he (Dr. Cooper) would earnestly warn the profession against the use of undiluted *salufer*, except under very special circumstances. Applied in the dry state it evidently sets free hydrofluoric acid, and has a property of eating through whatever substance it comes into contact with, to an extent that no other known caustic is capable of doing, and besides it is painful in its action. Dr. Cooper considers, from the effects of *salufer* given highly diluted internally, that it has a greater power of increasing the muscular forces of the aged than any remedy he has ever prescribed. There is under him now, among the out-patients, a case of butterfly lupus of *alæ nasi*, where the progress of the disease has been entirely arrested by a lotion of three grains of *salufer* to six ounces of water, and in this highly diluted form it is an admirable lotion, the particles of the *salufer* seeming to pitch upon the diseased tissue specially.

Dr. R. Hughes complained that *calendula* had not been proved, and that its effects in Dr. Cooper's hands might possibly be due to its local action alone. He (Dr. Cooper), considered we had a very significant proving of *calendula* in Stapf's *Archives*, and that this gives us a perfect picture of symptoms such as damp might produce; viz.—Swelling of sub-maxillary (and axillary) glands, shuddering in the back, feverish chilliness, chilliness and shiverings particularly *after drinking*, heat in the evening with coldness of the head and hands, intermingled with shivering and accompanied with *aversion to drinks*, &c. This aversion to drinks and aggravation after drinking is very significant owing to the fact that, he (Dr. Cooper) finds *calendula* specially called for in hydrogenoid states of the system, and where exacerbation of the symptoms ensues from living in a moist atmosphere. There are cases of deafness which get worse at the sea-side and these are among the ones that call for *calendula*:—one such has been given in the paper.

Dr. Dudgeon, in speaking, denied that the forcible impress of the head against the waves in diving, or that the immersion under the water gave rise to deafness; this however is quite the reverse of ordinary experience. Sea-water in its contact with the tympanal membrane gives rise to deafness in two ways, viz., from the *force* of the impact, and from the chill occasioned by the cold, for the ear is more sensitive to lowered temperature than any other organ of the body: to these reasons for the causation of deafness we may add another, the natural effect of the influence of water upon the

hydrogenoid, (*Vide* Glauvogl, *Text-book of Homœopathy*, p. 265. Translated by Geo. E. Shipman, Chicago.)

Mr. Knox-Shaw had complimented him (Dr. Cooper) upon having introduced such ear remedies as *Hydrastis* and *ferrum picricum*; these were indeed of undoubted use, but the cases that called for *calendula* were very much more frequently met with than those which were to be met by any of our usual ear remedies.

Dr. Hughes had questioned whether these internal effects of *calendula* were genuine and asked if he (Dr. Cooper) was perfectly certain of them. Dr. Cooper did not think there could be any reasonable doubt about the matter, but he very much preferred the assumption of an uncertain attitude, in fact, the chief object of his paper was to give others the opportunity of testing the matter; and, any way, he considered every contributor to medicine ought to be ready to review his own work unfavourably, which he could hardly do if he began by dogmatic and final averments; for this reason he preferred having the matter considered as problematical, while therefore, theoretically, his position regarding *calendula* is one of doubt; *practically*, he is fully convinced of its great utility and considers it the most frequently indicated ear remedy he has yet met with.

As to Dr. Hughes' objection that its action is merely local, he is at a loss to see how this can be maintained. The fact of depositing the particles of a medicinal substance upon the nasal, instead of buccal mucous membrane, can hardly be said to constitute it a local aural remedy. In every way he (Dr. Cooper) considers the exhibition of our sensitive and highly attenuated remedies by the nose instead of by the mouth is scientifically preferable, and certainly a more direct action upon the ear is secured by giving drugs through the nose, though as just said this can hardly be considered to bring such into the class of mere *local* remedies.

Then Dr. Moir had asked how these snuffs were prepared. The *calendula* snuff is simply the third trituration from the saccharated extract of the plant, but frequently he has used instead sugar of milk impregnated with the *calendula* mother tincture; in this case, however, care must be taken that the sugar of milk is very finely trituated, as otherwise its particles will irritate the nasal mucous membrane and so do harm. *Calendula* promises to do more for that very obstinate symptom, *the hearing better in a noise*, than any drug with which he is acquainted.

EXCEPTIONAL CASES OF ACUTE PNEUMONIA.

BY GILES F. GOLDSBROUGH, M.D.

THE cases I venture to bring before you this evening are four in number. When you have heard them, I do not think you will say they belie the title of my paper. I give them in as full detail as possible, because the points on which I desire to comment might otherwise be lost sight of.

CASE I.

F. S., a boy, age 14. His previous history had been that of ill-development. For two or three years he had had occasional attacks of pain in his right arm and side of chest, followed by a cough and free mucous expectoration. A year ago he had measles; the rash was a long time coming out, and convalescence was tedious, but according to his parents' report no pneumonia followed.

I was called to see him on the evening of March 3rd, 1885. He had been ill since February 27th with cough, dyspnoea, fever and delirium. He had been under allopathic treatment. I found the following conditions:—Temp. 103°. Pulse 140. Resp. 44, catching, and very restless; short cough; no expectoration; continuous chattering delirium, but answers questions correctly; no headache; pupils sensitive and normal; tongue dirty white, moist; papillæ red. Has had slight vomiting, but takes nourishment. There was dulness on percussion over whole of the base of the right lung, with loud tubular breathing and moist râles. Left lung normal. Great prostration.

I ordered linseed poultices for the side and *bell. φ* and *phos.* 1 every hour in alternation as medicines.

4th.—M. T. 101.4°. P. 130. R. 44. Had a few short naps in the night, otherwise the same. Continue treatment. E. T. 103°. P. 125. R. 44. More delirious, and marked tympanitic distension of abdomen. Gave *merc. cor.* 1 instead of *phos.*

5th.—M. T. 101°. P. 130. R. 44. Slept three hours. Lung condition much the same. Continue. E. T. 103°. Continue.

6th.—M. T. 102°. P. 120. R. 40. Is more prostrate but quieter. Return to *phos.* instead of *merc. cor.* E. T. 101°. P. 120. Continue.

7th.—M. T. 100°. P. 120. Only slight delirium; slept at intervals. Continue.

8th.—M. T. 100.6°. P. 120. Slight delirium. Lung condition the same.

9th.—T. 100°. P. 126. Very restless. Tongue red in the centre, otherwise white. Gave *acid phos.* 1 instead of the *phos.*

10th.—T. 100°. P. 120. R. 36. Tongue clean. Is quite sensible for the first time. Continue.

11th.—T. 99.4°. P. 120. Condition same as yesterday. Continue.

12th.—T. 101°. P. 125. R. 40. More cough. Does not seem so well. I have no report of the physical signs on this day, but regarded the increased rate of P. and R. and cough as an exacerbation of the pneumonic state. Gave *digitalis* ϕ and *phos.* 1 every hour alternately.

13th.—T. 99.2°. P. 125. R. 38. Cough much easier. Slept well. Continue.

14th.—T. 98°. P. 125. R. 36. Very weak. Cough still better. *Ipec.* and *sulphur.*

15th.—T. 99.2°. P. 125. Return to *digitalis* and *phos.*

16th.—T. 100°. P. 125. R. 40. Much the same in general condition. Right lung seems blocked and useless. Cough loose. Tongue clean. Quite sensible. There had been no expectoration throughout. *Ars. iod.* 3x was given as medicine.

From this date, for a period of three weeks, I have a similar report. There was much and increasing emaciation, though the appetite was fair. Several medicines were given according to the prevailing indications, notably *ars. iod.*, *hepar*, *phos.* and *stannum.* On April 11th he began to expectorate freely, bringing up large quantities of purulent matter. The temperature went down and pulse improved, and he began to put on flesh. My report for April 27th is T. 98.4°. Lung abnormally resonant, much contracted at the base, and a cracked pot sound at the apex. On May 4th he had a small bulging swelling over the right mamma, and was expectorating much less than usual. This continued until the 11th, and I thought we were to have an external opening, but pus came suddenly by the mouth very freely again,

and the swelling went quickly away. Improvement after this was still more rapid, and I was able to leave my patient to visit me on June 2.

In March, 1886, another small abscess formed in the lung. The temperature was from 100° to 101° for several days. He expectorated purulent matter freely, and by the second week in April was well again. The treatment consisted of poultices to the chest. *Gelsem. φ ant. tart.* 1 for a day or two followed by *gelsem.* and *silic.* 1. I have no indications for the *gelsem.* in my notes.

The present condition of this patient being somewhat interesting, I have asked him to come for your inspection. His shoulders project forward, and the chest is much contracted at the upper part, and expansion is very deficient. You will notice that there is contraction and flattening at the lower part of the right side, and on the left side, at the junction of the cartilages with the ribs, an angle is formed with its apex outwards, increasing from above downwards. I examined him on Dec 14th and found dulness on percussion at the right apex, with moist râles at the end of inspiration. I have been treating him since that time with the usual remedies. I may add I have the greatest difficulty in inspiring him with any interest in his physical well being.

CASE II.

I saw at 11 a.m. on July 22nd, 1889, W. P., age 25, a coachbuilder; not a strong man, though he never had a severe illness. Had had a slight cough for the past few weeks. Had rigors on the 20th instant, and shortness of breath, and felt languid. Took some aperient pills and went out on the 21st. He had been taken suddenly worse before I was called, and when I reached him was in a state of semi-collapse. His face was pale and drawn, nose pinched and lips thin and blue. He was conscious, and said he was intensely cold and aching all over, and, in addition, had an acute pain in the right hypochondrium. The pulse was very small, wiry and could not be counted. Respiration irregular and short. He coughed occasionally, and in my presence expectorated some rusty-coloured mucus. Had vomited several times, mostly bile. His tongue was moist, flabby and broad. I ordered hot bottles or bricks to be applied to the feet and thighs, a large linseed poultice to the

hypochondrium, one drachm of brandy every few minutes until he began to rally; the quantity then to be reduced, and *aconite* ϕ and *verat. alb.*, drop doses, every quarter of an hour in alternation. He was also to have hot milk with soda water and Brand's meat essence for nourishment.

At 10.30 p.m. he had rallied considerably. His face and lips were much better in colour. Pulse very small and rapid, about 200 per minute I imagine. Pain in the side the same. Cough very slight; no expectoration. Slight dyspnoea. Bowels had moved three times. Passed urine freely. No more vomiting. The temperature in the axilla was 102°. He complained of much aching in the limbs. I ordered 2 drachms of brandy every two hours, and changed the medicine to *veratrum viride* ϕ and *digitalis* ϕ alternately every hour. Otherwise continue the same.

23rd, 12 noon.—Had slept a little at intervals, was very restless and slightly delirious. Had four stools, loose, slimy, green, very offensive. Cough the same, no expectoration. Less pain in the side, but extreme tenderness in the epigastric and umbilical regions. Tongue broad, dry, thickly coated. Pulse 130; a little firmer. Temp. 100° in the axilla. Resp. shallow, quickened. I was able to move him sufficiently to ascertain that there was dulness on percussion throughout the right side of the chest. The treatment was changed as follows: *Verat. vir.* ϕ , and *ars. alt.* 3x. as medicines; two drams of whiskey (he preferred this) every four hours, barley water, sips of iced water, and thin milk and farinaceous foods.

At 7 p.m., T. 103°, P. 130. A marked improvement in the condition of the bowels. Otherwise the same. Continue.

I saw him again at 11 p.m. T. 105.2°, very restless and rather delirious. I changed the medicine to *aconite* ϕ and *bell.* ϕ every hour alternately.

24th.—In the morning a decided improvement. T 101°. P. 120. Cough slight and hacking, no expectoration. Had slept at intervals. One pale faecal stool. Continue.

At 10 p.m., T. 104°. P. 135. The nurse thought the temperature began to rise about 6.30. Much restless-

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ness and prostration. Condition of the chest appeared the same. No examination made. *Bell. ϕ , ars. alb.*

25th.—1 a.m., T. 104°. 5 a.m., T. 103°. 7 a.m., T. 101°. 11 a.m., T. 100.2°. P. 108. R. 36. 2 p.m., T. 99.5°. P. 104. R. 36. 10 p.m., T. 103°. P. 112. R. 36.

Much the same general condition as the previous day. Tongue cleaner. One normal stool. Abdominal tenderness nearly gone. Cough slight, with occasional dark brown expectoration. Takes nourishment well. Continue all measures.

26th.—1 a.m., T. 104°. P. ? R. 40. 4 a.m., T. 104°. P. 118. R. ? 6 a.m., T. 103°. P. 106. R. ? 8 a.m., T. 102.5°. P. 100. R. ? 10 a.m., T. 101°. P. 107. R. 37. 1 p.m., T. 100°. P. 102. R. 30. 4 p.m., T. 100°. P. 106. R. 32. 7 p.m., T. 103°. P. 118. R. 46. 9 p.m., T. 103.5°. P. 106. R. ?

Occasional delirium during the night. Still very restless, and complained much of sharp pain in right side of chest. Examination gave right lung entirely dull, no respiratory murmur, but vocal resonance much increased. No expectoration. Tongue dry. Pulse small. To have half an ounce of whiskey every four hours. *Aconite ϕ phos.* 1 as medicines.

27th.—1 a.m., T. 103°. 4 a.m., T. 102.5°. P. 100. 10.30 a.m., T. 100°. P. 102. 4 p.m., T. 101°. 7 p.m., T. 101°. P. 120. 10 p.m., T. 100.5°. 12 night, T. 100.5°.

Had a quiet night. Otherwise remains as yesterday. Continue.

28th.—4 a.m., T. 103°. 9 a.m., T. 102°. 12 noon, T. 101.5°. P. 122. 2 p.m., T. 102°. 5 p.m., T. 102°. P. 120. 7.30 p.m., T. 102.5°. 10.45 p.m., T. 100°. P. 96.

Much the same as yesterday and the day before. Medicine changed to *verat. vir. ϕ* and *phos.* 3x in the morning. In the afternoon he slept continuously for an hour and a half, and from that time improved in rapid strides. Continue.

29th.—2 a.m., T. 99°. 6 a.m., T. 98.4°. P. 98. 11 a.m. (time of visit) T. 98°. P. 84. R. 30.

Slept well in the night, waking only for a minute or two. Takes nourishment well. Physical signs the same. *Phos.* and *sulph.* were given as medicines.

The temperature did not rise again above 98°, nor the pulse above 84. Patient made steady progress in every

particular, so that I saw him last on August 13th. He was then up and could walk about, had no cough, the dulness on percussion was much less, and he could make limited use of the lung. About a week after he went to Worthing for ten days or a fortnight, and resumed his work shortly after his return.

I am sorry to offer such a fragmentary record of the respirations in this case. For the first few days my attention was taken up by the general condition of the patient. He was nursed by his wife for that part of the time, later on a sister, who was an asylum attendant and accustomed to acute illness, came and took care of him. I instructed her to take the temperature at the short intervals I have given them, also to count the pulse and respirations. Where there are gaps she was not sure of the correctness of her observations, so did not record them. This spoke well for the discipline of her training I thought. I may add that the patient and his wife and baby, six weeks old, occupied two rooms only of a house of eight rooms, where there were two other families. This fact leads me at once to my next case.

CASE III.

B., age 38, a policeman, who lived in the same house as W. P. He is a strong, healthy, sober man. "Never ailed anything," were his own words. On the morning of July 28th, 1889 (that is while attending my last patient), I was asked to see him. He had been on special duty on the 27th and got overheated, and subsequently felt very cold. He had also several times been in the room with the last patient, and had assisted in lifting him. He had had no sleep during the night, had very acute pain in the right side of the chest, so that he was rolling and tossing about the bed. Felt very cold, and breath very short. Tongue thickly coated, temperature in the axilla 102° and pulse 90. He was, of course, entitled to the services of the surgeon of his division, who had, I learned, been to see him, and had ordered a mustard plaster to his chest and promised to send medicine. Accordingly I demurred to prescribing or advising in any particular. On second consideration, however, as the man was suffering so acutely, I gave him some *aconite* ϕ and *bry.* ϕ , and advised a large linseed poultice in preference to the mustard. I made an express stipu-

lation that the police surgeon was to be informed of my action, and that I could do no more, except in consultation with him, or by his consent take up the case.

On July 30 I was asked, the police surgeon consenting, again to see the man and take up his case. Soon after taking the medicine on the 28th he felt relief from the pain, and had a little sleep, but he has not slept since, and he complains still of the acute pain. T. 102°. P. 100, full. R. 40, very difficult. Occasionally a cough, but no expectoration. Dulness on percussion over the lower two-thirds of the right lung; increased vocal resonance and tubular breathing. No noticeable friction sound. Continue linseed poultices. *Verat. vir. φ, phos.* 1 every hour alternately.

July 31.—T. 101.6°. P. 100, full. R. 40. Dyspnœa very distressing. Had no sleep. Directly he shuts his eyes he sees faces before them. Cough as before. No expectoration. Rattling of mucus in bronchi. Tongue thickly coated. Continue poultice. *Bell. φ, ant. tart.* 1.

August 1.—T. 102°. P. 116. R. 40. Had no sleep. General condition much the same. Slight expectoration, rusty colour. Bowels acted very frequently, and almost involuntarily; loose light-coloured stools. Change *ant. tart.* 1 for *phos.* Continue *bell.* till night, then *hyos.* 1x. if no sleep was obtained.

2nd.—I was called at 6.30 a.m. Patient had had no sleep, and I found his condition very critical. His face and neck were bluish-red, nails bluish. R. 64, very laboured, with loud rattling in the trachea. P. 120, irregular. Very restless, and becomes occasionally unconscious. Seeing no time was to be lost I gave him at once an ounce of whiskey, with an equal quantity of water, also two or three drops of *ipéc. φ.* He expectorated some rusty-coloured mucus almost directly, the pulse became more regular, the duskiess of his skin became less, and while I was present he had about three minutes' sleep. I ordered half an ounce of whiskey to be given every half-hour until my next visit, also *ant. tart.* 1, and *ipéc. φ* every quarter of an hour in alternation.

I returned at 11 a.m. He had had a few minutes' more sleep. His respirations were quieter. Pulse 120. T. 102.6°. Continue all measures.

At 9 p.m. the crisis was over. T. 100°. P. 112, regular. R. 40. Had slept a few minutes at intervals. He lies quite quiet in bed and his mind is clear. Expectorates brown mucus occasionally. Continue medicines and $\frac{3}{4}$ ss. whiskey every hour.

3rd.—T. 99.2°. P. 95. Respiration quite quiet. Slept fairly through the night. Says he feels much better. Expectorates slight white mucus. Tongue very brown. Continue medicines. Whiskey every two hours.

4th.—T. 98.8°. P. 85. Respiration very irregular. and restrained on account of sharp stabbing pain in the right hypochondrium, much aggravated by a deep inspiration. No friction sound. Dulness on percussion less. Expectoration very scanty. Gave *bry.* 1x instead of *ipéc.*

5th.—Improving generally, but no relief of pain. *Arnica* instead of *bry.*

6th.—As yet no relief of pain. I had regarded it as intercostal myalgia. He complained much of flatulence. Bowels regular. He was now taking half-ounce of whiskey two or three times daily. His tongue was much cleaner. T. 98°. P. 80. I prescribed *ranunculus b. φ* and *nux vom.* 3 in alternation.

This afforded much relief, and he progressed uninterruptedly afterwards. On August 13th the dulness on percussion had nearly disappeared, and the respiratory murmur was normal. The police-surgeon remarked to the patient, at one of his visits, that he had made a very quick recovery.

A few remarks are here necessary regarding the probable cause of W. P.'s illness, also that of B. I have already told you that they both lived in the same house. Two days before W. P. was taken ill he had eaten some fish, which, he said, his stomach turned much against. Towards the end of his illness (while B. was at his worst) his wife had a severe attack of diarrhœa with a temperature of 100°, which passed off under *baptisia* and *arsenicum* in thirty-six hours. At the same time three of B.'s children, who had not come near W. P.'s rooms, had foul, ulcerated mouths. The cistern in the house had not been cleansed for an indefinite period. I therefore ordered all drinking water to be boiled. At my request both landlord and sanitary inspector were communicated with. The latter reported no defects. I omitted to make enquiries as to the milk supply.

CASE IV.

S. J., a boy of 15, fair complexion, whom his mother considered delicate, was taken ill on September 25th, 1889. He had not long returned from a holiday in Scotland, and I was informed that the sanitary arrangements of the house at which he had been staying were very imperfect. I visited him on the afternoon of the day mentioned, and learned that an acute pain in his left side and feverishness had come on quite suddenly just previously to my visit. He was well in the morning, except being languid and having slight nasal catarrh. I found him with T. 105°. P. 138. R. quick and irregular. His tongue was coated, and he was very thirsty. I could detect no abnormal physical signs; I ordered a poultice to the side, and *acon. φ* and *bry. φ* every hour in alternation.

Sept. 26, 11 a.m.—A very restless night, occasionally delirious. Pain much the same. I examined the chest carefully all over, found nothing abnormal on the left side, but slight dulness and increased vocal resonance at the right base. T. 104.2°. P. 136. R. shallow and quick. Gave *digitalis φ* instead of *aconite*. Continue *bry.*

I saw him again at 10 p.m. T. 103°. P. 126. R. 40. Had slept a little during the day. Was in less pain. Continue.

27th, 11 a.m.—T. 103.2°. P. 128. R. 40. Short sleeps at intervals. Delirious between sleep. Answers my questions correctly but seems absent. Very prostrate and does not care to be moved. No change in the condition of the chest. Slight cough now and then. No expectoration.

28th.—T. 103.4°. P. 120. R. 36. Slept rather better. Delirium much same. Tongue cleaner. Complains of headache. Had two relaxed stools. Dulness cleared at right base, though an occasional pleuritic friction heard. Pain in left side not felt now. Medicine changed to *verat. vir. φ* and *bell. φ*.

29th.—T. 103.4°. P. 120. R. 36. A similar report to yesterday. Bowels acted five times. There is decided fulness of the abdomen. Continue. I have no record of his state for the past three evenings.

30th, 11 a.m.—T. 102.8°. P. 116. R. 40. Slept very little in the night. Delirium is continuous—a low

muttering and chattering, but can be roused to answer questions. Had seven stools in 24 hours, pale and watery in character. Abdomen the same. Tongue white, red at tip. Takes nourishment well. No cough or expectoration. Very prostrate. I did not disturb him to examine his chest. Ordered a tepid compress to the abdomen, and gave *bell. φ* and *ars. alb.* 3x as medicines.

At 5 p.m. I saw him, in consultation with Mr. Harris. T. 104.2°. P. 112. R. 40. We noticed at a glance that the right side of the chest was moving more than the left and on examination found decided dulness on percussion at the left apex, and crepitant râles at the end of inspiration. No stool since 8 a.m. Tongue was coated white all over. The delirium and prostration continued. Mr. Harris suggested *baptisia φ* and *ant. t.* 6. in alternation, a continuance of the compress to the abdomen, and a poultice to the left apex.

Oct. 1st, 11 a.m.—Sleeping quietly in a profuse perspiration. Had much less delirium and more sleep in the night. A slight loose cough. No stool. P. 80 soft and weak. R. about 30. I did not disturb him, but called again at 6 p.m. The report then was T. 97.6°. P. 80. R. 28. Much better in every way. Seems in a dreamy condition, as if trying to recollect where he had been. Gave *hepar 6* instead of *baptisia*.

Oct. 2nd.—T. 97.6°. P. 80. R. 26 Tongue clean. Slept well. Lies very quiet. Cough slight, but inclined to be troublesome. No expectoration. Dulness on percussion at left apex much the same. *Hepar 6, ipec 1.*

Oct. 12th.—He has continued to make progress. Dulness continues over the whole of the upper lobe of the left lung, but is less, and there is a sense of constriction when he attempts a full inspiration. His general health and strength are nearly regained. I ordered him to Hastings, and to be out in the air as much as possible in suitable weather between 12 and 4. I gave him *bry. 6* and *ars. iod. 2* as medicines.

I had an opportunity of examining his chest on Nov. 8th, and found it quite normal.

Pneumonia is a disease we are all familiar with in practice, yet it is surprising the difference of opinion expressed by different writers as to its true nature in the light of causation. It is not my purpose to enter into a discussion of these differences, but the cases I

have read to you being so far departures from the common type of the disease, suggest to the mind possible causes other than those ordinarily recognised, which at least may be held in the present uncertain state of opinion on the subject, to be factors in the production of what is termed *typhoid pneumonia*.

The causes which favour the development of ordinary pneumonia are held to be certain relations of sex, constitution, habits, occupations, barometric changes and unhygienic surroundings. Yet the character of the disease is of such a specific nature—an affection of the whole system rather than a local lesion having general symptoms (such as bronchitis or pleuritis for example) running, too, a course well defined though variable in duration, and ending in a definite and complete recovery—that the causes above given in the ordinary acceptance of their terms are not sufficient to explain the occurrence of the disease. No doubt a combination of influences is usually in operation; two of the most active of these being exposure to cold and sudden barometric changes. In an indefinite way the term unhygienic surroundings may cover the more specific influence, which shall decide there being a disease at all. Cases II. and IV., and secondarily Case III., certainly stimulate a search for a cause in this direction. In Cases II. and IV. there were no bad habits, bad occupations, or undue exposure to cold. In both there was the unmistakable influence of water and air contaminated with decayed vegetable or animal matter. In Case III. there was this likeness with a sudden exposure to cold, and in addition the inhalation of air contaminated by excretions from Case II. Is it not possible that all cases of pneumonia may own a marked specific cause such as I have suggested, in the same way that typhus fever is due to over-crowding, diphtheria to the inhalation of sewer gas, and enteric fever to the ingestion of decayed animal matter. To find a cause of this character is much more necessary in epidemic or typhoid pneumonia, midway between which and the acute sthenic form my cases appear to stand. Professor William Stokes mentions a remarkable occurrence of this epidemic in his treatise on *Diseases of the Chest*.* In Dublin a large

* *A Treatise on the Diagnosis and Treatment of Diseases of the Chest.* By William Stokes, M.D. Edited by Dr. Hudson. New Sydenham Society. 1882.

number of healthy, well-conducted men of the constabulary were attacked, and the true specific cause was not apparent. A curious fact was that at the same time there was progressing an epidemic of cerebro-spinal meningitis. I remember well a case of a woman occurring in the second year of my practice, where we distinctly traced the production of the disease to drinking water which had remained in an unused cistern for some time. Diarrhoea was a marked feature in the case, and proved very obstinate. *Baptisia, merc. cor.*, and *antim. tart.* were the medicines used. Juergenson, writing in Ziemssen's *Encyclopædia*, regards pneumonia as belonging to the class of malarial infections. Must one not add the influence of animal poisons received through air or water, and, regarding the intensity of the poison, *cæteris paribus*, anticipate the disease assuming the adynamic type?

"Is pneumonia contagious?" is a question which is but a step from the one we have been considering. I know of a family of five children, two of whom have had croupous pneumonia three or four times. If one takes it, it is always a time of anxiety on behalf of the other until the first is well. On one occasion four out of the five were ill at once. At another time, following measles, which they all had severely, three had double pneumonia. I cannot help thinking that if these children had lived apart, there would have been less likelihood of more than one being affected at a time. I do not mean to say they were not all similarly susceptible to external influences, but this would be an additional reason why they would be susceptible to the influence of each other.

Of course it would be impossible to say what influence, if any, operated in Case III. of my group, but I was much impressed with the coincidence, especially in relation to the other causes which I have already touched upon. The possible contagiousness of pneumonia suggests to the mind an analogy in tonsillitis. If persons have sensitive throats and they inhale the same air as some one affected with tonsillitis, I have not infrequently known them to have an attack of that disease.

What circumstances determine the formation of abscess or of purulent infiltration as a conclusion to the pneumonic process? This is an important point in prognosis. One might, at first thought, expect that

abscess would be more frequent in cases of the adynamic form. Such however appears not to be the case. I can find no tabulated results bearing on the point, but Professor Stokes remarks that the cases in the epidemic in Dublin, seldom went on to the third or fourth stages. Case I. of my group suggests the kind of constitution and conditions which might be anticipated specially to be slow in resolution and to favour the occurrence of suppuration. Ill development marked his history, and a state of vitality in the average of life much under the normal, particularly with regard to the oxygenation of the blood, and its consequent reactive apathy of mind and muscle would contribute to this result. It speaks well for the *vis medicatrix naturæ*, that he surmounted and threw off the incubus of a thorax half laden with pus.

I had intended referring to the delayed development of the local lesion in Case IV. as illustrating once more the general and systemic character of the disease, but time will not allow. I may just throw out one point for discussion. Assuming this general and systemic character, does a delayed development suggest the possibility of the local lesion being in itself the effort of nature to throw off the morbid influence? And when this lesion reaches a certain stage resolution follows as a necessary consequence of the local lesion having been developed.

Turning aside from speculations I now come to the more practical subject of treatment. A homœopathic practitioner can scarcely be surprised at a general scepticism as to the value of drugs in arresting or controlling pneumonia. When in past times in addition to the prevalent bleeding, blistering and purgation, *mercury* or *antimony* were given in massive doses, and there was a high mortality in consequence, unquestionably mankind becomes better off under the benign expectant attitude of a Dr. Bristowe or a Dr. Wilks. Let us hope that this scepticism may pave the way for an intelligent application of the rule of similars in the future. Homœopathy shows a good record, and her promises for the future are better even than her performances in the past.

Under the old heroic treatment I am afraid none of my four cases would have survived. Under the expectant treatment one might have survived, had vigorous stimulation been resorted to; and he might, perhaps, have

recovered quite as quickly as he did with the drugs I gave. I refer, of course, to Case III. The others were, I believe, influenced to a marked degree by the drugs which were administered.

One thing I endeavoured to keep constantly in view, namely, to treat the patient according to the totality of his condition, apart from any preconceived theory as to the nature of the disease. Whether every drug was well indicated or well chosen, or whether the almost invariable alternation of medicines, and the doses in which they were given, were the best to accomplish this object, I do not pretend to say. I leave the matter for your discussion.

The last time an important discussion took place on this subject amongst homœopathic practitioners was, I believe, at the Congress of 1883. It was based on a paper by Dr. Bryce, of Edinburgh, entitled *Clinical Notes*. Both paper and discussion, which are of a deeply interesting and instructive character, are given in full in the *Homœopathic Review* for October, 1883. The burden of Dr. Bryce's argument was, in the first place, that it is necessary to ascertain the totality of the morbid phenomena exhibited by the patient, and to prescribe accordingly; and, secondly, that if a prescription is based on pathological data, the dose required will be just within the physiological dose of the drug. He then adduces several cases of pneumonia, in which he administered drop or half-drop doses of *digitalis* ϕ on the ground that pathologically it meets the acute sthenic variety of the disease in its first stage of active congestion. His treatment was attended with much success.

Has his plan been given an extended trial, and with what results? Its relation to my present subject is as follows: I have given *digitalis* singly in several cases according to Dr. Bryce's suggestion and with his results. In some others there has been a reduction of temperature of one or two degrees, and an apparent mitigation of the severity of the attack. If acute active hyperæmia of the lung can be identified in any case, whether in the beginning of the illness or by extension from existing disease, it seems to me that Dr. Bryce has rendered us much indebted to him for his suggestion, and that *digitalis* might be used with benefit either singly or in alternation as the case might seem to require.

Baptisia is another drug which calls for some remark. If pneumonia can have, for its cause, the introduction into the system of decayed vegetable or animal matter, if the disease in the first few days of its course threaten to take on the adynamic condition, and if there be delirium of a muttering character, much pain in the back and limbs, a thickly coated tongue and diarrhoea, *baptisia* should undoubtedly be thought of. I believe the crisis was approaching in Case IV. before it was given, though the favourable termination may have been hastened by it as well as by the *tartar emetic*. And it has occurred to me, since Mr. Harris' suggestion of it on that occasion, that it might have been of use in Case II., though I did not think of it at the time.

Patients suffering from pneumonia seem to be particularly tolerant of alcohol. This is referred to by many writers. As failure of the heart's action is the chief source of danger in the disease, when judiciously used, alcohol is of the greatest possible service as a stimulant to tide the patient over the critical period. Personally I am indebted to Dr. Dyce Brown for advice in a case where this fact was very forcibly illustrated. In a case of pneumonia in a man aged 68, a free liver, complicated by previously existing organic heart disease, he advised increasing the stimulant to six or eight ounces or even more in the twenty-four hours. The result was not only beneficial to the pulse and heart's action, but as we increased the quantity of stimulant there was a palpable reduction of temperature. This patient made an excellent recovery, and with return to health, the quantity of stimulant was reduced to his normal minimum. There is a hospital not far from here to which acquaintances and patients are asked to contribute, where professedly every variety of disease is treated without alcohol. It would be extremely interesting to have before us by way of contrast, the details of the cases of pneumonia which are treated there and to compare results.

One more point and I have done. You will have noticed that in the cases I read I used a considerable number of medicines and changed them frequently. In all diseases running a rapid course, as soon as there is a change in the patient's condition for the worse, even though it may be simply an aggravation of the pre-existing state, it becomes a rule with me to make a

change in the medicine. This may sound to you a very trite observation. Yet when diseases pursue a certain cycle some might contend that aggravations might be really only apparent, and if the patient were left to himself he would recover. It is thus scarcely out of place to reiterate a firm belief that under the homœopathic rule of selection a beneficial influence is possible, if a true selection is made, and this belief leads one to seek that influence as being direct and soon, and without aggravation of the patient's state.

DISCUSSION.

Dr. DUDGEON said the points brought forward by Dr. Goldsbrough were very interesting. Abscess occurred, in his experience, not only in typhoid pneumonia, but in common acute pneumonia, and in embolic pneumonia. The malarious or epidemic character of pneumonia has been strongly supported, and the supposed origin in colds and chills discredited. He did not think Dr. Goldsbrough's cases proved that pneumonia was contagious.

Dr. HUGHES said Dr. Goldsbrough's cases well illustrated the utterly atypical character of the cases of pneumonia we generally meet with. He thought the details of the cases were more interesting to the man who conducted the case than to others who heard them read. He did not think *digitalis* had any influence on the essence of a pneumonia, *digitalis* not being related to lung tissue or fever. *Baptisia* he could understand being useful in cases of septic origin. He thought we should steadily work away with medicines homœopathically related to the condition of the lungs. Fleischmann gave nothing but *phosphorus* and got excellent results. Dr. Hughes thought that frequent changing of medicines without change of symptoms was bad.

Dr. CLARKE said that the paper of Dr. Goldsbrough raised many important points. If he might be allowed a criticism, he would say that the cases were somewhat undigested, and the points not brought out with sufficient clearness. This was especially so with the indications for the remedies given. He thought Dr. Hughes might have gone further: it was not medicines homœopathic to the condition of the lung, but to the state of the patient that were wanted. Our allopathic friends, like Dr. Gairdner and Dr. Dyce Duckworth, are always telling us that they treat patients and not diseases: it seemed as if members of the Society were rather going after treating diseases and not patients to-night.

Dr. BURFORD thought the cases were exceedingly valuable, and, although they might have been better digested, still in their details lay the chief part of their value. There are pneumonias that are infectious, and others secondary, and others idiopathic. Five men may get a chill on the top of an omnibus; four of them may take, as a result, a different affection—pneumonia, pleurisy, rheumatism, catarrh—and the fifth may escape any after-effect of any kind. Septic pneumonias were not treated of by Dr. Goldsbrough, and yet these are of frequent occurrence. After tying the carotid artery pneumonia will follow, and also after operations on the trachea. There is no sufficient explanation of these. Hypostatic pneumonia occurring in typhoid conditions is one of great interest; but he must attribute many pneumonias to chill. The barometric cases have been very frequent in his experience. A change of temperature—sudden east wind—always brought a batch of cases when he was in hospital work. The “Coccus” of pneumonia has had its day; after being described and much talked of, it has been quietly dropped. Dr. Octavius Sturges has recorded a number of cases in which infection was the cause. In most cases pneumonia was, he believed, constitutionally conditioned, the particular stimulus acting on the part which in each one is most vulnerable.

Mr. DUDLEY WRIGHT did not think the first case was really one of abscess of the lung, but of purulent pleuritis, which finally opened into the lung. He thought vomiting was infrequent in pneumonia. The feelings of patients were very important—those who were hopeful at the outset of the disease generally did well, and those who desponded died. Convalescence may be predicted before it actually sets in, but black specks in the hitherto rusty expectoration indicated the onset of resolution.

Dr. DAY announced that this was one of the diseases for Collective Investigation instituted by *The Review*. He hoped there would be better response than there had been as yet.

Dr. MOIR said there was too much in the paper to discuss the whole of. He agreed with Mr. Wright that the first case was one of empyema. He expected phthisis would follow. In all those cases where he was doubtful he put in a hypodermic needle. It was also well to evacuate these cases as soon as possible. Regarding medicines, his experience was, the fewer changes made the better.

Mr. KNOX SHAW thought the cases were most instructive and fruitful. He thought few men in busy practice could show such elaborate notes. Regarding the question of empyema and the desirability of evacuation of the pus, he instanced a case in which there was recurrent empyema

which had now healed. Homœopathy was singularly successful in the treatment of pneumonia, especially if we chose and stuck to one remedy, or at most two—say, *phos.* and *bry.*

Dr. GALLEY BLACKLEY thanked Dr. Goldsbrough for his paper, which he thought bore the stamp of freshness, and was by no means too elaborate. He did not agree with Dr. Burford in thinking that pneumonia so frequently succeeded barometric changes; on the Continent and in America pneumonia was invariably present after a long spell of intense cold, when the vital powers were depressed, and exposure almost invariably meant an attack of sthenic pneumonia.

Dr. CARFRAE (in the chair) would have liked more definite information as to physical signs, brown expectoration, for instance.

Dr. GOLDSBROUGH (in reply) thanked the society for the manner in which his paper had been received. Although the diagnosis of his first case might be open to the criticism passed upon it by several speakers, he still held to the opinion formed at the time of the patient's illness, that the condition was one of abscess or purulent infiltration of the lung. He believed that when the paper appeared in print the indications for most of the medicines administered would become apparent. He quite agreed that in ordinary cases of pneumonia, two or three medicines were sufficient throughout the illness; but in cases where the disease was not of the ordinary type, and fluctuations and changes in the patient's condition were rapid and often serious, he considered frequent change of medicine most desirable, if any effects could be wrought by drugs. He did not consider the contagiousness of pneumonia as established, but many facts occurred in practice from time to time that were very suggestive of it.

DISCUSSION UPON INFLUENZA.

OPENED BY DR. J. GALLEY BLACKLEY.

AN extraordinary meeting, convened by circular sent to every medical man whose name appeared in the *Homœopathic Directory*, was held on Jan. 16th, Dr. Carfrae, President, in the chair. Letters of regret at inability to attend (several containing contributions towards the discussion) were received from Drs. Douglas Moir (Manchester), Scriven (Dublin), Proctor (Birkenhead), Morehouse (Bexley Heath), Wolston (Edinburgh), Neatby (London), Shackleton (Sydenham), Ramsbotham (Leeds), Mackintosh (Torquay), Vernon (Yeovil), Webster (Guernsey), Bradshaw (London), McConnell Reed (Tottenham), and Dyce Brown (London).

The discussion was opened by Dr. J. GALLEY BLACKLEY (Hon. Sec.), who said : Gentlemen,—In the last number of the *Monthly Homœopathic Review*, the editors were kind enough to insert a letter, written by me on the 21st December last, giving the leading features of about a dozen cases which had occurred in my practice during the preceding week, and which appeared in many respects different from anything I had seen during my nineteen years' practice. For the reasons there stated, I had little hesitation in classing them as cases of the epidemic catarrh, of which we have heard so much during the past two months. In no one of these cases have I seen any reason to alter my opinion, but having had upwards of fifty new cases since the date of my letter I am only the more decided as to their true nature, viz., epidemic "influenza," and you have been called together this evening to ask you to give us the result, either of your practical acquaintance with the disease, or of your philosophic speculations as to its nature, and so help us in the all-important question of treatment. It would obviously be out of place, on an occasion like the present, to attempt anything like an exhaustive account of the history of the disease ; for this I would refer you to such books as "Hecker's Epidemics of the

Middle Ages,"* and the article upon Influenza in "Copland's Dictionary of Medicine," † both of which give most interesting accounts of the early epidemics. The latter, in particular, gives an exhaustive account of the epidemics of 1833 and 1837. With a view of limiting our discussion this evening to the subject of genuine Epidemic "Influenza," it may perhaps be as well to quote Copland's definition, which is, in fact, a brief description of the disease, and runs as follows:—

"Lassitude, pains in the head, loins or limbs, chills, horripilations and coryza followed by cough, by defluxions from the respiratory passages, by fever of a nervous or adynamic character, and by anxiety at the præcordia or pains about the margins of the ribs; the disease attacking a number of persons at the same time and often passing into asthenic inflammation of the respiratory surfaces or organs."

Except that there is for obvious reasons a lack of temperature records, Copland's account of the symptoms of the disease as seen by him during the epidemics of 1833 and 1837 might well have been written during the past few weeks, and for purposes of comparison it will be as well to read it. He says: "The simple form of influenza was most frequent in the young and middle-aged and the previously healthy, and usually commenced with chilliness, rigors or horripilations, lassitude, general depression or anxiety, gravedo and headache, followed in some hours by heat of skin, coryza, sneezing, fulness and tenderness of the eyes, soreness of the throat, hoarseness, cough, pain in the back and limbs, loss of sleep, and considerable fever. The cough was generally attended by more or less soreness of the chest, hurried respiration, slight dyspnœa; either pain or a tenderness and bruised sensation at the diaphragmatic margins of the ribs and epigastrium and wandering pains in the trunk, especially about the sides. Nausea, loss of appetite, sometimes vomiting, costiveness, *seldom* diarrhœa, and a white, slightly coated, or mucous appearance of the tongue were also present. These symptoms continued for 24, 36 or 48, hours, the cough being dry, and aggravating the sense of soreness and

* Translated by B. G. Babington, M.D., F.R.S., published by The Sydenham Society, London, 1846.

† Vol. II., Article "Influenza," page 423.

the pains about the chest. Afterwards expectoration became more abundant and easy, the skin softer and moister, and pain in the head or about the frontal sinuses and in the chest, back or limbs less severe. The pulse was generally quick, sometimes a little sharp, usually soft and weak; but it was often irregular or very changeable and uncertain. As the symptoms became mitigated about the third, fourth, or fifth day, perspiration became more abundant, and the urine deposited a copious sediment, but the cough frequently continued severe and obstinate, and the consequent debility was much greater and more prolonged than the severity or duration of the disease seemed to warrant. In the more severe cases these symptoms were generally very prominent, and the febrile phenomena fully developed, transient delirium even occurring, but in the slighter cases several of them were not very remarkable. In this form of the disease the chest sounded clear upon percussion, and respiration was clear and vesicular, no morbid râle being heard upon auscultation, but as the complaint proceeded a slight mucous râle was sometimes present."*

If we may single out any one feature as being characteristic of the present epidemic, I would say that it consists in the almost universal presence of severe muscular pains, and in the severity of the succeeding prostration. Premising then, that these are practically present in nearly all instances, I find, in looking back at the seventy or eighty cases I have seen, that these, when uncomplicated, fall under three distinct types: (a) the simple febrile; (b) digestive catarrhal; (c) the respiratory catarrhal.

1. Uncomplicated cases (a) simple febrile type:—

The simplest form of case which I have seen is that characterised by a short period, generally about twelve hours, of high fever followed by sweating, rapid fall of temperature, slight cough, weakness, muscular pains, and recovery after a few days of rest in doors. The following case may serve as an example:—

Miss D. R., aged 8, came home from school on December 20th in her usual health, and remained so until bedtime. Next morning she complained of not feeling well, and said she could not get up; she was

* *Ibid* p. 426.

flushed, and the skin was hot and dry and she refused food. At 5 p.m. the temp. was 105°, face flushed, eyes bright, and she had a very slight dry cough. At 10 p.m. the temp. was 103.4°, pulse 120, and respirations 40; tongue clean; throat slightly congested. Was ordered a hot bath and *aconite* and *bryonia*. Next morning the temp. had fallen to 100°, and by 4.30 p.m. it was normal. During the day she vomited some bile-stained mucus twice, and the bowels were slightly loose. She had no cough, and no abnormal chest sounds could be made out. There was no enlargement of either liver or spleen. At the end of four days she was about as usual. A fortnight later three brothers, aged respectively 18, 12 and 10, were seized in the same manner, but the maximum temperature was 103° to 103.4°.

(b) Cases characterised by gastric, hepatic and intestinal catarrh, and generally associated with very severe muscular pains in the neck, back, hypochondria, abdominal walls and lower extremities. Of this variety the two following cases may be taken as fair samples.

CASE I.

Mrs. H., aged 50. On December 21st had a rigor with flatulence and great nausea. First seen on December 22nd, when she complained of nausea and faintness with pains in bowels, thighs, knees, calves and feet, she said the shins felt cold. T. clean. R̄ *arsen*. Next day she complained much the same. On the 26th she had a further attack of faintness and nausea and bilious diarrhœa, with crampy and colicky pains in both hypochondria striking down into the iliac regions. Great rumbling in the bowels and pains in the knees. R̄ *bryon*.

On the 30th she had a relapse, having a fresh rigor followed by mild delirium in the night. Rep.

Dec. 31st.—Temp. 102.6, pulse 100. Has still severe muscular pains in back, thighs and legs. Some cough, with fine moist crepitus all over both lungs. R̄ *acon*. and *bry*.

(This patient's children, two sons and two daughters were all ailing at the same time). She developed some bronchial catarrh, and was only really convalescent at the end of a fortnight

CASE II.

Lady L., aged 65, slightly gouty and subject to occasional diarrhœa, was seized on December 6th with

bilious vomiting and diarrhoea, attended with great prostration. \mathcal{R} *arsen.* During the next day the diarrhoea, which was of a decidedly bilious character, became worse, as many as twenty small bilious stools being passed in the twenty-four hours. From the sudden explosive character of the defæcation, I gave her *aloe*, but without benefit. Next day there was a good deal of straining, with some mucus and bloody streaks in the stools, and for this condition I gave *podoph.* 1 gr. j 2 dis horis.

On Dec. 10th the patient complained of having for the last two nights, at about the same hour, 9 p.m., been attacked with very severe crampy pains, beginning in the hypochondria and extending apparently to the buttocks and down the thighs and into the calves, effectually preventing sleep. It was aggravated by each action of the bowels. For this state of things I ordered at night a lead and opium suppository, with *rhus tox* internally. Next day, as the pains were still very severe, I obtained the services of a masseuse, ordering a repetition of the suppository for that night only. The diarrhoea abated very slowly, and the pains, even at the end of ten days from the commencement of massage, had not absolutely gone, and the patient was still weak and prostrate. *Arnica* and *rhus* were both of service during this period. *China* ϕ , with a liberal exhibition of alcohol, completed a tardy convalescence.

(c). Cases characterised by catarrh of the respiratory passages, and also associated with muscular pains. Here is a sample case occurring in a patient usually free from all bronchial trouble.

Miss S., aged 50, neurotic subject and suffers much from neuralgia.

Dec. 19th.—Was quite well two days ago, early the next morning she began to cough. All yesterday the cough increased in violence, and to-day has been almost incessant, loud, noisy, with very scanty expectoration and causing severe pain in the vertex with every fit of coughing. Temp. is now 102. T. clean. Bowels regular. \mathcal{R} *acon.* and *bry.*

Dec. 20th. Temp. 100.8. Some comparative dulness over the left base behind; coarse crepitant râles all over both sides, back and front. Complains of very great pains in both lower extremities with extreme prostration. Rep. med.

Dec. 22nd.—Pains and prostration continue. To have massage to legs along with *arnic.* internally.

Dec. 23.—Temp. 100°.

Dec. 26.—Much cough, with very copious ropy expectoration voided with difficulty. *R. kal. bich.* 3x *gij.* 4 *tis.*

Jan. 6th.—Convalescent. (Eighteen days).

Of complicated cases I am happy to say that I have seen but few, and in these few there has invariably been a pre-existing malady, which has been lighted up into fresh activity by the ubiquitous poison. Of these the severe bronchial catarrh has naturally been the most common. Of pneumonia or pleurisy properly so-called I have not had a case. As an example of the dangers run by patients attacked with influenza when suffering from some previous ailment, I may just quote the following case—a patient of Dr. Purdom's, of Croydon, seen by me in consultation on the 13th inst., and for the following notes of which I am indebted to Dr. Purdom.

“Miss R. J., æt. 22, had suffered with palpitation and shortness of breath for years. Last spring was under my treatment for left pleurisy with effusion, and made a slow but good recovery from that. Then the symptoms of ‘Graves’s disease’ were patent, and for this she has been under treatment ever since. Has latterly had symptoms of impaired digestion with diarrhœa, or rather two or three large lightish motions in the day.

“*Latest attack.*—Two brothers and a sister had sharp influenza attacks. I was called to see Miss Ruth, January 6th, late, and found temp. 104, prostration, great tenderness and pain over bowels, severe diarrhœa, slight crepitation left base and slight ronchi left apex; previously she had been stout in bowels; still hypogastric tenderness (no catamenia for two months,) sickness came on at end of week. I tried *merc. dulc.* 2x and *bry.* 1x but the former seemed to make her sick at once. I thought there was plastic effusion over or in bowel. Prescribed *ars.* 3x, *merc.* 3x, and poppyhead fomentations to bowels. I went steadily on with these medicines during the week. Had twice 5 drops of *laudanum* in night when diarrhœa very bad. The lung symptoms cleared off. The diarrhœa, &c., all improved, save still great tenderness of hypogastric area and rectal tenesmus. (No mucus.) Motions mostly light, and I suspect that previously the chyme was passing through her bowels. Graves’s disease

symptoms much quieter. Pulse usually 100—120, now 84—88. Temp. on Saturday and Sunday about normal. Eyes not so prominent. Goitre much the same; with all this there seemed no rallying. Tongue dry and brown, gums or lips bleed. Abdomen sunk in very much."

So far Dr. Purdom. When I saw the patient on Monday I found diarrhoea bad again, stools being flaky and typhoid-looking, ten or twelve in the day. Tongue was dry and brown, lips and teeth covered with sordes, and lips cracked and bleeding. The patient was terribly emaciated, and the abdominal walls retracted to the utmost extent. No special tenderness could be felt on pressure, and no spots were visible. There was no enlargement of either liver or spleen. Temperature was 100° and pulse 100, somewhat wiry and jerky. I suggested a return to *arsen.* 3x, a drop every hour, and that *koumiss* should be relied upon as nourishment for a day or two. The latest accounts of the patient are that she is doing well.

I had hoped to have made some small contribution this evening towards the stock of our knowledge of the natural history of the "influenza," but sheer press of work during the last few weeks has rendered this impossible, so I have confined myself as you see to the strictly practical side of the subject, leaving it to others present to enlighten us upon the more abstruse questions involved. That we have to do with a specific fever, probably due to a microbe (although this latter has hitherto apparently eluded the vigilance of the bacteriologists), there can no longer be reasonable doubt. In attempting to summarise from the notes I have kept I find very little to add to the *résumé* given in the letter already alluded to (*vide* p. 61). The age of my patients has varied from 2½ years to 72, and I do not find a marked preponderance of either sex. In some households the males have been attacked first, and in others the females. *Arsenicum* still remains with me *facile princeps* in treatment, especially of those belonging to the third category, whilst *acon.* and *bryonia* have generally sufficed to effect a cure in those belonging to the simple febrile class.

Dr. DUDGEON said his experience differed somewhat from that of Dr. Blackley. He noticed three types: (1) Febrile, without catarrh; headache and pains in eyes,

back and extremities being the accompaniments. (2) That attended with extremely painful sore-throat, generally affecting one side. This is accompanied with fever. (3) The catarrhal form, with laryngeal or bronchial catarrh; a sub-variety of this is attended with diarrhœa. All are attended with headache. The medicine he had found best indicated in most cases was *aconite*. It had cut short many cases. For the catarrhal variety *arsenicum* is the remedy; for the sore throat, *mercurius*. With these three remedies he thought we could succeed in curing almost every case. He would not call the disease "epidemic catarrh," as there was often no catarrh present.

Dr. POPE said that though the cases of catarrh ordinarily occurring at this season had been numerous and severe around Grantham, he had seen but few cases at all comparable to the type of disease which had been prevailing to so large an extent in London, and therefore he was present that evening to learn rather than to speak. The remarks and observations he had listened to seemed to suggest a few thoughts. With regard to the infectious nature of the disease they were discussing, he thought that all catarrhs at this time of year were more or less infectious. They generally observed that if one member of a family had a cold it ran through the house, as it was termed; so in this peculiar kind of catarrh it, too, spread from person to person by contact. In studying this influenza from the recorded observations of those who had seen most of it, he had endeavoured to differentiate it from the ordinary catarrh. It seemed to him that the present type differed from that usually seen in—(1st) the suddenness of its attack. Persons were in their usual health, and within three hours were very ill, with a temperature of 102° to 103°. Then 2ndly, whereas lachrymal and nasal discharges were characteristic of the ordinary catarrh, they were only conspicuous by their absence in the generality of cases of the present epidemic. 3rdly. The severe bruise-like pain complained of in the extremities was a marked symptom of a genuine case. 4thly. The prostration which marked convalescence was much greater than was usually met with. 5thly. The proclivity, especially in the very old and very young, to localised congestions, more especially of the lungs, was very great and largely due to the intensity of the prostration and the enfeeble-

ment of the heart which the attack had engendered. These seemed to him to be the features of difference between the sporadic and epidemic influenzas. From all they had heard from Dr. Blackley, Dr. Moir, and others, it was quite clear that the disease varied considerably in its manifestations. Hence, it was impossible that there should be any one remedy for all cases. Here, as elsewhere, there could be no routine in prescribing; each case must be considered by itself. While this was so they might advantageously consider the indication for certain medicines. Most cases were ushered in with a fever and high temperature, closely resembling the fever of *aconite*, and he felt sure that that medicine given frequently at the commencement had warded off or cut short many an attack. Like Dr. Blackley, he had felt rather surprised at Dr. Dyce Brown having pointed to *baptisia* as a medicine to be used. To ascertain his reason he had gone to the *Materia Medica*, and on comparing the symptoms of *baptisia* with the descriptions of the disease given by Dr. Bezley Thorne in a recent number of the *Lancet*, he saw at once how closely the aching, bruise-like pains in the extremities produced by *baptisia* resembled those mentioned by Dr. Thorne as characteristic of influenza. He (Dr. Pope) had had an opportunity of testing this observation on one occasion in a young lady in whom this symptom was especially painful. He happened to see her soon after it had commenced, when she was in great suffering. He put a few drops of the tincture of *baptisia* into a tumbler of water, directing a dessert-spoonful to be taken every two hours. After the second dose the relief from pain was almost complete. This case was interesting, too, as pointing out one of the sequelæ of influenza. The patient was one subject to occasional attacks of right-hemicrania from any cause of weakness. After the pains in the limbs had ceased she was a good deal prostrated, and then followed the hemicrania, but not severely; this ceasing, violent otalgia set in, and when relieved on one side attacked the other ear; and then a medicine of great value, he thought, was to be found in *arsenic*. This was indicated by the character of the prostration, and from the tendency that seemed to exist to congestion of one organ or another, he thought that *arsenic* might with every advantage be continued until

recovery was complete. In the lung congestion, no medicine seemed to him so thoroughly homœopathic as *bryonia*. One or more of the speakers that evening had suggested that the influence of any medicine on the course of the disease might be held to be doubtful. But there was one thing which, in hearing of so large a number of cases as he had done that evening, had struck him as remarkable, only one fatal case had been mentioned, and it seemed by do means sure that that was a case of influenza. Now, if medicine had had no influence there would have been several at least, as there had been among practitioners who knew nothing of homœopathy. Then the complications and sequelæ appeared to be comparatively few. This, too, showed that medicine did check the disease, did render it harmless. In old people this influence of medicine was great and important, as he had recently seen. A gentleman eighty years of age during Christmas week had contracted a chill, followed by ordinary catarrh of the nose, eyes and throat. He had had three attacks of paralysis, the last occurring a year ago, leaving him hemiplegic, with loss of control over bowel and bladder since then. During the year he had been gradually failing. When he saw him on the Sunday evening after Christmas-day, he was hardly conscious, his temperature 101.4°, the left lung somewhat dull and respiration very indistinct; there was also a short, hacking cough which was more or less constant. Such a condition in such a subject seemed to leave no room for hope. *Aconite* and *bryonia* were given every hour, and by Wednesday the temperature was normal, the respiration clear and distinct, and all immediate danger was over. In such a case it seemed to him that the effect of medicine could not be doubted; without the specific remedies it was in the highest degree improbable that such a patient would have recovered, while had he been plied with alcoholic stimulants in the way they are usually plied in such cases, any recovery would have been impossible. Mr. Deane had referred to a case in which he had given *apis*. It seemed to him a remarkably good selection in such a case, but the type of disease appeared even lower than that resembled by *apis* and to call for *lachesis* or even *crotalus*. The same medicine would be required, too, in those cases where the prostration proceeded to faintness, and seemed to indicate an

anxious degree of cardiac failure. So it was that though typical cases might be met by well marked remedies, we must treat each case individually and be prepared with the entire resources of the *Materia Medica*.

Dr. MADDEN asked if any present could throw any light on the kind and extent of its infectiousness. He had no doubt it was infectious. He regarded it as infectious as scarlatina and measles. He wanted to know if it could be carried through a third person. Following the advice of Dr. Dobell, published in the medical papers, namely, to send out patients early, had resulted in several attacks of bronchitis in his practice. In several cases he had found signs of congestion. In these *phosph.* acted as a specific. He narrated a case of relapse in a girl of eleven. After apparently recovering a relapse occurred. A temperature of 105° was registered on the eighth day, and the day after this a characteristic crop of measles eruption came out. After some cases violent neuralgia followed. This was met by Schüssler's remedy, *kali phos.* He believed *antipyrin* was specific in many cases if given early enough, and thought it was probably homœopathic. The fever and pain were completely obliterated in a very short time. He gave 5 gr. tabloids every hour for two or three hours. He had seen several cases of gastric neuralgia, violent painful colic and retching without diarrhœa. *Cuprum* relieved the symptoms very rapidly.

Dr. MOIR agreed with Dr. Madden that it was infectious. At the beginning of the epidemic he observed that men were attacked—now it was all women. He read notes from a letter by Dr. A. S. Kennedy proving its infectiousness. He read notes of the first case of the kind he had seen, and the only fatal case. At the *post-mortem* there was some catarrhal pneumonia present—the spleen was soft and enlarged, and there was a reddish patch in the ileum, which made it suspicious of typhoid. In reference to the eruption, he had spoken with a gentleman who had been in Smyrna when the epidemic was there. A rash, which began on the palms of the hands, was observed in a majority of the cases there. *Aconite* he had used largely, also *phosphorus*. He agreed with Dr. Madden about the uncertainty of judging the effects of medicines, as the natural course of the disease was so varied.

Dr. HUGHES narrated a little outbreak of influenza in a house in Brighton, introduced by a French governess before the general epidemic appeared. Two children at first were taken, then the mother and father, who had typhlitis. He recovered under *lycopodium*. After that he saw no more of it for a fortnight; then several cases occurred—one in a young lady, with sudden prostrating headache, removed speedily by *bry.* 12. Next a tradesman was taken with violent pains in the spine. *Gelsem.* in a day or two removed that. It was not for some time after this that he came across a typical case. He should call these ordinarily a feverish cold. The distinction is that *aconite* does not cut them short. This separated between a true infection and a feverish attack from chill. He would like to ask the opinion of members on the spinal affection, and its connection with the powerlessness of the legs. *Sticta pulmonaria* in the 1st dilution met the dry cough that remained. He did not see any cases of catarrh in the beginning of an attack, though it frequently appeared during convalescence.

Surgeon DEANE, A.M.S, spoke of an outbreak of influenza among the troops. The first case was one of a man with high fever, the eyes being congested. He suggested *iodide of arsenic* and *phosphorus* alternately, as the man had pneumonia. Thirty cases presented themselves the next day. These separated themselves into the three types indicated by Dr. Dudgeon. All had frontal headache and backache. Some had epistaxis. Many had violent diarrhoea. Most of them he sent into hospital. *Veratrum* combated the diarrhoea in one case which he kept under his own treatment. Very few of the women in barracks had it, and very few children. He was advised by the Brigade-Surgeon to give *zinci-sulph.*, 30 grain doses, to cut the attacks short. This advice he did not follow. *Aconite* 3x had cut many cases short in twenty-four hours. The faintness and weakness that remained afterwards was noteworthy. Many had vertigo. Referring to the rash, one brother officer said the disease was dengue; but it has not the history of dengue, and the rash is not characteristic. He had seen one case (a lady) where there was an extensive eruption of erythematous spots, intensely irritating. He considered it very infectious. He called attention to the prevalence of measles along with the influenza.

Dr. MORRISSON would divide all his cases into two classes—the rheumatoid and the catarrhal. In regard to medicine, he had used *aconitine* 3x rather than *aconite*. *Arsenicum* is a good domestic remedy. *Merc. sol.* 3x had been of decided use in pains in the limbs. The two most useful medicines were *kali iod.* 2x and *gelsem.* For the febrile symptoms *gelsem.* rivals *aconite*. *Phos.* 4x was of more use in the cough, than higher attenuations. He asked if any had used *sabadilla*. He had found a micro-coccus in the expectoration, and he had observed a difference in the mucous globules. He had no doubt the disease was highly infectious, and in various ways. In one case it was communicated by letter from Germany. He had noticed a want of correspondence between the temperature and the pulse rate.

Mr. D. WRIGHT observed on the infectiousness of the disease, that the influenza cases that came into the hospital were put into two wards. The cases which originated among the patients already in the hospital occurred not in these wards, but in others. This did not favour the infection theory. The pulse was not frequent. It was very variable in force and rhythm. Great depression characterised the cases, and brandy was needed. The bronchial mucous membrane has been affected in most cases. The expectoration is very difficult to get rid of. Many patients had slight attacks of conjunctivitis, especially in the left eye. He had seen no true rash, but in some there was a blotchy appearance of the upper part of the chest. The child referred to by Dr. Moir died simply of collapse.

Dr. BURFORD said, referring to Dr. Morrisson's statement as to the microbes, that all efforts have failed to identify a specific one. In the majority of cases he was acquainted with, the incidence of the disease was on the hepato-renal system. All the symptoms were characterised by blood alteration, the charging of the blood with ptomaines. Very great stress must be laid on the amount of prostration that is left behind. It is the most dangerous clinical feature of the disease. The altered composition of the urine was a remarkable feature. He would like to see an estimate of the urea and phosphates passed in the cases in hospital.

Dr. GILBERT referred to the high temperature and cough. *Hyoscyamus* and *conium* were of no use in the night cough. *Gelsem.* did great good. In cardiac cases the prostration was very great and *arsen.* and *phos. acid 2x* were of great service. *Acon.* was his general remedy, until perspiration set in, then *bryonia* and *phosphorus*. He related cases showing that it was communicable by infection. He placed the infectious period at three days.

Dr. MOLSON had so frequently observed perversion of the sense of taste that he regarded it as a "characteristic" symptom; one patient said his bread and butter tasted like straw. He had had one case of otalgia with suppuration where *capsicum* proved useful. In another case with sanious discharge *belladonna* and *puls.* were of no use, but *plantago* dropped into the ear relieved at once. In all cases where there was fœtor of breath, he found *baptisia* an unrivalled remedy.

Mr. HEMPSON DENHAM said the disease was essentially a fever of an adynamic type. It is confined chiefly to the mucous membranes. It was a pharyngeal and laryngeal affection. In one case there was a large loss of blood from the kidneys. He thought defective draining had much to do with it.

Surgeon-Major KAYE, of Leamington, had seen one case imported from Park Lane. This case got well in three days. He suggested vapour-baths as auxiliary of *aconite*. Wet packs should also be made use of. As resident physician at Smedley's for some years he had had much experience in this treatment.

Dr. E. A. NEATBY wrote:—"Of the 24 cases in which I have been able to keep a record, the following is a summary of the chief points of interest.

Temp.—The maximum temp. was 105° (one case only); the average 102.2°. This average is probably too low, as several patients said they had felt hotter before I saw them. The highest temp. is rapidly attained in probably not longer than 6 hours; in only two cases did it rise after I first saw the patients. In one case the highest temp. registered was 99.6°. The average duration of pyrexia was 39 hours, the longest (without ascertainable complications) was four days, and the shortest 12 hours.

Pains.—The average duration of pains was three days.

Bowels.—The bowels were constipated in 14 cases, relaxed in 2, natural in 3 (no record in 5 cases).

Head.—Headache was a marked feature in 17 cases, mostly frontal, but also vertical.

Onset.—Always sudden; mode various. Vomiting in 2 cases, shivering in 3, sneezing in 1, pains in 1, sudden prostration in 1, diarrhœa in 1; in the rest no one feature predominated at onset.

Skin.—In several cases (number not kept) the skin perspired from the beginning.

Coryza.—Marked fluent coryza occurred in 4 cases,—on the 1st, 3rd, 4th and 7th day.

Relapses.—In 4 cases; 1 in a man from exposure, 2 in children from change of room, 1 while still in bed.

Complications.—Bronchitis 2 cases, pneumonia 1 case.

Treatment.—If the fever were “sthenic” and fairly high *aconite* 1x to 3x alone for three to six hours, followed by *bryonia* 1x to 3x for the pains. If there have been marked soreness and restlessness, with or without much pyrexia, *baptisia* 1x has given speedy relief. If *bryonia* has not relieved the head pain *belladonna* has answered well. Hot compresses were of much help also. If with the pyrexia the pulse has been small and the patient low, *arsenicum* has been given throughout. For a chilly feeling, with “cold shivers down the back,” either occurring from time to time, from turning in bed or uncovering even a hand, or spontaneously, *rhus tox* 12 was given. This at once relieved and permitted refreshing sleep, which was impossible before.”

“*The Epidemic in Children.*—The statement appeared in the *Lancet* (11th ult., p. 108) that no case of so-called influenza has been under the care of the medical officers of the Hospital for Sick Children, or of the Belgrave Hospital for Children, either as in-patients or as out-patients. It is granted that the disease is much less common in children and much less severe and less pronounced in them than in adults. There still remain cases sufficiently well defined to be classified under no other heading than that of the present epidemic fever. The suddenness of the onset, the absence of obvious cause (either “teething,” “cold” or gastric disturbance); the multiplicity of cases, and the presence of several cases in one family; the subsequent weakness and weariness have been enough to establish the diagnosis, in my judgment. In my own cases the average temperature has been about a degree higher than in adults, but the duration of the pyrexia has

been only 24 hours in children, in place of 39 hours, my general average. Flushed face, suffused eyes, pain in head (pain in back or limbs but rarely), are the only marked symptoms in most cases in children. Vomiting and pain in abdomen may occur. There is a higher proportion of relapses in children, and the relapse occurs on but slight provocation. In two children a second relapse occurred. In one little boy of 8 the temperature, after having been normal three days, and after the patient had been up in his room parts of two days, rose to 105° as at the onset, on his going into the nursery with his brothers and sisters. The relapse is more tedious than the original attack. In the above case there was moist crepitation at the base of the left lung, and the splenic dulness was slightly increased. In three relapse cases where I examined, the splenic dulness was increased."

"Writing of relapses, I may remark that the patient who had a relapse while still in bed had previously had a similar attack two years ago, just after leaving Gibraltar—the so-called "rock fever."

Dr. PROCTOR (Birkenhead) wrote:—"For the cases I have seen, *actæa*, *sabadilla*, and *arsenicum* have been most useful. *Actæa* corresponds to the more numerous group of cases where the rheumatic symptoms are predominant. I have found it useful also as a prophylactic. Where the catarrhal symptoms are in excess, then *sabadilla* and *arsenicum* are required. During the pyrexia, usually of 48 hours length, *acon.*, or *gels.*, or *baptisia* may be indicated, and for the debility of convalescence, *quinine* 1st decimal."

Dr. SCRIVEN (Dublin) wrote:—"We have had rather a severe outbreak of influenza here, commencing generally with sudden loss of strength, distressing frontal headache, creeping chills, sensation of cold down the back, with nausea, &c. For this I have found *gelsemin.* give marked and rapid relief. Some of my worst cases were on their legs in four days. In three instances *camphor* taken every hour on the *first* appearance of the symptoms of chill and collapse seemed to arrest it. In one instance, where the attack began in the evening, there was light delirium during the night, and temp. 102° in the morning when I saw the patient. He got nothing but *gelsemium.* Was attacked on Thursday, and to-day (Monday) is at work."

Dr. DOUGLAS MOIR wrote:—"I have had several marked cases. One, my own little girl of eight, began last Saturday, pains in head and back, temp. 102°. Sunday temp. 102.3°. Pupils very dilated, and said everything in room looked very large and seemed to go round. Bowels moved four times but not much relaxed. Pulse 120. Monday temp. 100°. During the day the left eye and nostril began to run and soaked a handkerchief in a few minutes. Since then she is improving, but gets rather hot each night."

Dr. MOREHOUSE (Bexley Heath) wrote:—

"As far as my experience goes, I have found *aconite* and *bryonia* the best things in the early stage, followed by *phosph.* and *arsenic.* For the severe muscular pains, especially about the head and eyes, I have found *dulcamara* most useful. I know in my own case I found most marked relief from it. We have had seven cases in the house, some of them rather severe, in one case a temperature of 104°. *Sodæ salicylat.* in small doses has also answered well with me when the symptoms have been more than those of ordinary rheumatism. The dose I give is grs. xx. in ζ vi. of water, a dessert-spoonful every three or four hours."

Dr. WOLSTON (Edinburgh) wrote:—"We have had the epidemic in full swing here. The chief symptoms are frontal headache, pains in the eyes, general malaise, with severe pains in all parts of the body, specially the back, profuse sweating, and tendency to bronchial catarrh afterwards. These last two symptoms are most marked; in fact it is a sweating sickness *minus* the sickness. In most cases the temp. goes only up to 101.5° or 102°, but in one it ran up to 110.5°, and was fatal. This case I shall not forget. Lady, 33, single, good health. Had no marked prodromata. Last Thursday, 9th, fell ill; had hot bath and went to bed. Temp. 101° pulse 100; vesp. Temp. 101.5° pulse 110, sweating freely.

Friday 10th.—Pulse 90, temp. 98.6°; had had a quiet night, and was convalescent. Had strict orders not to leave her bed or her room. At 8 p.m. went to a cold w.c.

Sept. 11th.—Got intensely cold after going to w.c., and had some whiskey administered by her friends. Sleepless night, pulse 120, temp. 101.5°, sweating profusely and very chilly. Gave *aconite* and *bryonia*. At 1 p.m. she ate some chicken jelly, at 4 p.m. got light-headed, and at

5 o'clock I was sent for, but being out did not see her till 7 p.m. At 5 p.m. she got comatose, at 6 the temp. was 106° in the palm of the hand. At 7 o'clock when I saw her she was comatose, breathing stertorous, pupils medially contracted, sphincters relaxed, pulseless, temp. 110.5° , and at 7.30 p.m. she died, $23\frac{1}{2}$ hours after getting her chill. Post mortem decomposition set in with a rapidity and fury which I could only imagine in a hot climate after a snake bite. *Moral*: We must make our patients careful of themselves after even a slight attack. Evidently a relapse is more dangerous than the initial fever whatever it may be. So far I cannot honestly say that I have seen any drug that appears to have any special controlling or markedly curative power. Others may have been more fortunate."

Dr. GALLEY BLACKLEY (in reply) said the most interesting question touched upon during the discussion was undoubtedly that concerning the infectiousness of the disease. We were evidently very much in the dark still, as opinions seem to differ so widely. Personally he (Dr. B.) came here disbelieving in the infectious character of the disease, but what he had just heard had rather altered his opinion, especially the striking incident mentioned by Dr. Gilbert. Dr. Morrisson had laid great stress upon the possibility of infection through letters, and instanced the heavy sick list at the general post-office in support of this idea. On the other hand it should not be forgotten that the employés at Telegraph Street have been affected nearly to the same extent, and here there could be no question of actual contagion. He was glad to hear Mr. Deane's opinion as to the non-identity of influenza and dengue. The rashes mentioned by German observers might have been caused by the *quinine* or *antipyryn* administered. He (Dr. B.), too, had seen a case where the virus of measles and that of influenza were undoubtedly present in the system at the same time. Dr. Pope's remarks upon *baptisia* were most interesting, and he should certainly give the drug a trial.

A vote of thanks to Dr. Blackley was moved by Dr. Pope and seconded by Dr. Carfrae—carried by acclamation.

G

ON BRONCHITIS AND ITS COMPLICATIONS IN CHILDREN.*

BY MR. DUDLEY D'A. WRIGHT.

House Surgeon to the London Homœopathic Hospital.

THE children's ward of the London Homœopathic Hospital affords us some excellent opportunities of studying both the clinical features and the treatment of the various diseases of children, for we have not here, as in many hospitals, set a restriction upon the ages of patients admitted, but have a certain number of cots set aside for the reception of infants.

Now with a disease such as bronchitis, which is as prone to attack the younger members of humanity as those of riper years, and which in the former is often apt to show itself in its most severe and dangerous forms, this non-restriction is evidently of the greatest advantage both to the public in general as well as to us who have the medical charge of them.

It has so chanced that during my residence here the number of such cases has been very large, and recognising their importance, and having by experience learnt how much with careful treatment we may do for this disease, I have paid to it all the attention I could possibly spare.

I propose, then, to bring before you to-night a few of the facts which the study of this disease at the bed-side has taught me, supplemented by some which I have gathered from the extensive literature on the subject.

And before commencing it would be as well for me to give you some idea of the limits which I have set for myself.

In the first place, I propose paying but little attention to the pathology of the complaint, and I shall only touch upon those points in its ætiology which may have some bearing upon the treatment, it being my chief object to bring before you the more important symptoms and complications and the treatment which I have found to be the most successful in each.

With regard to the ætiology the more important predisposing causes are, dentition, rickets, measles,

* Read Feb. 6th, 1890.

whooping-cough and intestinal catarrh. That the first is certainly a most common one is sufficiently shown by the fact that the majority of cases occur during the first and second years of life, that is, whilst dentition is in its greatest activity. Parents themselves often notice the connection, and commonly tell us that such and such a child "cut a tooth with bronchitis." Intestinal catarrh, though perhaps not such a common predisposing cause as the first mentioned, is still a fairly common one. It seems to bear the same relation to the time of year as does bronchitis, each appearing most frequently in the early spring and autumn. In hand-fed infants, diarrhœa is common in the autumn when the food of the cows is being changed, and thus it is as well to be on the alert for this, and to change the diet if any signs of intestinal catarrh present themselves. *Rickets* is admitted by all to have a certain influence in producing bronchitis; certain it is that its presence is often a bar to perfect recovery; moreover, in a few cases I believe I have seen bronchitis to be actually the starting point of rickets, a state of debility being left after an attack in which the symptoms of commencing rickets present themselves, and this, I believe, is the more likely to occur if there has been much exhausting diarrhœa.

As I have said before, spring and autumn are the most common periods in which this disease is apt to occur; for in them the severest thermometric fluctuations take place. My own data being taken only during the summer, autumn and winter months, I am not able to give any statements upon the point, but within the above time the majority of cases were admitted into the hospital during the month of October. It may be here interesting to remark, as showing how dependent this disease is upon thermometric fluctuations, that during a few cold days in the middle of August three cases of very severe capillary bronchitis were admitted into the wards, two of which ended fatally.

The above are only a few of the more interesting points in the ætiology of the disease, and may be classed as predisposing causes. The exact exciting cause is not always such an easy thing to determine in individual cases. Most commonly the child does what is usually called "catching a cold;" and although this is only begging the question, still is

very often the only explanation we can give. How a cold is caught, has received many explanations, one of the most plausible being Rosenthal's, whose experiments tend to show that after being for some time in a heated atmosphere the cutaneous capillaries become paralysed and dilated, thus causing a rush of blood to the surface which, in its turn, leads to an increased loss of heat and prevents the temperature of the body from rising to any great height. If now the skin is suddenly exposed to an atmosphere of normal temperature, the vessels still remain dilated, and with the considerable difference between the temperature of the body and that of the atmosphere much more heat is lost than would be the case if the vessels were in an undilated condition. The blood which was previously flowing through the subcutaneous tissues, is now driven to the internal organs and cools these off much more rapidly than it would do had the body been simply exposed to cold without the previous influence of heat.

If the organs are in a good condition, and not in any way predisposed to inflammation, no harm may result; but in many cases one or other of them is the *locus minoris resistentiæ*, and so an attack of enteritis, nephritis, hepatitis or bronchitis occurs.

Perhaps under the heading of exciting causes may be classed the presence of injurious substances in the atmosphere. Just as the lungs of coal-miners, needle-grinders and stonemasons become irritated by the fine dust present in the air of their workshops, so does the tender bronchial mucous membrane of children become irritated by the foul atmosphere of the homes in which many of them live. In the small ill-ventilated rooms of the poorer classes, in which, in not a few instances, several families live, eat and sleep all the year round without a window being once properly opened, the air must be teeming with organisms of all forms, which, though perhaps unable to act upon the more hardened bronchial mucous membranes of the adults, find a convenient soil in those of the younger members of the family. It should be, then, our first aim in treatment to remove them from this vitiated and poisonous atmosphere to the purer air of the hospital.

We now come to the study of the disease itself, of its

signs and symptoms, and this may be best done by taking a typical case of simple bronchitis.

Harry W—, aged 2½ years, was admitted on July 11th, under Dr. Clarke. History of several previous attacks of bronchitis, and there was a family history of consumption. On admission his temperature was 99.8°. He was a delicate looking boy, but there were no signs of rickets. Examination of chest gave no indications of any patches of dulness, but there were bubbling and cooing *râles* to be heard all over the chest. Dyspnœa was not a marked feature, and there was only a slight amount of retraction of the soft parts of the chest walls on inspiration. There was very free perspiration. The child was given a hot bath and put to bed, and *antimonium tartaricum* second centesimal, gtt. ii, alternately with the same amount of *phosphorus* third centesimal every three hours was ordered. A steam kettle was also used. The next morning the temperature was 99°, and a few coarse crepitations were to be heard over both lungs, but there were no signs indicative of any collapsed or pneumatic areas. A peculiar symptom was present in this case, which is not altogether uncommon. The worst attacks of coughing were accompanied by a spurious kind of crow. It was not exactly of the nature of a "whoop," nor did the child vomit after each attack of crowing. The child progressed favourably, and in six days all the moist sounds in the lungs had disappeared, only a few dry *râles* being left, and in nineteen days he was discharged cured. During the whole of the attack the pulse and respiration ratio was but little disturbed.

The above, apart from the crow, of which symptom I shall have occasion to speak later on, was a fairly typical case. In uncomplicated cases the temperature does not usually reach any great height, in this one it never rose above 100°F.; the dyspnœa is seldom extreme, and the pulse and respiration ratio is but little disturbed. It is otherwise, however, when the inflammation of the tubes has spread down to the smallest ramifications. In such cases there is often much fever, the dyspnœa is very urgent and the cough is constant; the pulse and respiration ratio is also usually disturbed, and this without there necessarily being any pneumonic complication. Added to these there is more or less cyanosis, and other

signs indicative of the hindrance of the oxygenation of the blood.

We will now consider the treatment of uncomplicated cases of bronchitis.

In slight ones, all that is necessary is to put the little patient to bed after having given a warm bath. I think that this latter point should never be neglected, it not only has the effect of making the cough easier, but it also removes the restlessness and uneasiness which, especially in infants, is often such a very distressing symptom. The bath should be about 110° F.; this carefully given should not tend to produce any collapse or faintness. The patient may be left in the bath from 5 to 10 minutes, and sponged well all over, taken out, dried quickly and put into a flannel gown, or in the absence of this, between blankets. The effect of the warm bath and after-application of flannel will be to produce a relaxation of the cutaneous capillaries which, in about half an hour, will be followed by free perspiration with immense relief to the patient, who will probably fall into a quiet sleep and awake afterwards with all the symptoms much relieved.

Future examinations can be easily made by means of applying the ear to the child's chest without removing the flannels, so as to avoid exposure. One remark about the sleeping coverings of infants and young children may not be out of place here. If you watch one in a restless sleep you will find that in spite of all your efforts to prevent it, the child will invariably get his legs outside the bed clothes, and thus stand the chance of catching a fresh chill. This cannot be prevented, and the best way to prevent any mischief coming of it is to have a flannel combination drawers and vest made for the child, and these should fasten by means of tapes round the ankles and wrists.

With the above precautions no harm will come from keeping the window open day and night, for I consider this another important item. The fresh air will never do harm provided the temperature of the room be kept at about 68° F. by means of a fire. Of course the cot should not be placed directly in the line of the draught from the window. A thermometer should be hung in the room to ensure the maintenance of the equable temperature. In tiny children a swing cot with head

curtains is of great advantage, and the thermometer may be hung at the cot's head.

In all but the mildest cases, but most especially in those in which there is either an absence of secretion from the bronchial tubes as shown by the dry cough and dry râles, or in which the secretion is tenacious and difficult of expectoration—I do not mean actual expectoration from the mouth, for children under five nearly always swallow their sputa, but when the mucous seems to hang about the bronchial tubes—one or other of the various kinds of steam bronchitis kettles is of great service. By the use of this, the air around the patient will be kept moist, and at an uniform temperature, and this will not only have the above-mentioned effect upon the secretion but will also tend to relieve any spasm of the tubes which may be present.

Spasm of the tubes in the course of an attack of acute bronchitis is much more common than is supposed, and it may appear even when the attack is slight, making it, for the time, appear to be of great severity, indeed, it is the more or less sudden occurrence of this spasm which often leads mothers to bring their children to the hospital for the relief of a bronchitis which would otherwise have been left to take its own course at home untreated. We constantly meet here with cases of the following type. The child has had a slight cough for a few days; suddenly for some unknown reason the breathing becomes difficult and perhaps attended with crowing, for the spasm may affect the glottis as well as the tubes themselves. The child soon becomes cyanosed, and it may seem as if suffocation were impending. On examination one expects to find marked capillary bronchitis with possibly one or other lung complication, but instead of this only a few dry râles are heard, the breath sounds being very feeble. These are just the cases in which a hot bath will remove all the difficulty and speedily set matters to rights, and more especially if it be followed by a dose of *aconite* or *spongia*.

With regard to the medicinal treatment of an uncomplicated attack of bronchitis, no drug seems to succeed so well as *antimonium tartaricum*. The majority of cases treated here had this medicine, though some had *aconite* in alternation. For myself I prefer the former alone

unless there is great restlessness, quick pulse and high temperature, when the alternation may be beneficial. No other medicines are as a rule required unless some complication sets in, and I now propose to take up a few of the most common, and the one to which most of you would give the first place is the spreading down of the inflammation to the minuter tubes and the supervention of patches of catarrhal pneumonia.

One of the worst cases of this nature I have seen in this hospital was that of Albert P—, aged 19 months, who was admitted under the care of Dr. Blackley for a very extensive and disfiguring nævus of the left ear and temporal region, which had received great benefit from repeated application of the galvano-cautery. Just before the child was to be discharged he developed an attack of measles. The usual catarrhal symptoms appeared at the commencement of the illness, and remained of only slight character for the first week. But as the rash was disappearing the cough became worse, and the temperature, which had not gone above 101.4° , suddenly rose to 104.8° . By physical examination patches of dulness with minute crepitations were found at the back of the right lung and catarrhal pneumonia was diagnosed. *Aconite* 1x gtt.i, every half hour was ordered. The temperature still rose, and the next day was 106.6° . The same evening it fell to 103.6° , and finally rose to 105.8 and remained about this height for the next few days, when the child died. On post-mortem examination extensive pneumonia was found in both lungs, more especially in the right, the lowest lobe of which was solid, so that isolated portions sank in water.

In this case there was practically no difficulty about the diagnosis. The physical signs, together with the sudden rise of the temperature, were sufficient to establish the diagnosis of catarrhal pneumonia. Many cases, however, are not so easily determined as this. The commonest sign of pneumonic consolidation is stated to be a sudden rise of the temperature, with aggravation of the symptoms, the temperature afterwards often showing an evening rise and morning fall so long as the condition lasts, but I have seen not a few cases in which physical signs alone were the only guide to the diagnosis.

Such a case was that of Daisy W—, aged eight weeks, admitted under Dr. Blackley with rather severe bron-

chitis, which had invaded the capillary bronchi, and in whom Dr. Blackley and I both diagnosed, a few days after admission, pneumonic patches at the left base from the following signs:—retraction of the soft parts of the chest walls on inspiration, with rapid breathing and marked dyspnoea. A patch of comparative dulness at the left base with harsh breathing and small crepitations to be heard with inspiration; added to this there was increased vocal resonance at this spot whenever the child cried, and the heart's sounds were abnormally conducted to this area, and yet with all the above signs present, which in themselves were pathognomonic of catarrhal pneumonia, the temperature never went above 101° (see Chart 2), and I have seen a few other similar cases. So, in my own mind, the changed physical signs are the only reliable indications upon which to diagnose the presence of patches of pneumonia.

To pass on to the treatment of this condition. Except the child's temperature on admission be very high, there is no reason why it should not have a hot bath. The child should then be put into a tent cot, and a steam kettle used to moisten the atmosphere, and this is kept working day and night until all the signs have passed away and the child is well over the attack.

If the patient is not below 1 year of age a jacket poultice to the chest is a good thing. It should be made as light as possible and never too hot (the best test is to see if one can bear its heat against the cheek). In the place of a poultice, hot fomentations or spongio-piline may be used with advantage. In children under 1 year of age the application to the chest of wool, or better a jacket made of "Gamgee tissue" with some camphorated oil or a few drops of turpentine sprinkled on, is preferable, as they are often unable to bear the weight of a poultice, which may increase the difficulty in breathing and even be an indirect cause of death. It is as well to sprinkle the camphor only on that part of the jacket which is in contact with the back, for its odour—which to some people and therefore possibly to children is very unpleasant and liable to embarrass the respiration,—is less likely to make itself perceived than it would if the liniment were sprinkled on the part of the wool in apposition to the front of the chest.

In some cases mustard poultices made with one tablespoonful of mustard to four or five of linseed, do a great deal of good. Mixed in this proportion it may be kept on three or four hours without causing more than slight redness of the skin.

In the majority of cases, some stimulant will be needed. If the case be one of catarrhal pneumonia when admitted, and if, as is usually the case, there is great collapse with subnormal temperature, some form of stimulant is imperatively called for, and it is in these conditions that I have found small doses of *carbonate of ammonia* preferable to brandy. The action is much more speedy and I believe that it lessens, if not entirely removes, the spasms of the tubes which is nearly always present. I pass round a chart (No. 2) of the temperature in one case in which this treatment was adopted, and I could show some more like it. You will see how the temperature of the child rose as the collapsed condition gradually passed off. The next chart is one of a similar case in which brandy was given, and it here appears to have done as well as the *ammonium carbonate*, but in reality the condition was not so good and the child eventually died. With regard to the dose of the *ammonia*, I generally order $\frac{1}{8}$ to $\frac{1}{16}$ of a grain every one or two hours in a teaspoonful of water. If it appears to be causing any irritation of the intestinal tract it should be stopped directly, and it is seldom necessary to give more than three or four doses, when its place may be taken by brandy, which, in infants, can be given in ten minim doses every one or two hours, and in older children half-teaspoonful every hour, or more frequently if necessary. Its effects must be watched, if it is doing good it will slow the pulse, diminish the number of respirations, and probably help to lower the temperature slightly.

The diet must be strictly attended to, and all articles carefully avoided which are likely to cause diarrhoea. To this end milk and barley or lime water to children under one year, and milk, custard and chicken broth in older children may be administered. With regard to medicines, the treatment which has succeeded most in this hospital is that of giving *antimonium tartaricum* so long as there is no very high temperature. If the temperature goes above 104° something else will have

to be done. *Aconite* often succeeds now, but even this will sometimes fail, and it is in such cases that we find so much benefit ensue from the external application of cold in one form or another. In infants a bath at 100° F. gradually reduced until the temperature falls is the best method. In older children tepid sponging or the application of cold compresses to the chest are the best. The latter is especially useful, the first application causing the patient to take several deep inspirations which in themselves do a great deal of good.

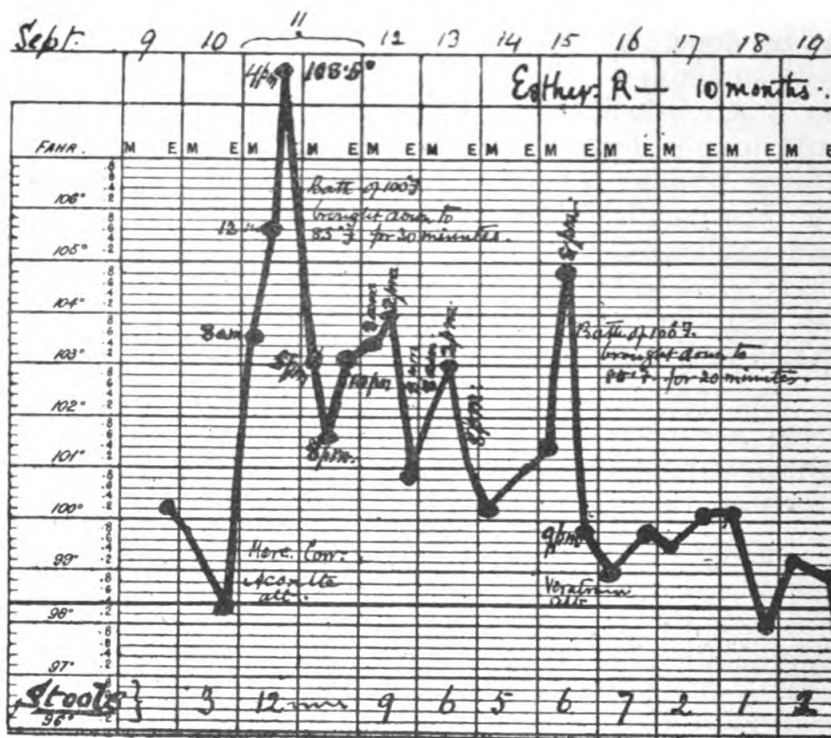
The application of ice to the chest wall, which has been so successful in the treatment of acute lobar pneumonia of children when there is hyperpyrexia, does not seem to be suited to cases of catarrhal pneumonia.

During the sponging or bathing, the general condition must be carefully watched, and if any sign of collapse appears the treatment had best be suspended, and stimulants given if necessary; but I have never seen any trouble follow.

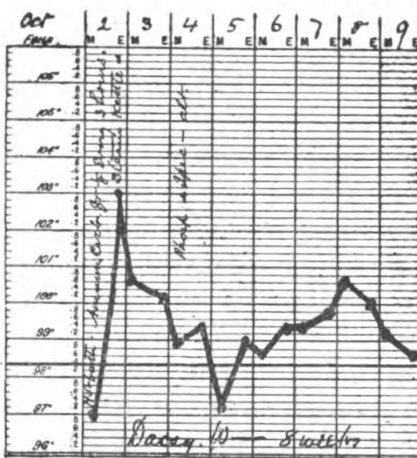
Intestinal catarrh with profuse diarrhoea is another very serious complication, and not an uncommon one. Some explain its occurrence by saying that it is due to the patient having swallowed the expectoration, but in any case, in children, there is generally a good deal of congestion of the intestinal mucous membrane, and any slight irritation will bring on a profuse diarrhoea which is usually sooner or later complicated with hyperpyrexia.

I pass round the temperature chart (No. 1) of a child of ten months with enteritis and slight bronchitis. In this case the temperature suddenly rose to the alarming height of 108.6 which with the use of a bath commencing at 100° F. and reduced to 85°, the patient being kept in it for thirty minutes, was brought down to 103° and finally to 101.6°. Four days later it again rose to 104.8°, but this was easily reduced by similar treatment, and the child was finally discharged cured.

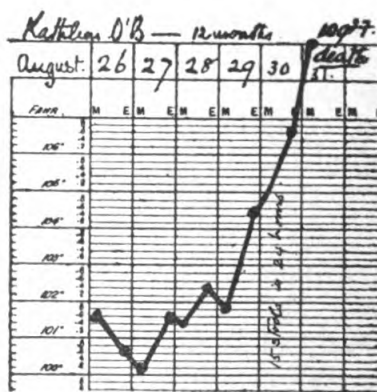
A case somewhat similar to this occurred a few months before, in which after passing 15 stools the child's temperature rose to 109°. Unfortunately I did not then know what a cold bath would do for such temperatures, or else the case might not have terminated fatally. (Chart 8).



1



2



3

I had occasion, in the earlier part of this paper, to refer to spasm of the bronchial tubes. In not a few cases the spasm affects the glottis and then appears the characteristic breathing, Whilst the child is quiet perhaps there is but little to be noticed, but if it coughs, each inspiration between the expulsive expirations is

attended with a crow, not unlike that of whooping cough, only differing from it in the fact that there is no preliminary series of expiratory efforts before the prolonged "whoop" comes, and the attack is not usually followed by vomiting.

And in connection with this, I have noticed that an ulcer may appear on the frænum linguæ, showing that it is not in pertussis alone that this complication is liable to occur, but in any case in which the tongue is shot forward during the cough and the frænum rubbed against the projecting lower central incisors.

In treating this spasm, a hot bath will probably set matters to right. If the case becomes urgent, as it is apt to do when it comes on suddenly in the night, we generally have a certain remedy in the inhalation of a little chloroform or æther. For more chronic cases, in which the spasm is of moderate severity and liable to come on every night, *aconite*, *spongia* and *causticum* are three medicines which I believe I have seen do good.

I will now devote the last few minutes to the consideration of the chronic form of bronchitis as it occurs in children. The following is a case:—

Ada S., aged 8 years, had been in the hospital several times before, under Dr. Moir, with attacks of the acute form, and once with pneumonia of the base of the right lung, two years ago. When last seen she had the aspect of a patient suffering from chronic bronchitis, with cyanosed lips and face, and clubbing of the finger ends, with cold moist hands and feet and dilated external jugular veins. The chest itself was barrel-shaped and had a transverse constriction on either side. There was deficient expansion of the right side and emphysema was indicated at both bases behind, by retraction of the intercostal spaces during inspiration and a hyperesonant percussion note. There was some slight dulness at the left apex. The vesicular murmur was very indistinctly heard on the right side probably owing to the emphysema, and over the whole chest, but more especially on the left side, coarse bubbling and crepitant râles were to be heard. The apex beat of the heart was displaced downwards and outwards, and there was evident enlargement of the right ventricle with epigastric pulsation.

There was a constant hacking cough with expectoration of muco-pus which occasionally had a fœtid odour.

This was evidently a case of chronic bronchitis and emphysema, with probably some dilated bronchi as evinced by the expectoration.

With regard to the treatment of such cases, the scope here for the use of medicines is enormous, and cannot possibly be discussed now; but I should like to mention one form of treatment which I have seen extremely successful in Dr. Blackley's hands, namely the daily inhalation for about an hour of the vapour of pumiline obtained as follows:—

R̄
 Olei Pumilionis ℥lxxx.
 Magnesiæ Carbonatis ℥ii.
 Aquæ ℥ii.

The first two ingredients should be rubbed well together, and the water added afterwards. If two teaspoonfuls of this be added to four tablespoonfuls of water, and this put into the inhaler containing half a pint of boiling water, the pumiline vapour will come off, and may be inhaled by the patient.

This has succeeded so well in adults that I see no reason why it should not do good in the case of children.

Our attention should also be directed to the hygienic treatment of these cases, which consists in allowing plenty of fresh air, daily tepid sponging whilst standing in warm water, so as to give a general tone to the circulation, and thus possibly ward off chills and friction to the skin, especially over the thorax. Flannel should be worn next to the skin, both day and night, and great care should be taken to prevent the child from being exposed to chills.

Cod-liver oil, alone or with maltine, after breakfast, in teaspoonful doses, will probably be found of much benefit, or it may be rubbed into the skin, though, from the unpleasant odour hanging about the child, this is generally objected to.

There are many other points which time will not permit me to speak of to-night, and I only hope that they will be brought up in the discussion which follows.

Before closing I wish to thank Drs. Blackley, Clarke and Moir for having very kindly given me permission to make free use of the notes of their cases.

DISCUSSION.

DR. EDWARD BLAKE approved of the use of the bath in every case of lung disease. He followed the bath by oiling with plain oil, or oil with phosphorus, or cod-liver oil. Sudden cyanosis in children with bronchitis showed the blocking of one of the larger bronchi. He preferred *antim. tart.* in trituration to the tincture. *Sambucus* is more appropriate to infants than *ipecac.* *Sambucus* is invaluable in snuffles in non-syphilitic children. The normal temperature of a child at 1 p.m. is 100° F., so the temperature was a somewhat uncertain factor to go by. He did not agree that sublingual ulcer was due to striking the frænum against the teeth, as it occurred in babies where there were no teeth. He had used *pinol* with success. He thought poultices were going out of fashion. He used them still. For babies they should not be heavy. He had devised an apparatus of straps for applying poultices and preventing them slipping down (obtainable from Cozens, 68, Seymour Street, W.). He mentioned the "Leiter tubes" with approbation as being cheaper than meal poultices and far more scientific, because the temperature of the poultice can be made at one desired point for an indefinite time without injury to the skin, and the exposure involved in replacing the ordinary appliance is avoided.

Dr. COOPER spoke of the necessity of preventing bronchitis when continually recurring. He adopted a process of sponging and rubbing and gradual exposure to air. He had used *antim. tart.* with success, but when he got on a very bad case of spasm, weak pulse, inability to lie down, chest choked with phlegm, nothing acted like the *acetum lobeliæ inflatæ*. Resin stirred with a hot poker gave off a vapour which was as good an inhalant as he knew. In old-standing cases of winter bronchitis preparations of *strychnine* have very good effect. *Kali iod.* 30 would often prevent recurring attacks in children, especially when complicated with ear diseases.

Dr. MOIR compared hospital cases with those in private practice, the former occurring often in patients with broken-down constitutions to begin with. There was a connection with nose and throat diseases and bronchitis, as pointed out by Dr. Cooper. He believed few children knew how to breathe properly. He was obliged to Dr. Blake for the hint about this. He thought *antim. tart.* was the best medicine, and was better in trituration than in solution. He also approved of the bath. Of vapours, turpentine was very good. *Kreosote* was better than *pumiline*, especially when there was fetid expectoration. *Stannum* 3 was excellent in cases of bronchorrhœa where there was abundant purulent expectoration.

Dr. BURFORD congratulated Mr. Wright on his paper. It was always interesting to have cases detailed as observed in hospitals, where the conditions could be so much better commanded than in private practice. In reference to the question of spasm in these cases, he did not think it existed. There was impaction of the tubes, but no signs of spasm. The value of the old emetic was proof of this. The condition was one of atony, and not of spasm. One symptom was of great use to him in discovering those latent cases of chest affection. The fan-like movement of the *alæ nasi* pointed to the presence of lung lesion when there was nothing else to distinguish between this and general nervous irritation. Why *antimonium tart.* does not act in solution is the fact that there is a fungus which destroys its chemical composition. Referring to the bath, he much preferred sponging.

Dr. DYCE BROWN considered the paper very full and exceedingly interesting. He placed *phosphorus* quite as high as *antim. tart.*, if not higher. He owed this hint to Dr. Hughes. He always used the trituration of *antim. tart.* Dr. Brown agreed with Mr. Wright that there may be spasm as well as blocking in the capillary tubes. He was interested to hear of Dr. Cooper's success with *lobelia*. From the pathogenesis he should expect it to be useful in spasmodic cases. Sometimes very severe cases occur in connection with teething, and in such *chamomilla* is often very effective.

Dr. NEATBY thought the paper eminently practical and valuable as being founded on personal experience. He differed from Mr. Wright as to bronchitis being a result of diarrhœa. Where the one followed the other it was not an effect, but both were dependent on the same constitutional or ætiological condition. Referring to the use of *aconite* to reduce temperature in well established cases, he thought it was useless, and naturally so. He had got much good from *phosph.* and from *chamomilla*, for the use of which he was indebted to Dr. Dyce Brown's suggestion.

Dr. WOLSTON thought the paper most practical and interesting. It was necessary to bear in mind concurrent complaints. He was reminded of a case seen by the late Professor Henderson with him. The bronchitic condition disappeared, but the child did not get well. At the post-mortem an encysted abscess was found, due to blocking of a bronchus. He had found cold compresses often act most satisfactorily. If an ulcer of the frænum be present, as sometimes happens especially if whooping cough complicates the bronchitis, *merc. cor.* relieves with lightning rapidity. *Lycopodium* is of great value in cases where a fan-like action of the *alæ nasi* occurs.

He also agreed that *phosphorus* was invaluable in many cases, and for this reason—that there was often some lobular pneumonia connected with these cases. *Scilla* had given him good results. Keeping the mouth shut was of very great importance. As for *chamomilla*, he did not know the disease in children in which it is not useful.

Dr. DAY, referring to the methods of teaching children to breathe through the nose, said he had seen in the *Hahnemannian Monthly* a plan described of fastening an "obturator" over the mouth during sleep. He agreed that *carbonate of ammonia* was a better stimulant than *alcohol* on account of the effect of the latter in inhibiting the control of the heart. He referred to the connection of whooping-cough with bronchitis.

Dr. HUGHES congratulated the Society on the acquisition of Mr. Wright, who had read such an excellent paper. Mr. Wright, as a younger man, necessarily paid more attention to the general treatment than the medicinal. The seniors paid more attention to the medicines. He explained the use of *phosphorus* in catarrhal pneumonia as being due to the fact that the case had got out of the sphere of the bronchial artery into that of the pulmonary artery. If given in heavy doses it will do harm: he gives nothing lower than the 2d centesimal, often the 3rd, and in subacute cases the 6th. *Iodine* is of great value when there is lobular pneumonia in patches with pain. He believed it was when there was plastic inflammation that it was specially useful. He agreed about giving *antim. tart.* in trituration, but he had found the *vinum* quite effective. The question of chronic bronchitis is too large to enter upon, but he mentioned the value of *calcareo iodata* introduced by Dr. Meyhoffer. Its indication is wasting in children, *calcareo carb.* being more suited to fat children.

Dr. CLARKE had been much interested in the paper, and hoped Mr. Wright would read many more. In reference to the case of his mentioned, he wished to point out that the prescriptions were not his own, but Mr. Wright's, and therefore the result must be ascribed to him. Many speakers had mentioned external applications in great variety, and he was much struck with the fact that each particular application was much better than all the rest in the hands of the member who mentioned it. For his part he did not place much reliance in any, though he did not discard them entirely. For success in the use of medicines, strict individualizing was necessary. The prescription should not depend on the name of the disease, or the supposed pathological condition. Diseases were not entities because they had names. *Phosphorus* would cure in a *phosphorus* case, and *antim. tart.* in *antim. tart.* case; *iodine*, again, would cure in a case where it

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was indicated, and this in spite of any name—pneumonia, bronchitis, catarrhal pneumonia—that might be given to the disease.

Dr. DUDGEON had used *antim. tart.* for many years in bronchial catarrh both of children and of old people. He never found any failure of power in the tincture. He usually gave it in the 3rd. ; and with all deference to Mr. Wyborn, he did not think the higher attenuations were less stable than the lower. With regard to spasm, he was not very clear about it, and he would rather have had the symptoms than the name. He criticised the term “catarrhal pneumonia” ; what was so called seemed to him to be a prolongation of the catarrhal process to the minute bronchial ramifications and air-cells. The term pneumonia, he thought, should be confined to the croupous disease. Nothnagel says that besides epidemic influenza an epidemic pneumonia is prevalent at present, and the two diseases often co-exist, or the pneumonia follows the influenza, often proving fatal. He objected to Dr. Hughes' distinction between *phosphorus* and *antim. tart.*, as *antim. tart.* had produced pneumonia as well as *phosphorus*. *Iodine* was excellent in cases of real or croupous pneumonia.

Dr. GALLEY BLACKLEY was much gratified by the paper. He could say the same as Dr. Clarke, with respect to some of his cases mentioned, that the treatment was Mr. Wright's rather than his own. He also agreed with Dr. Clarke as to the necessity of individualizing cases. With respect to the use of *phosphorus* in catarrhal pneumonia as advocated by Dr. Hughes, he entirely dissented from this, and agreed with Dr. Dudgeon that the two diseases were quite distinct, and *antim. tart.* was the remedy most frequently indicated for the latter. With regard to *iodine*, he had yet to learn that *calc. iod.* contains the virtues of *calcareia* and *iodine* ; *arsen. iod.* is very different in its action from either *arsenicum* or *iodine*.

Dr. CARFRAE (in the chair) approved of the paper as being clinical and practical, and as having drawn forth a most useful discussion. He did not agree with Dr. Cooper as to the virtues of *lobelia*. He found Gould's *phosphorus* more satisfactory than the ordinary tincture. It mixes better with water or milk.

Mr. DUDLEY WRIGHT (in reply) thanked the members for the kind way in which his paper had been received. He still held that spasm did occur along with congestion. It is in these cases that the inhalation of ether relieves all difficulty. Dry cooing râles are heard. Where there is plugging, moist sounds are heard if any are heard at all. In the wards the solution of antimony acted well, perhaps, because it was not kept long enough to be acted upon by the ferment spokeno.

GONORRHŒAL INFECTION IN WOMEN: ITS
DIAGNOSIS AND TREATMENT.

By EDWARD BLAKE, M.D., V.P.*

MR. PRESIDENT AND GENTLEMEN,—The gonorrhœal virus when introduced into the circulation of a woman, so insidiously undermines her constitution that its ravages are often either overlooked or else they are attributed to some collateral agency bearing no true causative relation. It saps her vital energy, it poisons indeed the very springs of life. The results of gonorrhœal infection have so often marred the peace and destroyed the happiness of home, nay they have proved even fatal to so many unhappy women, that nothing can be said strong enough to direct the attention of medical men to the vast importance of stamping out this evil. On doctors it must largely depend to wage a successful crusade against this curse of civilised life. It seems to be demonstrable that the prevalence of gonorrhœa in married women is to a large extent the direct result of our own ignorance or indifference.

The fact is that latent gonorrhœa or gleet in males is looked upon as too light a matter by the profession at large and consequently by the public. A young man having "sown his wild oats," contemplates entering the married state. He goes to the doctor to ask if he be fit for marriage. If he have a gleet, a neglected phymosis or a stricture and we suffer him to marry without a plain protest, are we not indirectly responsible for the terrible life-long misery that may ensue? *If even the tip of the urethral orifice be adherent in the morning only, a man is totally unfit to contract marriage.*

Again if after violent exertion, especially if the effort be accompanied with indulgence in malt liquor, a single drop of muco-pus can be expressed from the *meatus urinarius* next morning, that man is unfit for marriage. He is in a condition more surely to convey infection to his wife than to another. But alas! infection is conveyed

* Read Thursday, March 6th, 1890.

without any of these conditions by tainted semen and by the Cowperian Fluid.*

A latent gonorrhœa has been described as occurring in women. This view is probably erroneous; it appears to be based on a want of care in investigation. It seems more likely that in every case this disease, contracted for the first time, has to pass through an acute stadium. This early stage does indeed vary greatly in its severity. The intensity does not probably depend so much on the virulence of the contagious material, as Saenger suggests; it seems more likely that it bears a far closer relationship to the temporary health of the subject, to certain anatomic peculiarities of the pudenda and to the natural vigour of her constitution. You are all familiar with plenty of examples in germ-invasion where these points manifestly hold good. Add to this that the special course and history of any given case is much modified by the method of invasion, of which more anon.

Typical Case.—The history of a typical case of infection in a modest married woman is as follows. A robust girl in vigorous health is married to a man who has led an immoral life. He has a morning gleet. He has been assured by a physician, who is unfortunately not an expert with the endoscope, that he is "cured." The wedding festivities cause an increased discharge. A few days elapse and the luckless bride begins to feel a little irritation in Bartholini's glands followed by suppurative catarrh of very varying intensity. This passes most naturally, in the case of an average woman, hopelessly ignorant of physiology, as the mere result of physical interference. It is treated late and we know too well the sequel.

Syphilis may be a more serious disease in men than clap, though when caught early in a well-fed man and not over-treated, it is often a very mild business. Gonorrhœa has possibly proved more frequently fatal through its remote effects in the case even of man than the more dreaded disorder, but as to the question which is the more

* I must admit that after carefully investigating the vast mass of new material of which this is a very brief digest, I came to the deliberate conviction that I could never recommend any girl to marry a reformed rake, and that my conscience would sternly convict me were I to give any man once infected a certificate of fitness to marry.



disastrous in its effects on the female economy, there exists not a shadow of doubt in the minds of those most competent to judge.

Methods of Invasion.—Anatomical differences readily suggest why the initiation of the infection in a woman may differ materially from that stage in man.

1. The disorder may commence in the urethra, and if neglected it often leaves a persistent inflamed and hypertrophied ring round the meatus.

2. A common site, the recognition of which we owe to Neisser, is in the Bartholinian follicles, a crescentic group of which are found extending from the fossa navicularis upwards on each side between the carunculæ and the labia majora.

3. A third and very common site is the cervix. Let us stop to note the curious fact that the cervix, which appears to enjoy a practically perfect immunity from syphilis, is peculiarly prone to gonorrhœal infection. This method of invasion explains why so many women, who have escaped the more external perils, fall victims after delivery.

The cervix, eroded or lacerated as it frequently is during delivery, forms an open door for the reception of gonococci. Added to this the peculiar condition of the whole organism after delivery and during subinvolution, renders the woman an easy prey to any morbid influence. Under this heading may be placed the cases in which tainted semen has carried the gonococcus straight to the endometrium.

I will stop here to plead that every medical man, for the sake of that priceless organ the eye, will order a warm germicide vaginal douche before every delivery at which he officiates.

Also that those who instruct midwives and monthly nurses should teach them not to apply to the face of the newly born babe a sponge or flannel without disinfecting it. Nor to touch its eyes with a non-disinfected hand. No towel which has approached the mother's genitalia should be used to the face of the child, as probably children are not directly infected as they travel along the maternal passages, but afterwards by the hand of the surgeon or that of the nurse or by some infected organic fabric.

If during delivery the vagina and ostium externum swarm with diplococci, streptococci* and staphylococci and no antiseptic be used, these germs are carried freely into the uterine cavity on the finger or on the obstetric instrument. We can understand why it is well not to introduce the hand in order to tear away an adherent afterbirth. We may realise how in a hundred ways septic infection of the uterine lacunæ may take place. If antiseptic douches are not used after delivery, we can imagine the probable result of semi-putrescent blood lying swarming with bacteria on a pre-existing erosion or on a recently acquired cervical laceration.

These form the needed factors to set up the acute stadium of gonorrhœal infection even if the patient be fortunate enough to escape puerperal phlebitis.

In view of the convection of gonorrhœa by the surgeon from one patient to another, sponges, specula, and all instruments which cannot be boiled, should be strictly interdicted in pelvic practice.

Latest Continental Views of Minute Pathology.—It has been asserted by Neisser that—

1. We cannot have gonorrhœa without the gonococcus.
2. Where gonococcus is found there is true gonorrhœa.
3. The number of gonococci form an absolute test of the gravity of the case: their departure proves its cure to be complete.

Alas! Neisser was too much enamoured of his new born bantling, for all these positions have been found to be quite untenable. A far more scientific view of the matter is that first heard by me from Dr. Burford. Dr. Burford's position is that this germ of the gonococcus is everywhere to be found, in fact it is always present in the air, its most appropriate soil and surroundings are found in the genitals when suppurating. With the tendency of the fittest to survive, it will grow and multiply. Encountering, as we know it does, an infinite variety of microbes of varying character it will crowd them out for

* *Streptococcus pyogenes*, long twisted chains found in pyæmic abscesses, and in moist gangrene. *Staphylococcus pyogenes albus*, irregular clusters found in newly opened acute abscesses. *Staphylococcus p. aureus*, in acute abscesses, whitlows and boils.—*Pathological Mycology*, Woodhead & Hare. Sect. I., p. 130.

a time, and then having gradually exhausted all the special soil necessary for its own elaboration, in time it tends slowly itself to perish.

Of course this position must be taken as hypothetical merely, but it is a good working hypothesis. An interesting analogy may be found in the vegetable world. A very ordinary English wild flower is the coltsfoot—*Tussilago farfara*. An unique species, it is only found on newly turned ground. If a new railway line be cut through a hillside, if a well be sunk, a quarry made or a mine newly worked, there the coltsfoot makes its appearance when there is none to be seen elsewhere in the vicinity. It is a curious plant, throwing out its yellow blossom in early spring before the leaves appear. Its silky pappus is specially affected by the ordinary English goldfinch to line its nest with. Poor people boil the leaves for cough and miners smoke them when work is bad and “bacca” dear.

The first year these leaves will measure four to five inches across, and every year they grow smaller, until finally, having exhausted their own special pabulum in the soil, they vanish completely, leaving only their seeds ready to spring into life if the subsoil be again disturbed.

Were space to permit it even, this is scarcely the place to go into the elaborate researches that have been made by many modern observers on the life history of the gonococcus and its true relation to this venereal disorder. Suffice it here to say that Sanger, the gifted clinical teacher of gynecology in Leipsic University, has touched the true keynote when he says in his work on this subject just published: “The bacterial test of venereal character alone is worthless. The clinical tests are necessarily sometimes weak, there is often at work some potent motive for deceiving the doctor. *A given diagnosis can be regarded as entirely free from suspicion, only when the purely clinical criteria and the bacterial tests are quite absolute and quite coincident.*” This is worth recording in letters of gold.

That our knowledge of the gonococcus is a great aid in precisionising the pathology of intrapelvic gonorrhœa is indeed true, and we are under a great debt to Noeggerath for initiating, as well as to Neisser for pursuing, this deeply important line of research.

By adding to our clinical knowledge of the invasion, course, and results of this insidious foe, a good sound knowledge of the most important points of its more transcendental pathology, we need fall but rarely into any very grievous diagnostic error.

The method of commencement of an extra-vaginal gonorrhœal attack in a woman is very typical and distinctive.

1st. Suddenness of purulent discharge, especially in a woman not before prone to yellow leucorrhœa.

2nd. The extreme profuseness of the discharge.

3rd. Usually, but not necessarily, acute temporary dysuria.

If the disease extend unchecked up the vagina, and especially if pregnancy now complicate matters, countless nodules (adenoid)* appear. This constitutes granular colpitis, said to be pathognomonic of venereal origin. From these granules may spring pointed condylomata, never yet seen in an untainted subject.

Of course if the endometrium be involved, placentitis gonorrhœica is set up and abortion threatens. It may be averted with care, but floodings may give rise to an erroneous suspicion of placenta prævia.

If delivered at full term, the gonorrhœal irritation has fallen into abeyance, but after delivery there is usually a great outburst of germ activity. And any of the well known perils of childbed may come to the fore.

Should the infection pass upwards by way of the vaginal mucosa, then there seems to be a tendency specially to Fallopian disease. This may take the forms of pyosalpinx, hydrosalpinx, Fallopian stenosis, simple or interstitial salpingitis. As these conditions are usually symmetrical, of course sterility is the rule. But occasionally tubal pregnancy occurs.

The inflammation may extend and set up peritonitis perioöphoritis, or ovarian abscess. Passive intractable hyperplasia is often present giving rise to a doughy feeling, the so-called "succulent uterus."

If on the other hand the upward track of the infection be along the submucous circumvaginal cellular tissue,

* This term "adenoid," used by Sanger, is a little misleading. There are no glands in the vaginæ of mammals.

the patient appears to be more prone to cellulitis, to local or general peritonitis or to pelvic abscess.

It needs hardly to be said that interference surgically with patients at this stage should be undertaken with the greatest circumspection.

A very little thought will make us perfectly able to understand why operations for pyosalpinx, hydrosalpinx, ovarian hyperplasia or ovarian abscess probably undertaken in a large proportion of cases with a pelvis swarming with diplococci, are far more serious than simple uncomplicated ovariectomies.

It prepares us to realise more fully what we know to be clinically correct, that if the subject survive, great relief is felt for a longer or more brief period, then too often a relapse into miserably defective health is experienced.

Perils of Uterine Sound and Hard Pessaries.—In this state of things, much more common than we might suppose, the use of the uterine sound is absolutely contra-indicated. It is indeed curious within fifty years of Simpson's giving to the world his favourite instrument of diagnosis, to find the "men of light and leading" condemning the sound in no measured terms as the lethal weapon with which the light-hearted youth goes gaily to battle, as the friend of the young woman in trouble, and of the unprincipled abortionist!

No amount of precaution in the way of disinfecting or sterilising the sound is of any use in protecting a woman from injury through its use. This is because the septic material is carried from the cervix to the deeper portions of the uterus to infect the latter.

When we come to deal with treatment we shall observe the dangers associated with ordinary hot irrigation in gonorrhæal cases.

As some evidence of the great need of a better general knowledge of the wide-spread nature of this disease, I may mention that I have frequently removed hard pessaries from women with severe and well-marked passive pelvic inflammations. Their introduction under such conditions is too truly a "deed done in darkness" both mental and physical. Hard pessaries are seldom needed, nearly everything that can be done by them can be better done by pledgets of absorbent cotton or tampons of animal wool with the decided advantage of introducing

at the same time one of the infinite varieties of glycerole as a curative agent. Though occasionally useful, I think it would have been on the whole a better thing for women had hard pessaries never been dreamed of by man.

Puerperal septicæmia, bubo, pyæmia, parametritis, suppurative phlebitis it should be remembered are never induced by pure uncomplicated gonorrhœa. They are always the product of a mixed infection.

Old age in woman confers no immunity from invasion. Mucous cirrhosis, senile colpitis and resulting atresia, with or without pyometra, are common results of gonorrhœa of the aged.

Bartholinitis and its results, including the very characteristic petechial stainings or purple spots in the immediate neighbourhood of the follicles, *macule gonorrhœicæ*, are more than suggestive of infection.

Urethritis plain, and interstitial, *periurethritis, cystitis, ureteritis, pyelitis* without the presence of lithiasis, *nephritis*, the last two not very common, are all aids, when present, to diagnosis.

It is useful to remember that whilst the onslaught of clap in women is marked by its suddenness, on the other hand the chronic stage is longer than in ordinary uncomplicated inflammations. Again the outbursts of irregular activity are more acute. They correspond with epochs of vascular excitement, especially after coitus, menstruation, gestation and child-bed.

Commonest Cause of Sterility.—Sterility, when not associated with good health, especially with marked hysteria, is very suggestive. Sterility after one child, so happily styled by the German writers “*ein kind sterilität*,” is very very common.

An obstinate and corrosive discharge, copious at its commencement, not yielding to ordinary measures, is always good ground for suspicion.

If venereal, its tendency is to cause intertrigo in the acute stage, and pruritus in the chronic.

Of course it will be differentiated from glycosuria, with which, however, we must remember, that it may co-exist. The recollection of the commonest cause of pruritus vulvæ, when it comes during active sexual life, may explain its occasional intractability.

Strangury not always present as in the male, and often arising from non-venereal causes, naturally attracts less attention. Persistent *pyuria*, whether the patient be prone to lithiasis or not, should always arrest our notice. Specimens should, of course, be obtained immediately after a vaginal douche to be of any clinical value.

Difficulty in walking from the *œdema vulvæ* is often present in addition to the chafing. Discomfort during sitting from the same reason, sometimes is complained of.

The pains might be confounded with those of dysmenorrhœa, but the following point may serve to distinguish ordinary cases.

In nulliparous dysmenorrhœa the pains ordinarily descend in a fairly steady diminishing scale from fifteen years of age to thirty, when they always cease *unless associated with active pelvic disease*.

The pains of gonorrhœa (*colica scortorum*), caused chiefly by adhesions, having begun suddenly after an illness, are characterised by an erratic flight of alternate rise and fall, with no tendency to disappear till the change of life.

Destructive *conjunctivitis* in the mother, or in the child, are practically unknown apart from gonorrhœal infection.

The history of the case, the sequence of symptoms, the clinical experience of the physician go for much.

Not so much can be said as to the social or moral status of the patients in aiding diagnosis, I have personally been more misled than aided by taking the latter into consideration.

To make a correct diagnosis in obscure and recondite cases it is essential to examine the husband. We should therefore have the signs of male gonorrhœa at our finger tips. The chief symptoms are :—

Pus in the urethra; retention followed by dysuria; gonorrhœal threads in urine; blood disks in urine; everted, swollen, reddened meatus, adherent in the morning; aggravation of pre-existing phymosis; later on stenosis meatus; signs of stricture, thick bladder; shuddering during micturition; hot urine, forked or diminished stream; "stammering" bladder; dribbling of urine after micturition; oozing of Cowper's fluid; tenderness of urethra or of prostate; abdominal discomfort after coitus, coffee, alcohol or prolonged exertion; chordee, epididy-

mitis, orchitis, bubo, backache, anæmia, osteo-arthritis ; peculiar pubic parasite, spreading to aspects of flexion ; sterility, the semen becomes white and flocculent and its characteristic pungent odour departs ; history of destructive conjunctivitis purulenta.

It seems probable that if gonorrhœa in man were never treated it would rarely lead to stricture.

There are one or two axioms which will help us in meeting this disease in a scientific and rational way.

The urethra should always be syringed from within,* never from outside. To syringe centripetally is to carry the gonococcus to the membranous portion, and thus to lay the foundation of a future stricture.

Bougies and catheters should consist of perfectly non-absorbent materials.

They should be boiled and sterilised before and after use.

They should be freely smeared with an appropriate germicide.

The urethra should be irrigated most scrupulously with an antiseptic before employment.

The reverberating irrigator must never be thrust far into the urethra at first.

It should be passed half-an-inch only, and warm perchloride solution 1-10,000th allowed to play, and as it plays the nozzle may be introduced in a spiral direction till all tender spots be passed. Then a disinfected syringe is used to fill the urethra with warm germicide oil. Then under rare exceptional circumstances the metallic bougie may be used, preferably with a continuous current, which should supplant the antiquated and dangerous urethrotome and the perilous splitting dilator.

Dirty, rough, bougies and gum-elastic catheters are a prolific source of needless stricture, cruelly inflicted on a credulous and ignorant patient by the thoughtless and incompetent surgeon.

I have recently removed a gleet of many years' duration in a gentleman of 50, who has since his 21st year had claps innumerable.

First of all the contraction of meatus was overcome and a death-blow dealt at the swarming colonies of

* By means of a reverberating syringe.

diplococci in the navicular fossa by passing the largest possible silver catheter just three-quarters-of-an-inch into the urethra, ten minutes after injecting a saturated solution of cocain.

The negative pole of a voltaic battery was now attached, and the positive pole placed on the pubes.

A current of five milliamperes was passed, the *séance* lasting 3 minutes. This caused the removal of the meatal constriction, due to passive recurrent interstitial periurethritis.

Then after a week of daily sublimate irrigation the gleet ceased without special internal treatment.

The material used in the irrigating water was an aqueous solution of corrosive sublimate, never exceeding one in ten thousand, with warm water.

If meatal stenosis exist, the orifice can be dilated by means of a Kramer's otoscope or a bivalve nasal speculum, through which the continuous current may be passed. A silk glove guarding the operator's hand.

But we need many strings to our bow. If bichloride fail, we may try glyceroles of *hydrastis*, of *thuja*, of *santal*, and of *copaiba*, made weak and without spirit, *borax*, *boroglyceride*, and *salicylate of sodæ*.

What I will call, for convenience, "ballooning," I have found of great service in getting into the intra-urethral follicles and to wash away mucopus, so that the applications may really reach the diseased structures and not merely cause an albuminous superficial clogging. Ballooning is practised in the following way: The nose piece of the irrigator is removed and the top part introduced into the urethra, the root of penis compressed, organ bent up at right angles. Now the urethra is forcibly dilated to any desired point by hydrostatic pressure.

This is very valuable as a method of preliminary alkaline douching to remove encumbering diseased products, proliferated epithelium, muco-pus, &c., before the actual curative irrigation.

It is confidently asserted by Bumm and by Saenger, the greatest living authorities, that if deep infections be present they are always of a mixed character, that is to say they are induced, not by the gonococcus nor by the venereal poison pure and simple, but by gonorrhœa plus septicæmia.

We know all of us too well the pallid cachectic wretches soaked with gonorrhœa, the skin often stained with chloasma, who live as a standing protest against the impurity and selfishness of man.

This status from which no woman ever recovers is known as the "cachexia gonorrhœica." But the gonorrhœal virus alone, without pus products, will not serve to induce it.

Thus the synovial and cartilage changes in man, in women the severe local pelvic disturbances, the profound anæmia, the acid saliva with sore lip-commissure, the lichen urticatus, the pharyngeal incoördination are always due to mixed infection.

Supposing that an already tubercular woman gets gonorrhœal infection, she then absorbs the broken down pus products as well as the diplococcus, and her pathologic state is the product of her original dyscrasia plus septic absorption, whilst only her purely local pelvic troubles are the direct result of the clap. A similar, though not so severe a condition, is induced by neglected hip-joint disease and by chronic suppurating gums.

Treatment.—If, as rarely happens, we are consulted during the acute stage, then the ordinary internal treatment of clap in the male benefits a woman also.

But we should recollect that it is not safe to predict that the procedures which benefit a woman will relieve a man. Thus carbolic acid, which is a most valuable injection in acute female gonorrhœa, produces such severe suffering in man that no patient would submit to a second injection. Permanganate of potash causes frightful pain to a man whilst it gives rise to no suffering when introduced into the vagina. On the other hand silver nitrate does not appear to have quite so much tendency to cause atresia in man as it does in women.

When a woman comes to me with pus welling freely from the vagina, I order continuous douche all day long of warm water and carbolic acid. The strength 10 grains to the ounce. The solution growing weaker and the douches less frequent as improvement sets in. *Calendula* may with advantage be added in the next stage, if the cervix be denuded of epithelium, if many punctiform vaginal adenoids appear or if the intertrigo be distressing.

When the distressing pruritus begins, a capital combination is *phenol* absolute, five grains; *hazeline*, one

ounce ; of this one tablespoonful to a quart of warm water three times a day.

If this fail to relieve the itching, then *borax*, *alum nitrate* or *chloral* may be used one drachm to the pint.

Acute urethro-cystitis, *camphor monobromide*, *aconite*, *uva ursi*, and *capsicum*.

Passive catarrh of bladder : *Copaiba*, *cubeb*s, *santal oil*, *buchu*, *ferrum muriaticum* and *rosemary oil*.

Vaginismus, lead lotion, but this condition is always reflex, and the cause must be sought for with scrupulous care.

In the happily rare event of furious erotism, *coffea*, *raphanus sativus*, *salix nigra*, *origanum* or *platinum* may be thought of.

Urticaria general. The first intense agony of itching is helped by *apis mellifica*. You will, however, earn the patient's gratitude if you immediately order her a hot bath. After which she is *patted*, not rubbed, dry with a hot sheet thrown over her, and then well smeared with 10 grains of *chloral* to the ounce of *glycerine*. The same remedy (*chloral*) suitably diluted may be also given internally ; failing that *copaiba*, then *sulphur* have proved useful.

The cut corner of mouth is kept painted with *tr. calend.* s.v.r. and *tr. benzoïnæ* equal parts. A piece of soap plaster across the lips at the side ensures rest essential to healing. *Merc. corr.* then *biborate of soda* in 12th centesimal are the remedies. This apparently unimportant symptom is really of serious moment because it gravely impairs nutrition, as mastication becomes such a painful process.

For the cervical erosion, or granular os, so often present, nothing has answered my purpose so well as pure *phenol*.

In the uncommon cases where it has failed I have used super-saturated acidulated solutions of *zinc chloride* and of *silver nitrate*, the latter only in hyper-patulous os, where some stenotic cicatrisation is desirable.

Sänger uses exclusively as a douche *bichloride of mercury* 1/2000th to 1/500th.

He recommends first day *tamponade of glycerole of tannin* to detach superficial vaginal epithelium. Next day copious alkaline douches, then plain water, then corrosive sublimate solution. Then pack the vagina

quite full of *iodoform* gauze, or with pledgets of absorbent cotton soaked in *iodised glycerine*.

If there be neoplasms it is well to pencil them with *iodine*. All the douches are best applied in Marion Sims' posture, as now practised at Buda Pesth, the so-called genupectoral position. Then the vagina balloons out and the *plicæ palmatæ* are to a considerable extent smoothed out.

If gonococci be present, hot douches are contra-indicated. To neutralise the gonorrhœal virus at the uterine neck, if there be a general tendency to neoplasms, I use *thuja* tampons with anhydrous *glycerine*.

Glycerole of santal acts well for packing the urethra. If much cervical hypertrophy, *iodised glycerine* is indicated, or *iodoform* or *iodol* with *glycerine*. The various forms of *iodine* not only reduce hyperplasiæ, but they penetrate the tissues and thoroughly neutralise germs. They also appear to aid in the removal of the obstinate and disfiguring *acne menti*. The *iodine* is sometimes tasted by the patient a few minutes after introduction into the genital passages.

In endometritis villosa, if associated with recurrent hæmorrhages, scraping the endometrium with the blunt or the sharp curette, though deprecated by Saenger, certainly cures the hæmorrhage. I have never seen it followed by the dreadful results named by him.

Ordinary endometritis of the gonorrhœal type is best treated by thorough dilatation. Then a double slip of lint dipped in *iodised phenol* (saturated solution for bad cases, diluted for mild examples) is introduced into the uterine cavity and left for a few hours. If this be done in the consulting room, it is a capital plan to smear the slip freely with potash soap. This facilitates introduction and postpones pain till the patient has time to get home and go to bed.

It is a good plan in cold wet weather to treat such cases if possible at the home of the patient. I have tried all the methods of dilatation and I unhesitatingly give the palm to rapid metallic divergent dilators.* A saturated solution of *cocain* is applied to ostium internum by dipping a wool-clad probe and laying it in cervix ten minutes before operating. With a plentiful use of germi-

* Personally, I prefer a modification of Palmer's dilator.

cides, clean nails and boiled instruments I never get a mishap. Sponge tents are apt to set up cellulitis. Laminaria tents are painful and tedious and they necessitate so many interviews, a grave matter for distant and not wealthy patients. Hegar's dilators take up so much time and space.

It is enough in a mild case, and with an irritable nervous patient, to swab the endometrium with *iodised phenol* after drying it and leave a vaginal glycerine tampon instead of an intra-uterine slip.

Abstinence from meat and from all alcoholic drinks should be enjoined. Patients do better in bed.

COMMENTARY.

It is refreshing to find that Sanger falls back after all on clinical evidence—*der klinische standpunkt*. By which he means the history, the sequence of symptoms and personal experience in phenomena must always count for much in diagnosis.

DISCUSSION.

Dr. JAGIELSKI remarked that Dr. Blake had not confined his remarks to gonorrhoea in women, but had treated of the disease in men. He had not dealt with the disease in prostitutes, or the subject of immunity after one or more attacks. He referred to the question of cocci and said we should probably never get to the bottom of it. He believed we were safest to stick to our homoeopathic doctrines and attenuations. Homoeopaths have facts to go on. He asked if Dr. Blake had found some of the antiseptics painful. The tar preparations are generally calming. He praised creoline and gauze. He agreed with Dr. Blake in deprecating the use of the sound and pessaries.

Dr. HUGHES hoped Dr. Blake would not take it as ungracious if fault were found with his paper, put together with such great pains. He had hoped Dr. Blake would have treated the subject differently. Most of what he had stated could be read in current literature, and if he had briefly summarised this, and had given us from his practical experience the power and sphere of homoeopathy in these diseases it would have been better. Dr. Hughes referred to the discussion on influenza. Germs were spoken of there, but that was of minor interest, the treatment was what concerned us most. The same remark applied to the discussion at the last meeting. He thought the diseases referred to by Dr. Blake might be treated in the same way by studying medicines homoeopathi-

cally related to these inflammations, avoiding the host of local applications referred to by Dr. Blake. Dr. Hughes believed the old school practitioners were doing just as much harm by their internal drugging and local application as our forefathers did by their bleedings. The gentle measures of homœopathy were much to be preferred.

Mr. KNOX SHAW confessed that he had learnt much this evening. He was astonished to learn how many of his friends and intimates must be affected by gonorrhœa. If he had drawn his conclusion on the paper he would say it was gonorrhœa gone mad. He felt there was a danger of looking at things through special spectacles. He was also struck with the wide-spread nature of the disease, extending from peer to peasant. Mr. Knox Shaw questioned if every case of ophthalmia in the infant was due to gonorrhœa, and also if it was due to sponges. The ventilation of the lying-in room, and the careful washing of the child, had been enough to largely diminish the number of cases. He thought most cases were caused by unhealthy discharges from the mother, not necessarily gonorrhœal. He gave a different explanation of the harmless use of the uterine sound in Edinburgh from Dr. Blake.

Dr. DAY said in the treatment of gonorrhœa in the male he had found the *nitrate of hydrastin* bougie with *hydrastis* at intervals very efficient. The shuddering after micturition, named by Dr. Blake, was a normal condition aggravated by the gonorrhœa.

Dr. MADDEN thanked Dr. Blake for his paper, and repeated Dr. Hughes' criticism of the want of homœopathy in his paper. Dr. Blake had not given the diagnostic distinction between gonorrhœal and simple pelvic inflammations.

Dr. BURFORD did not agree with Dr. Hughes' wholesale condemnation of Dr. Blake's paper. All that could be known of a disease should be brought forward. Dr. Blake was excused from giving a detailed account of treatment, since the condition, as at present known, was not more than ten years old. One criticism of Dr. Blake's paper was the want of Dr. Blake in the paper and too much of other people. The clinical history of the disease might have been gone into more fully. There is a chronic gonorrhœa which may exist without any acute stage. Immediately after labour there may come fever, dry tongue, delirium, and it may be death. Dr. Grigg had described this, and he found rupture of the fallopian tube due to gonorrhœa in the husband. He was glad the gonococcus had been slain. There was no evidence that the gonococcus was the cause of the disease. There was no evidence that the gonococcus existed in any other part beside the secretions. A

secretion containing the gonococcus alone has not been found. Gonorrhœal peritonitis is always confined to the pelvic cavity. Two other anatomical points are unknown in this country. The vagina contains no mucous glands, though the vulva does. The fallopian tubes also contain no mucous glands. Tait has given a good name to the condition of the fallopian tube—*desquamative salpingitis*. This rendered the adhesion of the surfaces very likely. He agreed with Mr. Shaw that all cases of ophthalmia in the newly born were not by any means due to gonorrhœa.

Dr. BLACKLEY agreed with Mr. Shaw with regard to ophthalmia neonatorum, that it was not so prevalent as Dr. Blake made out. He used no antiseptic, but wiped the child's eyes with a soft cambric handkerchief.

Dr. DUDGEON said the recent great revival of gonorrhœal affection and its effects was not original. Dr. Wolff forty years ago ascribed to it every evil that flesh is heir to, including smallpox. He related a case in a man of business that had recently come under his notice.

Dr. BLAKE (in reply) agreed with Sanger, that every prostitute got the disease within three months, and ever after was capable of handing it on. Dr. Hughes was not right in saying his remarks could be read in books. Besides, it would be ridiculous to attempt to teach Dr. Hughes medicines—he knew them all himself; but he could teach him some pathology. The ultimate pathology must be known. He had thoroughly enjoyed the comic remarks of Mr. Knox Shaw. He was sorry, but he must still believe in the prevalence of the disease. He disagreed with Dr. Burford as to the gonococcus not being found in deeper tissues. Cases where the cervix is first involved are difficult to make out. He apologised for the length of his paper.

BRITISH HOMŒOPATHIC SOCIETY.

CLINICAL EVENING.

Pemphigus of Conjunctiva ; Cases of Lupus ; Raynaud's Disease ; Myelitis ; Stammering ; Abdominal Tumours ; Hemiplegia ; Sympathetic Ophthalmia.

PEMPHIGUS OF CONJUNCTIVA.

MR. KNOX SHAW in introducing his patient said : The case I wish to bring before the notice of this Society is one of considerable rarity and unusual interest.

It consists of an alteration of the conjunctiva, so that the lids are becoming bound down to the globe of the eye, and the cornea is becoming covered by a membrane. There has been no trachoma and no injury from lime or other escharotic to cause this.

Only a few of such cases are on record, being variously described by Graefe as essential atrophy of the conjunctiva ; by Stellwag as syndesmitis degenerativa ; and by Schweigger, Steffan and others as pemphigus of the conjunctiva. In 1886 Mr. W. Lang reported three cases to the Ophthalmological Society as pemphigus, two at least bearing a great resemblance to the present case. Messrs. Critchett and Juler also in the same year showed two cases (one of which was Mr. Lang's three cases) which they described as essential atrophy.

It seems possible from the investigations of Steffan, Schweigger, Bäumlér and others for the pemphigoid eruption to attack mucous membrane only. In the present case we have certainly never observed any vesication of the conjunctiva, but there have been undoubted vesicles of pemphigus on the hard palate, epiglottis and the mucous membrane covering the arytoids.

To make sure of this latter point the patient has been examined by an experienced laryngologist who informed me that there was an almost similar case to this now in the eye-wards of Guy's Hospital.

Under these circumstances, and though we have never seen an actual vesicle on the conjunctiva, I am

inclined to class this case under the nomenclature of pemphigus.

He has been now some time under observation, and I was inclined at first to attribute his trouble to a very obstinate trichiasis; and I operated upon him several times for the relief of this affection. Finding the disease of the conjunctiva slowly increased in spite of this, I became conscious that I had an unusual disease to deal with. At a consultation with Mr. Critchett the probable nature of the disease was pointed out to me.

The patient is aged 55. He first complained of inflamed eyes at Easter, 1887. Came under treatment at the hospital in March, 1889. No history of syphilis: gout twice: once quite lately.

MYELITIS.

Dr. E. A. NEATBY showed a patient who had recovered from paraplegia, and a case of lupus of the foot.

The first was a boy of ten years of age, who first came under treatment more than 12 months ago. He complained of loss of power of legs and great pain in cervical spine, which had resisted treatment for a length of time. The deep reflexes of lower limbs were increased, but the superficial reflexes as high as the epigastrium were almost, if not entirely abolished. *Belladonna* had at once removed the pain, but the legs did not regain power. The boy was, after a time, sent to a special hospital for diseases of the nervous system; during his stay there the paralysis increased, and he left the institution unable to move a muscle of the lower limbs. He was subject to frequent jerking of the legs. The reflexes were in the same condition, the organic reflexes remaining unaffected throughout. A short time after his return home the boy began to notice a little power in his legs. This gradually increased, until after three or four months he was able to walk steadily without support. The knee jerks are still increased, though they are less active than formerly; ankle clonus cannot now be developed by the careful trials made.

The chief remedies were *lathyrus*, *pulsatilla*, and *silicea*.

LUPUS OF FOOT.

The second patient, Emily W., æt. 20, had suffered from lupus of the foot from the time she was three or four years old. She has had many operations at different hospitals. During the last few years she has suffered from very frequent attacks of erysipelas—sometimes two or three times in a month. Occasionally it occurs in the foot, extending from the site of the lupus; more frequently however it affects the leg higher up, and not the foot. The lupus had much deformed the toes. The treatment has consisted of the local use of a powder of *silico-fluoride of sodium* and *starch*, 1 in 200, and the administration of *arsenic* internally, in various dilutions.

STAMMERING.

Dr. EDWARD BLAKE showed a patient who had recovered from stammering through education, under his direction, of the external pterygoid muscles.

ABDOMINAL TUMOUR.

Dr. BURFORD showed a case of abdominal cyst of parovarian origin, in a patient aged 59. It was of considerable dimensions, the patient measuring 40 inches round the umbilicus. It was first noticed some six years ago, but during the last six months had grown rapidly, and now was a source of considerable discomfort to her. It appeared first as a right-sided swelling in the pelvis; but now occupied the whole anterior portion of the abdominal cavity. Percussion thrill was easily obtainable in all diameters; there was some free fluid in the flanks, chiefly the left; but no friction fremitus or signs of adhesions. *Per vaginam* the uterus was displaced toward the symphysis, and the thrill was easily made out from the fingers on the abdomen to the fingers in the posterior cul-de-sac. The patient had a very characteristic *facies uterina*. Operation was contemplated shortly.

HEMIPLEGIA.

Dr. BUCK showed a patient suffering from hemiplegia, and read the following notes:—

H. B., female, aged 32 years. Before she was 18 she had suffered from three attacks of rheumatic fever, the

last one was followed by symptoms of chorea, which lasted for some months.

Since I have known her, now about eight or nine years, there has always been a loud systolic murmur in the mitral area. On November 27th I received an urgent summons to see her, and found her in a semi-comatose condition, lying upon the couch upon her left side, unable to reply to questions, and moaning occasionally as if in pain. She could not recognise me, and it was only after great persuasion, and by speaking sharply, that I could get her to put out the tongue; it was thickly coated. The pulse was rapid and feeble, pupils were dilated, and acting sluggishly to the light. The hands and extremities were cold. The conjunctiva of the left eye-ball was quite insensible to touch, and the right partially so. I was informed that for the past few days she had been dyspeptic and unwell, for which she had taken *nux vom.* in two drop doses. Her friends attributed her present symptoms to the fact of her having taken too much of the remedy. Before the attack commenced, she complained of a swimming sensation and of giddiness in the head, accompanied with a disposition to vomit. The temperature was sub-normal. I had her removed to a bedroom, and in about two hours I saw her again. The pulse had improved, and she was much warmer, but still unable to recognise any one. I found complete ptosis of the left eye-lid, the mouth drawn to the right side, complete motor paralysis of the right arm and leg, with partial loss of sensation on the same side. The superficial reflexes and knee jerk absent. Upon examining the heart I found the systolic murmur before mentioned had quite disappeared, and in its place a rough, harsh sound was to be heard.

Evening visit: Pulse was 80, temperature normal. She had taken nourishment in small quantities, and she was able to recognise her friends, and spoke in monosyllables.

The articulation was indistinct, and she would harp upon one word or phrase.

"Cow," for instance, was given in reply to questions. At another stage of the illness it was "believe it," and "what o'clock is it?"

On the 29th complained of pain in the left side of the head, by putting her hand up to the part and moaning. During the day she became very flushed. Temperature

rose to 101°. Pupils were now contracted. This flushed condition lasted for a few hours, but the headache remained. She found much relief from the application of hot water pack to the head; cold increased the discomfort. Temperature 99°.

November 30. Able now to answer questions more clearly. Dr. Blackley saw her with me in consultation. There was still ptosis of the left eyelid and partial ptosis of the right also. Loss of motor power and sensation impaired in the affected limbs; plantar reflex absent; knee jerk normal. With the ophthalmoscope the fundus and disc were found healthy. No ankle clonus could be obtained. The tongue was projected slightly to the right. From this date she continued to improve in speech. The tongue slowly cleaned, and she took more freely of nourishment. The headache gradually passed away, and the pulse also improved in quality. The pupils reacted to strong light, and the temperature remained about normal; improvement was maintained, and on December 4th there was still some anæsthesia of the calf, as shown by application of heat, tickling and pricking: the latter was felt when the pin was freely applied, causing her to draw up the affected leg. Plantar reflex diminished on the right side; knee jerk normal; hearing and pupils normal; no reaction of muscle upon application of the induced current. A rough, free systolic murmur was heard in the mitral area, more distinct than it was previously.

There was more sensation over the face, but the movements of the muscles were still impaired.

December 16. Plantar reflex increased. Tongue projected straight; ankle clonus well marked; knee jerk exaggerated; no power of movement in hand; arm only.

February 12. She is now able to walk with some assistance; the toe of the right foot drags the ground, and occasionally she brings the heel down. The movement of the leg from the hip is awkward and uncertain.

March 22. Squeezing and pinching the arm is now felt and produces pain; sensibility to touch is equal upon both sides; pupils also equal; hearing, touch and smell normal; plantar reflex equal on both sides; ankle clonus well marked: patella reflex exaggerated on the right side. Absence of voluntary movement in the arm and hand. She can flex the thigh upon the abdomen and the leg

upon the thigh ; no movement in the foot or toes. Skin is of a bluish colour of the affected limbs, alternating with pallor. Affected side is cold to the touch, the lower extremities colder than the arm ; the hand is at times quite warm. The speech is stuttering and hesitating.

There is a slight rigidity of the muscles of the arm and fore-arm ; condition of the heart sounds are similar as were mentioned before.

Catamenia regular, and she has perfect control over both rectum and bladder. The medicines given at the onset of the attack was *arsenicum* for the head symptoms, *gelsem.* and *belladonna*, and afterwards *kali iodatum*, and finally *ignatia*.

My opinion is that this is a case of hemiplegia of abrupt onset, owing to embolism of the branch of the middle cerebral artery, supplying, at a point below the decussation of the fibres of the motor oculi, the motor tract to the face, arm and leg, and caused by the separation of a vegetation from the mitral valve. At first thought one might, considering the age of the patient (a young unmarried woman of a highly emotional character) think that there might be some hysterical or other functional cause for these symptoms, but the sudden onset of the paralysis, the cause and implication of the facial muscles in addition to the extremities, together with the aphasia points to organic mischief, which is further supported by the alteration in the cardiac sounds.

The differential diagnosis from hæmorrhage is almost certainly made out by the above-mentioned cardiac condition, the age of the patient and the absence of any signs of vascular disease.

SYMMETRICAL GANGRENE.

Dr. GALLEY BLACKLEY showed a case of *Raynaud's Disease*, of which he gave the following history :—

Elizabeth R., aged 20. Admitted into the London Homœopathic Hospital, Feb. 28, 1890. Disease first showed itself at age of 15. Began at back of right heel ; patient noticed that the part was blue and rather swollen, but there was no pain ; in about six months the skin broke, and became scaly over the place, but there was no discharge. Later on the other heel was similarly

affected. When about 16 years old the fingers began to swell; patient thought it was caused by chilblains for some time. The left ring finger was first affected, then one of the right hand fingers, and in the course of six months all the fingers were bluish in colour, and much enlarged. They were always cold and moist; never had any pain in them and though the skin was cracked in places and covered with a thin yellow crust, there was no actual discharge. The toes were similarly attacked about the same time, and a few spots appeared on the legs. Spots on the arm followed, and then the face was attacked. By the time she was about 17, she was covered as at present, and though the sores heal up in some places they break down again in others, and there has been little alteration for better or worse since that time.

Present State.—A well nourished and well developed girl. Temperature normal. Urine 1030, acid, no albumen, deposit of urates.

Face.—The cheeks are swollen. Skin feels hard and thickened, rather bluish in colour; near the centre of each cheek is an irregular circular superficial sore. These secrete a thin discharge which dries and forms a crust. There is a similar though smaller sore on the forehead at the root of the nose, one near the centre of the lower lip, and one on the chin. The bridge of the nose appears thickened. The ears, especially the left, are cold, bluish, swollen, and, around the perforations for the earrings, cracked and covered with thin yellowish crusts.

Chest and Abdomen.—Skin quite free here; all organs normal.

Arms.—On left, below and rather behind the deltoid insertion is a large sore, about 2 by 1½ inches. It is oval in shape comparatively superficial, though deeper than those on the face. The base looks unhealthy and is partly covered by a yellowish crust, there is a little discharge still coming. Along the outer side of the arm are a few similar though smaller sores, some of them covered with crust others quite healed and having a blue appearance. The right arm is in a similar condition, the spots corresponding in position. The fore-arms are marked in the same way, with small spots and one rather larger on each wrist.

Hands swollen, bluish in colour and covered on their palmar surfaces with a cold perspiration. Fingers of both hands much swollen and terminal joints of third fingers partially luxated. Thumbs are very large, skin scaly over pulps, nails almost disappeared.

Legs.—Thighs free from disease, but below the knees are numerous spots, the positions of which correspond more or less accurately. On each heel is a sore similar to those on the wrists.

Feet are affected like the hands. Toes are much swollen especially the big toes, and the nails here have also nearly gone, soles are cold and moist. Patient was kept in hospital nearly a month. Had various medicines but *arsenicum* 1 seemed to do most good. The sores were painted with a mixture of *tr. benzoin co.* and *collodion flex.*, and under this treatment they improved considerably. Temperature remained normal and the general health seemed perfect.

A CASE OF LUPUS.*

Dr. BLACKLEY next exhibited the case of Sarah H., age 29, admitted into the hospital March 13, 1890, under his care, for extensive lupus of face and hand.

Family history good; one sister has eczema, a cousin suffered from lupus.

Present Disease began at twelve years. Began in some inflamed skin left after bursting of an abscess at corner of left eye, small pimples formed which enlarged, amalgamated, and eventually spread all over face. As a rule the pimples were dry, but occasionally discharged a little pus. Left forefinger attacked nine years ago, necrosis of proximal phalanx followed, the bone separated, and finger became curled on back of hand. Skin on back of hand affected by tubercular ulceration two years ago. Has been under treatment for years, and has been in this hospital before.

Condition on admission.—Thin and weakly woman; on face, neck, elbow and hands are numerous old cicatrices.

Face.—Alæ nasi have been eaten away, as also left lower eyelid (leading to epiphora); upper lip and cheeks

* From notes taken by Mr. W. S. Cox, Assistant Resident Medical Officer, London Homœopathic Hospital.

hard, and thickened by tubercular deposit, are red and shiny in parts, show pale cicatrices in others ; a little active ulceration still going on.

Left hand.—First finger as described, third also shows strumous dactylitis ; back of hand red, raw and moist, with tubercular ulceration. There is also a patch of ulceration at the back of each elbow. Lungs and heart normal, no evidence of phthisis.

Urine.—1,020, acid, no albumen, no deposit.

Temperatare normal ; eats and sleeps well ; a little itching in the hand at times, otherwise no pain. Ordered *kali bichrom.* internally and externally. Condition of face and hand improving.

SYMPATHETIC OPHTHALMIA.

Mr. DUDLEY WRIGHT showed a patient who had recovered from severe sympathetic ophthalmia, in whom perfect vision in the affected eye had been obtained.

Sarah J., 46 years. Came to the hospital on the evening of July 27th, with the history of having had two pieces of broken glass thrown at her half an hour before presenting herself for treatment. When seen, two wounds were found, one at the outer angle of the left eye over the brow, and another over the left malar prominence ; both were bleeding very freely. There was also a very marked "black eye," both lids being extremely swollen and closing the palpebral fissure. She made no complaint of pain in the eye, which I unfortunately did not examine. An iodoform dressing was applied to the skin wounds, and she was told to come the next day.

July 29th.—She presented herself again in two days, for she discovered that she could not see with the left eye. The wounds had nearly healed, and on separating the lids, which were still considerably swollen, it was found that the left eye had received a wound in the ciliary region in the upper and outer part, causing a prominent staphyloma, with the iris included in it, causing great irregularity of the pupil. There was extreme congestion of the conjunctival vessels ; there was iritis and there was an effusion of blood into the anterior chamber which filled up its lower half ; there appeared, also, to be some slight dislocation of the lens. The following day no such displacement could be found,

so that if it had been present it must have rectified itself. Dr. Burford happening to be in the hospital at the time saw the patient with me, and advised *atropine* drops (gr. iv. ad. ʒi.) for both eyes and hot fomentations to injured eye. The patient was advised to come into the hospital but refused. She was not complaining of much pain in the eye, but she could not count fingers placed in front of the eye.

The right eye was painful and there was considerable lachrymation.

The next day (July 30th), she said she was feeling better; the pain was less but still shot up into forehead from the right eye. The vision was improved, being able to see fingers placed in front of the injured (left) eye. The blood in the anterior chamber was diminishing in quantity, but the staphyloma was still very prominent, and extreme congestion of the conjunctival vessels still present. *Atropine* drops twice a day and fomentations continued. She came regularly every day and improved so that on August 2nd the note made was "no pain in right eye, sees fairly well with it. Left eye decidedly better; conjunctivitis and iritis much less. Staphyloma still prominent and no change in shape of pupil." She continued to improve with the daily treatment. On August 8th Dr. Burford kindly made an ophthalmoscopic examination and found some detachment of the retina of left eye, but it was difficult to localise owing to intense photophobia. The vessels in the vertical meridian were plainly seen and she had fair perception of light in the left eye. The treatment was continued until the 15th August, nineteen days after the accident, when distinct signs of irritation of the right eye were seen, with great supra-orbital pain. The left eye was so much better and sight was so much improved in it, that it was thought advisable to let her use that eye only, as she still refused treatment as an in-patient and wished to continue work. The right eye was accordingly bandaged and compress applied. She came back the next day about the same and consented to come into the hospital as she could use neither eye now.

Compresses were used for both eyes, and *gels.* 1x gtt. ii. om. 4tis hor. ordered. *Atropine* to be used at night. Under this treatment she steadily improved, the *atropine* being soon discontinued. On September 5th she was discharged cured, with no pain or photophobia, or signs

of inflammation in either eye; the left eye was still much disfigured, owing to the ovoid shape of the pupil, but the staphyloma was much less prominent.

Vision = R.E. $\frac{6}{8}$ & J. 16 \bar{c} + 1.25 = J 4.

L.E. $\frac{6}{36}$ & J. 6. c + 1.75 = $\frac{6}{18}$ & c + 2.75 = J. 2.

Ophthalmoscopic examination showed both discs normal, and no detachment of the retina of left eye.

Dr. ROBERSON DAY exhibited a number of microscopic sections of pathological specimens obtained chiefly in the *post mortem* room of the London Homœopathic Hospital.

DISCUSSION.

Dr. DUDGEON said Mr. Shaw's eye case was very interesting. In some respects it resembled pterygium, but certainly was a case which presented difficulties.

Dr. BLAKE thought it might interest those who had studied hypnotism to hear that the treatment by suggestion in his case had appeared to increase the vocal clonus. He thought much could be done for general chorea by medicines. On Dr. Arthur Clifton's indication of "quiet in sleep" he gave *agaricus* in a case and cured it at once, after *ignatia* had signally failed.

Dr. MOIR was much interested in the eye case. Operations so far had been of no avail. The only thing he thought of was the implantation of rabbit conjunctiva. Commenting on Dr. Buck's case of hemiplegia he said age was no criterion, hæmorrhage may occur at any age.

Dr. DAY had had a similar case to Dr. Buck's in a girl, in which embolism of the left cerebral artery took place and the patient died.

Dr. GALLEY BLACKLEY repeated Dr. Blake's question—Why should cases of *limb-chorea* be considered suitable for a physician, and cases of *lip-chorea* be sent to an elocutionist? Dr. Blackley was inclined to think manual and gymnastic treatment were the best for most cases of chorea. In his experience cases did well under these methods without any medicine whatever. Dr. Blackley said he had seen the case described by Dr. Buck, and quite concurred in his opinion. The mitral bruit is now louder than when Dr. Blackley saw the patient on November 30th. He had also seen another case of the same kind, occurring in a young woman of eight-and-twenty, where recovery after a time was almost complete.

Dr. NEATBY remarked that the condition of the reflexes in Dr. Buck's case of hemiplegia was somewhat unusual. Immediately after the attack they were abolished—the common condition; but for some two or three weeks they were described as normal, the exaggeration of reflex action only being noted after an unusually long period. In other words, the “descending changes” following the cerebral lesion developed much more slowly than is common. In reply to Mr. Wright's question he said that he had used the *silico-fluoride of calcium*, 1 part to 200 of starch.

Mr. WRIGHT, in reply to questions, said his patient was a scrubber. At first she would not come into the hospital but stuck to her work, and came as an out-patient. *Aconite* and *belladonna*, and afterwards *gelsemium* were the chief internal remedies. The case, when in hospital, was treated under Dr. Moir in Mr. Shaw's absence. Mr. Wright asked in what strength Dr. Neatby had used the *salufer*.

NOTES ON INFLUENZA.

BY BYRES MOIR, M.B.

Physician to the London Homoeopathic Hospital.

THOUGH isolated cases of influenza are still occurring, we can now consider the outbreak as over, and while it is still fresh in our memories, it is well for us to compare notes and see what we have learnt about the many interesting points it has presented.

On referring to the text books which give an account of previous outbreaks, we find that they all agree about the chief characters; the following definition, given in Tanner's *System of Medicine*, is a fair sample of the rest. "*Influenza* (from the Italian), so called because the phenomena were thought to be due to the influence of the stars—or epidemic catarrhal fever, or in France '*La Grippe*'—is an epidemic disorder attended with great depression, chilliness, running from the eyes and nose, frontal headache, cough, restlessness and fever."

In the *Annals of Influenza*, published by the Sydenham Society, we have more or less full notes of seventeen outbreaks, occurring since 1510, and there can be no question of the late epidemic being of the same character and from the same cause, though each outbreak has shown slight differences.

The first news of the outbreak that is so far obtainable, is from Tomsk, in Central Siberia, where it was reported to be present on October 3rd by Dr. Clemow, and by the third week of October it was prevalent in St. Petersburg. It had reached Vienna by the end of November, and soon after this date it appeared in Paris. About the second week of December it was prevalent in Stockholm, Berlin and Hamburg, and its general prevalence in London was noted about Christmas. In January it was heard of in Canada and the United States, and in February in India, the Cape and Australia, so we may consider it to have been pandemic.

It is usually stated that the spring is the time for its occurrence, but out of the seventeen outbreaks in the *Annals* nine are mentioned as beginning in the autumn. In nearly all it has been preceded by damp, variable

weather. Sir Thos. Watson says: "Rapid thaws and heavy fogs have in past time been noticed in association with outbreaks of this disease."

In considering the general symptoms of the late outbreak, the first thing that strikes one is the variety both in the character and severity of the symptoms met with. As a definition of the disease I would give the following: "An epidemic specific fever, marked by rapid onset, rise of temperature, frontal headache, pain in the loins and limbs, great prostration of strength, mental depression and loss of appetite, the fever subsiding in from twenty-four hours to three days, often with profuse perspirations, leaving a state of weakness much greater than one would expect. Catarrhal symptoms are frequently found to follow the febrile stage."

In comparing this with previous accounts, the first thing to notice is the DIFFERENT POSITION WHICH CATARRHAL SYMPTOMS HOLD, especially the discharge from the eyes and nose. Dr. Crawford, in his article in Arndt's *System of Medicine*, speaking of former outbreaks, says: "The eyes are sore and dull, and it follows very quickly that they are bathed in the exudation peculiar to the disease. The eyes lachrymate profusely and the nostrils fill, and discharge abundant mucoid secretions which are mostly of an excoriating nature. Accompanying this severe coryza there is a frequent and irrepressible sneezing." I have not myself seen a single case in which coryza was a prominent feature; in many there was marked injection of the eyeball but no discharge, and a few had a running from the nose, but usually after the febrile stage. In reference to this point Dr. Sykes, in his report on the outbreak in St. Pancras, says, nasal catarrh is conspicuous only by its absence.

THE SYMPTOM PAIN has been constant, and often very intense. Nearly all complained of it in the frontal region and the eyeballs. Many say that the eyeballs were painful on any movement; next in frequency the seat of pain was the lumbar region and the thighs; in others the pain was more general, several telling me that they ached all over.

THE FEVER set in suddenly, without distinct rigors, the average temperature being from 101° to 103° F., and only exceptionally rising to 104°; the pyrexia lasted from one to three days, but in many cases the attack was

K

less acute, and lasted longer. My later cases have, in several instances, been of a marked intermittent type.

THE PROSTRATION, often present from the very first, and remaining for a long time, is one of the most typical features. I had several cases of syncope in young men in splendid health before the attack, and several cases admitted to the hospital seem to have dropped at their work.

ENLARGEMENT OF THE SPLEEN was found in a good many cases. In a fatal case occurring in the Hospital in a girl of 13, the spleen weighed $6\frac{1}{2}$ ozs., the normal weight for an adult being 6 ozs.

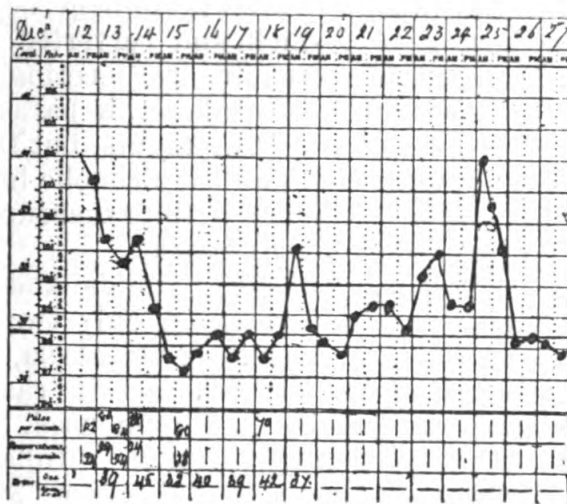
VOMITING of a bilious character with diarrhœa has been very frequent.

Among the SPECIAL SYMPTOMS I should give the first place, not on account of its severity, but from being most common, to BRONCHITIS, and this varied in degree from simple irritation of the upper bronchi, coming on with troublesome cough on the 2nd and 3rd day, to a widespread bronchitis. In the character of the expectorations I noticed a difference from what has been reported before. Graves laid down, as a distinguishing feature, that the expectoration was particularly full of air bubbles. My experience was that the expectoration was in large yellow lumps, containing very little air, the frothy mucus being quite exceptional. There has also been an absence of the dyspnœa which has been so prominent before.

PNEUMONIA was a very frequent complication, and one of the most serious; it was decidedly atypical, occurring in patches at different parts of the lung, the physical signs not being so marked as one would expect from the condition of the patient. "Rusty" expectoration was seldom present, and remissions were frequent, all these points showing that it was really of a catarrhal nature (broncho-pneumonia) and not croupous. But as it was often seen at the very onset of the febrile stage, it could not in every case be due to an extension of the catarrh, but rather caused by the specific poison.

I have the full notes of a case which was in the Hospital under Dr. Blackley, which is so typical of the cases met with that I thought at first of reading it in full, but by looking at the accompanying chart of the

temperature you will be able to see the remittent character of the attack.



Among the respiratory complications I would next mention HÆMOPTYSIS, of which I have had several instances, and when this is associated with catarrhal pneumonia it makes it very difficult to diagnose from a case of phthisis. There is a patient in the hospital at present who illustrates this. He had very severe hæmoptysis, lasting for several days, with slight dulness and some crepitus at the apices. The hæmoptysis has quite ceased, and the condition of the lungs appears to be returning to normal.

THE GASTRO-INTESTINAL SYMPTOMS have been too numerous for me to go into in detail, but there is a type which stands out clearly before me, and of which I have had many instances. The onset is usually very slow and insidious, the fever little, seldom more than 100°F., the patients generally not being bad enough to keep in bed, though their appearance at once shows very great depression; the tongue is thickly coated, the breath foul, there is complete loss of appetite and a tendency to syncope. The bowels are confined, or alternately loose and confined, and in many ways these cases make one think at once of walking-typhoid. These have been the most protracted cases that I have had to treat, relapses have been common, and usually several weeks elapsed before they seemed to be over the attacks, and, often, even then a state of general depression and anæmia lasted longer.

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Several observers have separated a portion of their cases under the nervous type, but in my experience NERVOUS SYMPTOMS have not been prominent, beyond the pains, neuralgia, loss of smell and perverted taste, to which Dr. Molson referred at the last meeting. I have seen very few cases with delirium. One patient in the Hospital was delirious for several nights, but that could be traced to a previous well-marked alcoholic history.

I shall only enumerate some of the EXCEPTIONAL SYMPTOMS which I have come across myself.

Epistaxis. Swelling of the parotids and cervical glands. Eruptions I have seen in only two or three cases; these were not of the nature of roseola, but large purplish blotches on the trunks, and in cases where neither *antipyrin* or *quinine* had been used. Pleurisy of a mild type; peritonitis, cystitis. Inflammation of the middle ear has been common at a late period of the outbreak, and more as a sequelæ. And I would like to ask Dr. Cooper if he noticed any peculiarity in the form of it, as it appears to have been more prevalent than can be explained by the simple spread of catarrh. In several cases that I saw, there was no sore throat—it came on suddenly with slight pain, almost the first thing they noticed being a discharge of blood or pus in the meatus.

THE PERIOD OF INCUBATION seems to be variable, the average being about two days, but with the doubt about contagiousness it is very difficult to decide accurately.

RELAPSES have been said to have been frequent and brought on by too early exposure. I have had a few cases where relapses occurred, and in some of them I am sure that they were not true relapses, but the attack taking on an intermittent type, as they came on when the patient had been strictly confined to bed; and often about the fourth day, when I expected the patient would be able to get up for the first time, I found on my visit a return of fever and to some extent of pains, but not so severe. In only two or three cases have I seen two true attacks with same patient—one of these I am now attending who had her first attack in January.

CONTAGIOUSNESS.—At the last meeting, when influenza was discussed, several members expressed their conviction as to the contagiousness of the disorder, and in my own mind there is very little doubt about it, viz., that it

is capable of being transmitted directly from the sick to the healthy. But that alone will not account for its wide prevalence and rapid spreading; nor can we look upon it as highly contagious; for frequently only one in a household suffered, and, as a rule, it was those exposed to out-of-door influences who fell victims to it, more than those in contact with the sick.

THE DURATION OF THE OUTBREAK in a general form was, roughly, about six weeks—though isolated cases are still occurring, and I have one under treatment at present.

My friend Mr. Gwilliam, F. R. Met. Society, has kindly sent me a few notes on the weather which prevailed in London between November 1st, 1889, and March 15th, 1890.* They illustrate well what we find in the old reports, that damp, variable weather in winter was always associated with an outbreak, and next is worth noticing the unusual heat of January, when the outbreak was at its height. It is also interesting to note that while the progress of the disorder is, roughly, from east to west, the prevailing winds were entirely south west and northerly.

In previous epidemics an outbreak in animals has been reported as occurring either at the same time or previously, and this epidemic has been no exception. Dr. Sykes, in his report mentioned before, says that in the St. Pancras district 927 horses had influenza between the middle of September and the end of January last.

I was anxious to find out whether the disease in horses was similar to the one we had to treat, and to get some reliable information on the subject I wrote to my friend Mr. Hurndall, and he has most kindly sent me a very careful report of his experiences, of which I first intended to give you an extract, but as he is here himself this evening, I think it will be more satisfactory if he will refer to the chief points himself. He also obtained for me a report from Messrs. Edgar Brothers, veterinary surgeons at Dartford, and they have sent me a paper with most interesting clinical cases, and the results of the treatment are most gratifying from a homœopathic point of view.

In examining the reports, the first thing that strikes one is that there was a similar outbreak in 1881 and 1882, more extensive than the late one, while there was then

(* See page 146.)

no epidemic of influenza among human beings. Mr. Hurndall gives a very graphic account of the symptoms, which exactly correspond to the accounts which I quoted at the beginning as typical of previous attacks in human beings, and to which the term specific epidemic catarrh appears to be rightly applied, the œdema of the eyelids, with profuse lachrymal discharge, being a prominent symptom, the only difference in symptoms being that in horses there is a marked œdema of the legs. The nasal discharge is also absent in horses.

The contagiousness from horses to man seems to be disputed. Dr. Sykes, in his report, says: "No single instance could be found in which the disease had been communicated from horse to man; on the contrary, the evidence pointed distinctly against such direct communicability."

Messrs. Edgar Brothers state that there is not sufficient evidence to make a statement with regard to it, while Mr. Hurndall, on the other hand, is quite sure that he caught it himself from a horse.

After you have heard Mr. Hurndall I think you will agree with me in thinking that the outbreak in human beings and horses has been of exactly the same nature. If there had been time I would have liked to have gone in more detail into Messrs. Edgar's cases, as they were persuaded by Mr. Hurndall to try homœopathic remedies, and got splendid results from what he considers the specific for the disease, viz., *arsen. iodid.*, after having tried all the ordinary remedies. He also recommends its use as a prophylactic.

WITH REGARD TO MORTALITY, this, if taken by a percentage, is certainly slight, but the effect on the death rate is very marked. In London the last two weeks of December the death rate was 20.7 and 19.5 respectively; it then rose, and in January was, 4th, 26.5; 11th, 32.3; 18th, 30.2; 25th, 25.2; and on February 1st it had dropped again to 20.9. In Paris the death rate was still more strikingly influenced, rising from 20.2 on November 2nd to 61.7 on January 4th.

In London in January 378 persons were reported as dying from influenza, and 1,384 cases of death from affections of the respiratory organs, above the corrected averages, and this at a time when the weather was so exceptionally mild. In my own practice out of over 300

cases I have had only one death, and that in a child that died two days after admission to the hospital, in whom the virulence of the attack was well marked. I would like each gentleman here to-night, to state how many cases he has lost.

It is impossible to-night to dwell much on THE SUBJECT OF TREATMENT, but certainly influenza is a disease in which, from its manifold symptoms, homœopathy ought to show to advantage, and I must say that my own results have been most satisfactory. Dr. Dudgeon, in his article in the *Homœopathic World*, gives capitally the leading drugs, and I think we can congratulate ourselves when we compare the treatment of the orthodox school. At the discussion at the Medical Society on February 22nd, the use of *antipyrin* and *antifebrin*, about which we heard so much at first, was strongly deprecated, and the only treatment approved of seemed to be simple diaphoretics and rest in bed, with *salicylate of soda* if there were any arthritic complications.

And now, gentlemen, in conclusion, with regard to THE ACTUAL CAUSE OF THE OUTBREAK, we seem to be in quite as much ignorance as when it received the name of influenza. The specific microbe has not yet been discovered, but the general opinion seems to be in favour of its being a great outbreak of malarial poison, that it is propagated through the air, and that it is also more or less contagious.

Opposed to this view, however, is the difficulty that if the infection is caused by the air, it would be chiefly propagated in the direction of the prevailing wind; but it seems to have in some instances spread most rapidly against the wind, and the last outbreak has not differed in its mode of spreading from previous attacks, in spite of the great increase of travelling in the present day. We must, therefore, look for other conditions beside the mere presence of a germ in the air as the determining causes of the actual outbreak.

I quite agree with what Dr. Dudgeon says about epidemic catarrh being a misnomer, the catarrh not being an essential part of the disease, but an accidental attendant on some cases of it; and till we arrive at more definite conclusions about it, the name of influenza, taken in its original sense and not in its more modern meaning, is one which we can continue to use.

DISCUSSION.

Mr. HURNDALL read the following notes :—

The following remarks must please be accepted as the result of personal observation anent a specific epizootic disease affecting *equines*.

The outbreak commenced somewhere about September, 1889, and though not so general perhaps as the previous one in 1881 and 1882, it certainly attacked a very large number of horses in some districts of England, while in others no cases occurred at all. Though more noticeable in large studs of horses than where only a small number of animals were employed, it by no means followed that every large stud was affected, as many such escaped entirely. For instance, the London Omnibus Carriage Company, Limited, which owns some five hundred horses, all under my professional care, had not one case ; it cannot be claimed that this company could possibly ensure protection against infection while the horses were engaged on their journeys, though of course special hygienic precautions were taken in and about the stables.

I should characterise influenza as a specific catarrhal fever. I am given to understand that it may affect various species, but I have never observed it in any but horses and the human subject, and I am decidedly of opinion that it is peculiar to these only, just as *pleuro-pneumonia contagiosa* is peculiar to bovines.

The subjects of this malady experience an almost overwhelming depression ; the animal stands with head dependent almost to the ground, so listless that it is well nigh impossible to induce him to move ; prostrate to a degree ; surface temperature of body and extremities varies, sometimes the skin is clammy and cold, at others dry and hot ; the internal temperature is on an average about 105° F., though I have known it in one case rise not higher than 103°, while in one other it slightly exceeded 107°. The pulse is extremely feeble, in many cases barely perceptible at the sub-maxillary artery ; heart beats from sixty to ninety per minute (normal forty) ; visible mucous membranes, saffron coloured or intensely injected ; the eyelids and the conjunctival membrane tumefied, from which a profuse secretion of acrid fluid is poured forth ; in the greater number of cases the Schneiderian membrane is dry ; in some instances, however, there is a sero-mucoid discharge from the nostrils. All four legs, and especially the hind ones, are painfully œdematous ; and the animal appears to suffer from extreme muscular debility. There is an almost entire loss of appetite ; the mucous membrane of the mouth is dry ; the lips are tumefied ; the throat frequently so sore that in the earlier stage it is with difficulty even fluids can be swallowed ; the *fæces* are dry, hard, pellety, frequently coated

with glairy mucus and very foetid; the urine scanty and tinged with bile.

The symptoms are not unusually nervous, thoracic and abdominal at one and the same time, though generally one or other predominates; judging from the yellow appearance of the visible mucous membranes (which I conclude indicated an involvement of the liver), the abdominal symptoms presented themselves in a more marked degree. Bearing in mind, however, the extreme and prolonged depression, the condition of the pulse, the dyspnoea and other physical signs, it could not be said that nervous and thoracic symptoms were not evident and that to a decided extent. The auscultatory sounds were not in my cases very marked; indeed, I could not name any abnormality beyond a slight roughness at the bottom of trachea on inspiring. I had no cases that went on to bronchitis or pneumonia, a fact due, as I believe, to the selection of the drug, hereafter to be referred to, and to fairly good nursing.

I should have stated in the first place that rigors are by no means constantly observed; they occur occasionally, and that only, so far as I have observed, when the internal temperature is very high.

I am not able to give you any description of *post-mortem* appearances, not having lost a single case; and, so far as I can learn from those of my *confrères* who have been less favoured than myself, death rarely occurs apart from serious complications, such as pneumonia, when the ordinary lesions are presented.

The disease, apart from complications, runs its course under Hahnemann's therapeutics rapidly, and terminates very favourably.

In all my cases, whether the symptoms were nervous, thoracic or abdominal, I have relied on one remedy, and one remedy only, which is *iodide of arsenic*. I have found that this drug is capable of lowering the internal temperature within from twelve to twenty-four hours, from which time it gradually and steadily abates; the hurried and anxious respirations were quieted and strengthened; the swelling of the eyelids became rapidly reduced, and the irritating discharge of fluid speedily lessened; the depression gave place to a bright and cheerful expression; the œdematous swelling of the legs and the consequent tenderness relaxed; the appetite returned and convalescence was soon established.

If the picture of symptoms, so imperfectly drawn, partly from my want of aptitude for such work and partly in consequence of being compelled to hurry over its execution, does not represent, from a Hahnemannian view, a pathogenetic likeness of *iodide of arsenic*, I confess that in my humble

judgment it would be difficult to find one that does ; but to give honour to whom honour is due I am indebted, after Hahnemann, to Dr. E. M. Hale, from whose *Special Therapeutics* I obtained the suggestion respecting this drug.

Moreover, I believe fully with Dr. Hale that this drug is the one remedy in all cases of " true " influenza, and further that it will serve as a most successful prophylactic, and in the same degree as Hahnemann himself claims for *belladonna* as against scarlet fever.

My friend Henry Edgar, M.R.C.V.S., of Dartford, who has had a larger number of cases under his care than I, and who commenced to treat cases according to the prevailing custom among allopathic practitioners, has since tested the efficacy—of course comparatively—of *iodide of arsenic*, with the result, I believe, that he never after had recourse to any other treatment.

That the disease is communicable from animals to man I fully believe, as I feel satisfied that I was myself an instance of it ; that I fell a victim to influenza after visiting what proved to be the worst case that came under my care, I have no doubt ; my temperature was over 105° F., my limbs frightfully stiff and painful, my eyes were almost closed with swelling of lids, appetite clean gone, physical depression beyond anything I can explain in words. I went to bed, took *ars. iod.* 8x. gr. v. four times a day ; remained upstairs two days, came down the third, and was out at work the fourth. This was too soon, I confess, as I had a slight touch of bronchitis thereafter.

Dr. GALLEY BLACKLEY said he had seen amongst the sequelæ of influenza, one very severe case of inflammation of the middle ear, pus formed and burrowed under the temporal fascia, finally discharging slowly by an opening in the external meatus. He had also seen one case of parotitis in consultation with Dr. Cooper. The swelling in this case was so dense and impinged so much upon the left side of the pharynx that he (Dr. B.) inclined to the idea of a new growth being present. It turned out to be pus, however, and was duly evacuated. In another case seen with Dr. Buck and Dr. Maddox, in addition to pneumonia there was inflammation of the left lobe of the thyroid followed by suppuration, the abscess was emptied by means of the aspirator and the patient did well. He (the speaker) had seen many cases of a low form of lobular pneumonia following influenza, several of which had been taken for phthisis by their ordinary medical attendant. These cases had usually done well in the long run.

Dr. DRYSDALE had been struck by the intense coldness of the limbs in many cases, and he had found *verat. v.* of more use than *aconite*. *Eupatorium* had been successful where the

bone pains were prominent. The cases were generally easily dealt with. He had had no fatal cases, and no remaining chronic disease. He had seen no case of infection, and believed the disease to be malarial. In one case pneumonia had supervened and had yielded to the ordinary medicines, but there was disproportionate rapidity of the pulse, which continued in convalescence, and here *laurocerasus* proved useful.

Dr. HUGHES thought all must be glad of this second opportunity of comparing notes. He found homœopathic treatment very effective. None of his cases had given him any anxiety. He found it a pure fever. The fever had been frequently indicative of *gelsem.* (pains in the spine) and of *belladonna*; when *aconite* was indicated it did not act so promptly as *gelsem.* or *belladonna.* Dr. Hughes had seen no instance of personal contagion. He thought it might be contagious when there was catarrh. He thought the disease was analogous to cholera, and he was inclined to connect it with the floods in China. He found it had given homœopathy a good lift, as all the epidemics did.

Dr. CLARKE congratulated Dr. Moir on having made a subject which many thought to be played out quite fresh and interesting. He would only refer to one or two points; and first, in regard to contagion between men and horses. One of his out-patients was employed in a stable where many horses had influenza. His master had the disease, and believed he caught it from the horses. Dr. Clarke's patient was quite convinced that he had taken it from the horses he had to attend to. He rapidly improved under treatment, and on comparing his experience with that of his master, who was treated allopathically, he considered himself much the better off. Dr. Clarke had had two cases in which brain complications occurred. One was in a young woman who was admitted to the hospital. He saw her the day after admission, and found her delirious, and complaining of pain in the head. She would only lie on one side. There was a very offensive odour, which, it appeared, proceeded from the ear. *Baptisia* was prescribed. The following day she became suddenly hemiplegic, and died in about half an hour. At the post-mortem a large cavity was found in one hemisphere of the brain, which had been the site of an abscess discharging fetid pus through the ear. This must have existed a long time. The influenza sufficed to determine the fatal result, but the death could hardly be ascribed to the influenza. It was the only fatal case he had had. The other case was that of an old lady of seventy, who became suddenly attacked one evening with vomiting and headache; these got better when she was taken with lumbago; then this subsided and the

headache returned—right-sided chiefly. One morning he found her paralyzed all down the left side. One peculiar symptom was confusion of mind as to time. She always imagined it was afternoon. *Lachesis* was the only medicine he could find corresponding to this, and under it the symptom rapidly disappeared. On giving another medicine for similar symptoms, and omitting the *lach.*, the symptom returned. *Lach.* was given again, and again it disappeared, and the patient is rapidly recovering the power of her side. Just recently he had had some of the severest cases, one in a young boy who was attacked in almost all parts at once—stomach, liver, chest (bronchitis, pneumonia and pleurisy). He was in a critical state for some days, but made a rapid recovery.

Dr. SPEIRS ALEXANDER (Plymouth) had had about 150 cases in the West of England. Among them were some mental cases, which eventually did well. He had found *aconite* of very little use. *Gelsem.* and *ver. viride* were much more often indicated. In two typhoid cases *baptis.* and *gels.* did something to reduce the temperature, but it was only after *sulphur* was given that the temperature was decidedly and permanently lowered. If catarrh occurred at all, it was after the initial symptoms had been overcome. He gave *arsen. alb.*, which was very efficacious, and had the advantage over the iodide that it was proved. [Dr. Hughes remarked that the *iodide* was also proved, and referred to the *Cyclopædia*.] He believed it was contagious, and he gave cases in proof. In regard to sequelæ he had among others one case, a man who had a second attack quickly following the first, and in another month again he came back with anasarca and albuminuria. *Bryonia* covered the totality of symptoms and improved the case at once, *arsenicum* finally curing him.

Dr. BLACK NOBLE had only one death among some three hundred patients. The patient he lost was a lady aged 79, who had been previously broken down by ill-health. She took pneumonia and simply did not rally, dying in three days. He gave *arsenic*, and attributed his success to its use. He gave it as prophylactic, and took it himself and found it effectual.

Dr. HILBERS had one case that terminated in bad abscess in the ear, and another in which erythema nodosum was one of the symptoms.

Mr. KNOX SHAW had had little personal experience in the epidemic except in his own house. His children were taken with gastric symptoms which he attributed to unwholesome milk, but found afterwards they must have been due to influenza. Mr. Frank Shaw noticed in many of his cases that the pulse bore no relation to the temperature. He had

seen one boy who developed severe otitis externa. He saw in *The Lancet* that in some cases there was pus in the joints. A man in the hospital at St. Leonards, with old ulcer of the leg, was seized with symptoms of influenza, in a few days he developed severe erysipelas of the leg, but eventually got quite well. Referring to the influence of influenza on the death-rate, he found that that of Hastings was increased, also the percentage due to diseases of the respiratory organs.

Dr. BURFORD related one case in which the influenza was conveyed to a house in the country by a gentleman who visited the house, and was attacked by the disease two days after his arrival. Others in the house took it from him. In some cases ovarian dropsy seems to have been stimulated into greater activity by the influenza. A case of severe stomatitis following a second attack of influenza has come under his care.

Dr. DUDGEON (in the chair) remarked on the occurrence of affections of the spinal cord in influenza. He had had two cases. One was in a servant girl. There was pain from the nape of neck to cauda equina. The arms were numb and powerless.

Another case, a lady nearly 70, had influenza early in the year. He was sent for recently, early in the morning, and found the right arm very weak, its muscles had lost all power of co-ordination. The right leg was completely powerless. This continued for several days, but had now subsided. A month before the attack she had very acute pain all down the spine and sciatic nerves. Now that the paresis had subsided, a sort of lumbago had come on.

He had lost no case of influenza, but he attributes one death to the sequelæ of it. A lady who had been under his care for fifteen years with degenerative disease of the liver, got along very well till she took influenza. She was taken with violent pain in the liver. This soon subsided under remedies, but the other symptoms continued and she died. Referring to the disputed point of the infectiousness of influenza, he said, a patient labouring under the disease went to a remote village in Kent where there was no influenza, and the disease broke out in the farm where she was, and spread among those who frequented it.

Dr. MOIR (in reply) regretted that, in the hurry of bringing away his paper, he had left out an important sheet which dealt with otitis. In the hospital there were two cases of general anasarca and albuminuria. Both did well. He summarized the mortality in the experience of the members present, and compared it with the allopathic, which gave a much higher rate of mortality.

NOTES OF INFLUENZA IN HORSES,
1889 and 1890.

By H. EDGAR, M.R.C.V.S.E.

OUR first case occurred on 19th November, 1889; after this the cases rapidly increased. At the beginning of December (2nd or 3rd), between 30 and 40 cases in hand, from this time the epidemic became general, and cases increased to the middle of January when they began to wane, and our last cure was on 28th January, 1890.

We had experience of the catarrhal, pneumonic, enteric and rheumatic forms of the disease. We only lost two cases, in both of which the horses were worked after the disease was developed, and the animals were *in extremis* when we were called in, and they were both old horses.

Our first treatment at the commencement of the epidemic consisted of febrifuge medicine, in conjunction with *carbolic acid* and *liq. arsenicalis*. From this treatment we had three or four cases of relapse, otherwise it was fairly successful; we also tried *salicylate of soda*, *salicine* and *iodide of arsenic* 3x, the latter we considered by far the most successful, as we did not have a relapse, and the animals were soon convalescent. Next to this treatment we found the *sodæ sal.* the best.

Below will be found clinical notes of four or five typical cases with treatment:—

CASE I.

Roan Mare. Mr. B. 30th December, 1889. Temp. 105.6°. P. 72. Œdema of legs; eyes closed from œdema, from which there was a profuse discharge of thick mucus; head hung in corner of manger; moved very stiffly; would neither eat nor drink anything. Gave *ars. iodide* 3x three times daily.

Dec. 31st. T. 103.2°. P. 68. Less œdema; no discharge from eyes; much brighter, feeding fairly well.

Jan. 1st, 1890. T. 100.2°. P. 52. Feeding well; œdema gone.

Jan. 2nd. T. 99.8°. P. 40. Feeding well; convalescent.

Jan. 4th. Continued doing well; went to light work.

CASE II.

Black horse, aged 13 years. Mr. K. 13th January, 1890.

		Pulse.	Temp.	
Jan. 13	10 a.m.	52	103.4°	Anorexia.
	6 p.m.	56	104.4°	Œdema in hind legs.
„ 14	9.30 a.m.	64 heart	104.8°	Eyes closed.
	6 p.m.	64 heart	104°	
		<small>Pulse imperceptible at maxilla.</small>		
„ 15	9.30 a.m.	60 max.	103°	
	6 p.m.	56 „	103°	
„ 16	10.30 a.m.	48	100.8°	
	6.30 p.m.	48	100.4°	
„ 17	9.30 a.m.	44	99.4°	Feeding well.
	6 p.m.	42	99.4°	Exercised, "staggered"
„ 18	9.30 a.m.	42	98.4°	„
	6 p.m.	42	98.4°	
„ 19	12 noon	48	99.9°	

Continued to do well.

In this case *ars. iod.* 3x was given three times daily.

CASE III.

Mrs. K., grey mare, six years old.

Jan. 16	9 a.m.	...	P. 56	...	T. 103.9°
	6.30 p.m.	...	P. 60	...	T. 104.8°
„ 17	9.30 a.m.	...	P. 56	...	T. 104.2°
	6 p.m.	...	P. 60	...	T. 105.2° Anorexia
„ 18	9.30 a.m.	..	P. 48	...	T. 102.2° Feeding
	6 p.m.	...	P. 60	...	T. 105.6°
„ 19	12 noon	...	P. 64	...	T. 104.4°
„ 20	„	...	P. 56	...	T. 102.2°
„ 21	„	...	P. 48	...	T. 100°
„ 22	„	...	P. 48	...	T. 99.9°
„ 23	„	...	P. 50	...	T. 99.8°

Continued to do well.

This case was treated with *salicine* three times daily.

CASE IV.

Mr. K., brown horse.

Jan. 9th. P. 65. T. 104°. Attacked during night; anorexia; eyes partly closed; great stiffness of hind limbs; œdema up to hocks. Partial loss of power of hind legs; at each attempt to walk fetlocks knuckled over as in early stages of azoturea; very lame of one hind leg, difficulty in standing.

Jan. 10th. Condition about the same.

11th. Could stand straight on limbs and walk without knuckling over.

12th. Walking round box fairly well, lameness going off.

13th. Not lame in box; limbs normal excepting œdema. Treatment *ars. iod.* 3x three times daily.

Continued to do well.

CASE V.

Mr. C. Jan. 11th. Brown horse. Had been afflicted with influenza four days; an ordinary case found at 6 a.m. on 11th in great pain, constantly getting up and down; could only stand with difficulty, both hind fetlocks being flexed, and intense lameness with flexion of near fore fetlock; great pain on pressure of flexor tendons. P. 50. T. 100°4 (temperature had been 104° a day or two previously); quite unable to walk, and could only be moved over in stall with considerable difficulty.

10 a.m. Treatment for rheumatoid condition, local injections of *morphia*, and legs well rubbed with *ammoniated oil*, and bandaged with flannel. *Salicylate of soda* and *amm. sesquicarb.* given internally.

5 p.m. In no pain after injection of *morphia*; feeding fairly well; could stand quite easily. *Sod. sal.* continued.

12th. Could stand well and turn round in stall; had not been seen down from previous evening. P. at 45, temp. 100°.

13th. Progressing well, lameness gone, œdema less, appetite good. P. 45. T. 100°. Same treatment continued.

14th. Doing well, and so continued.

CASE VI.

Mr. K. Brown horse.

Jan. 20.	12 noon.	P. 56 small and feeble.	T. 105.6°	Anorexia.
„ 21.	„	P. 56 do.	T. 104.6°	
„ 22.	„	P. 52 stronger.	T. 104.9°	
„ 23.	„	P. 52 do.	T. 104.9°	
„ 24.	„	P. 56 heart.	T. 105°	
„ 25.	„	P. 60 do.	T. 103.4°	

Treatment.—*Salicine* given up to the evening of the 25th, when *ars. iod.* 3x was commenced.

9.30 a.m., Jan. 26th. The horse was lying down, had been so since 1 a.m.; could scarcely stand when made to rise, and only remained up two or three minutes; breathing very heavily, and with great difficulty. P. 50 at heart. T. 102.8°. All four legs very much swollen, and so tender could hardly bear to be touched from elbows and thighs downwards, tendons more particularly painful. Had horse removed into loose box; legs bandaged; gave *ars. iod.* 3x every four hours.

12.30 p.m. Pulse and temp. same, but pulse better, could be felt at jaw; breathing much better; stands much better, and for about five minutes at a time. Eating some hay and speared barley.

6.30. Improvement still maintained. P. 56 "jaw." T. 102.4°. Feeding better; stands better and longer; breathing much relieved; legs less painful.

Jan. 27th, 10 a.m. P. 48. T. 100.6°. 6.30 p.m. P. 44. T. 100.2°. Very much better; standing for an hour or two at a time, walks much better, legs less painful; breathing normal.

Jan. 28th, 12.30 p.m. P. 42. T. 100°.

Jan. 29th., 7 p.m. P. 42. T. 99.4°.

Continued to do well.

In the treatment of all cases the animals were kept warm, and sanitary arrangements made as perfect as possible.

Ars. iod. 3 was tried as a prophylactic on three horses in a stable where influenza broke out. One powder was given daily for ten days, and neither of them failed with it, and kept at hard work continuously.

NOTES ON THE WEATHER WHICH PREVAILED
IN LONDON BETWEEN NOVEMBER 1ST, 1889,
AND MARCH 15TH, 1890.

By G. T. GWILLIAM, F.R. Met. Soc.

NOVEMBER, 1889.

The temperature in this month was uniformly high. The average daily excess of the first 20 days was 3.5°. The last ten days differed considerably one from another in temperature, a warm period (22nd—25th) being followed by low temperature and frosts (26th—30th). The month was remarkable for its very small rainfall (0.76 in.), and it was the driest November in London since 1879.

The direction of the wind was very variable, but S.W. winds were prevalent in the beginning, and N.W. at the end of the month.

DECEMBER, 1889.

During the first 15 days the weather was cold, with some pretty sharp frosts between the 1st and 5th. The mean temperature of the 15 days was 35.2°, and was 6.0° below the average for this period.

From the 16th to the 25th the weather was warm; the average daily excess of temperature was 4.6°. The last six days were cold, particularly the 29th, which was 12.1° below its average; on this day the maximum temperature did not reach 32°.

The prevailing wind was S.W. (17 days), excepting at the commencement and close of the month, when northerly winds predominated. The month was damp, with frequent small falls of rain, giving a total fall of 1.45 inch, which is about equal to the average.

JANUARY, 1890.

After the first three days temperature was remarkably high throughout the month, the excessive mildness of the days being even more exceptional than the warmth of the nights. On *no fewer than 18 days* temperature "in the shade" rose to, and above 50°, a number almost unparalleled in January. The mean temperature of the

28 days ending February 1st was 44.9° , and nearly 7° above the average for this period of the year. The mean temperature of the month (1st to 31st) was 43.5° , and the only Januarys as warm as this *in the present century* were 1834, 1846, 1875 and 1884. The wind was S.W. on 24 of the 28 days ending February 1st. It was a wet month, rain falling on 22 days.

FEBRUARY, 1890.

Cold weather set in on the 3rd, lasting until the end of the month, excepting the four days 16th to 19th, which were in excess of their average temperatures. Frosts were frequent, but not very severe until the 28th, which was the coldest day of the month. The mean temperature of the month was 38.0° , 1.6° below the average for February. The wind was chiefly from the N.E. and N.N.E. (18 days), S.W. on only three days. This was a very dry month, the total 0.84 in. *largely due* to melting snow on the 14th.

MARCH, 1890.

The first four days were memorable for the *extremely severe* frost, and the piercing N.N.E. winds. The *lowest shade* temperatures on the 4th were, 18° at Bayswater, 16° at Regent's Park, 15° at Brixton, 13° at Greenwich, the last being the lowest temperature there in March *since 1845!* Since the 5th temperature has been above the average.

The mean temperature of each week ending Saturday from November 2nd, 1889, to March 15th, 1890, at Lansdowne Crescent, W., was as follows:—

	1889.	Mean temp.
Week ending November 2	...	48.4°
„	„ 9	... 47.1°
„	„ 16	... 47.8°
„	„ 23	... 45.1°
„	„ 30	... 37.9°
„	December 7	... 32.5°
„	„ 14	... 37.5°
„	„ 21	... 43.0°
„	„ 28	... 40.7°

L 2

	1890.	Mean Temp.
Week ending January	4 ...	32.5°
„	„ 11 ...	47.7°
„	„ 18 ...	45.9°
„	„ 25 ...	42.8°
„	February 1 ...	43.4°
„	„ 8 ...	38.0°
„	„ 15 ...	35.7°
„	„ 22 ...	40.2°
„	March 1 ...	35.8°
„	„ 8 ...	36.8°
„	„ 15 ...	43.6°

Mean monthly temperature, Nov.-Feb., 1889-90 :—

	Mean. Temp.	Difference from average.
1889.		
November	44.6°	1.2° above.
December	37.6°	2.3° below.
1890.		
January	43.5°	5.2° above.
February	38.0°	1.7° below.
Average 4 months ...	40.9°	0.6° above.

ON THE FUNCTIONS AND LESIONS OF THE
FALLOPIAN TUBES, IN THE LIGHT OF
MODERN GYNÆCOLOGY.

BY GEO. H. BURFORD, M.B.

Assistant Physician to the Gynæcological Department at the London
Homœopathic Hospital, late House Physician, London Hospital for
Women.

THE history of the development of every department of natural knowledge is that of the continual exuviation of old conceptions and the continued assimilation of new ones. Two rules of procedure the scientific mind keeps ever before it; the first, that every observation shall be capable of continual verification; the second, that every interpretation of natural phenomena shall be altered, expanded, or abandoned, when required by wider knowledge and newer discovery.

The scientific basis of the art of gynæcology is in this latter transitional condition; and to the wider conceptions and the exacter knowledge of recent times I wish to call your attention to-night. But as with a time-limit must be a space-limit also, the special facts and connoted ideas for our consideration will be those associated with the tubes of Fallopius.

Now in no department of gynæcology has recent research been more fruitful, and recent observation more revolutionary, than in the sphere of the Fallopian tubes. Ten short years ago they seemed the most insignificant elements in the pelvic mechanism; to-day, the facts relative to them rival in extent and importance those appertaining to the ovary itself. At the commencement of this decade, not a text-book but passed them over as unimportant or meaningless; and no voice was heard calling attention to the new epoch at hand. Old gynæcology was fast passing into a *reductio ad absurdum*. Wedded to old instruments and old ideas, it had over-

looked lacerations of the cervix, and called every glandular hypertrophy or ectropion an ulcer; it relied for its diagnostic skill on that doubtful instrument the sound, and thought the part of the uterus showed by the speculum to be all that demanded attention; it tapped ovarian cysts, and maimed its hundreds with stem-pessaries. But the epoch-making forces were at hand; and these undoubtedly were the success of abdominal sections, specially in their remote issues; and the perfection of that method of precision, the bimanual. To the former we owe what knowledge we possess of the functions and curable lesions of the tubes; from the latter we derive our exact diagnostic knowledge of the nature and relations of foreign masses in the pelvis. Take away all the facts revealed by these two modern methods, and our usefulness is crippled and our resources barren. To the last decade, then, I give the title of "progressive epoch"; and what it has done for us in the closer knowledge of the Fallopian tubes I must now recount.

We are all familiar with the embryonic stages of growth of these uterine appendages. From the Müllerian ducts and the Wolffian bodies the generative apparatus of later life is chiefly derived; but from the Müllerian ducts alone the uterus and Fallopian tubes are developed. By the eighth week of embryonic life, the Müllerian ducts appear as two tubular processes, adjacent but distinct from each other. At the end of the twelfth week the opposed lower segments of these tubes have fused, so as to form a single tube below, a double tube above. The twentieth week shows a decided differentiation into Fallopian tubes above, and uterus and vagina below. From this time to the termination of foetal existence, the tubes gradually assume a rectangular relation to the uterine axis, the *corpus uteri* becomes well marked, and, finally, in the angle of union the deposition of tissue forms the thick vault of the *fundus uteri*. The development of the genital canal is now complete.

Abnormalities may arise from the arrested development of any part of the evolving genital tube (lower, middle, or upper third), or from the non-absorption of the septum between the tubes, in whole or in part.

II.—*Structure of the Tubes of Fallopius.*

Of prime importance is it to remember that the Fallopian tubes are only partially surrounded by peritoneum; this fact is essential to know in tracing the natural history of some ectopic gestations and hæmatoceles. Slung in a meso-salpinx, one aspect of the tube is directly related to the connective tissue of the broad ligament; while its outer and free extremity is possessed of a moderate range of mobility, permitting its adhesion to other viscera, its dislocation in tubal lesion, and its close application to the ovary as the climax of a series of muscular movements at the time of the period.

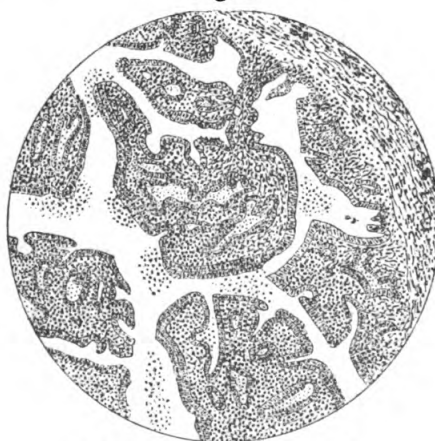
Of the three tubal tissue-tunics, the inner is the only one possessing characters for remark. The outer one is the usual peritoneal investment; the middle, a mass of non-stripped muscular fibre, arranged in a thick circular and a thin longitudinal layer; but with the inner lining centres the chief interest of the tube. *In this epithelial sheet are conjoined several extraordinary anatomical anomalies.* Although freely secreting mucus, glands are entirely wanting in it; and the usual goblet or chalice cells are conspicuously absent. Its surface is thrown into a highly complex system of plications and reduplications, whose function is only to be explained on the theory of increase of secreting surface. And the superficial cell layer of this secreting membrane is continuously ciliated, until the free end of the tube is reached, when the epithelium suddenly becomes squamous, and the tubal lumen debouches into the serous cavity.

Fig. 1.



Transverse section of a single plica from the Fallopian tube.

Fig. 2.



Transverse section of a Fallopian tube.

Much controversy has raged round the question of glands or no glands in the tubes of Fallopius. Because its contents were found to be mucous, therefore it ought to have glands; if it ought to have them, they must therefore exist. But the most assiduous histological hunt failed to disclose more than a favourable appearance here and there which might fairly be construed as glandular. Bland Sutton in England, and Hennig in Germany, have taken the question up, but seeking for glands where none existed have left the matter much as they found it. Speaking of this topic, that most distinguished of Vienna histologists, Prof. Weichselbaum, declared to the writer that prolonged observation had entirely failed to disclose glandular structures in the tubes. And the gynecologist at the Poliklinik, Prof. Lott, plainly declared that the whole epithelial lining of the tube was a secreting sheet, and in this view of Lott's we entirely coincide.

Now, the unification of these conflicting views is easily effected, and the cause of the mental confusion is a very interesting instance of Bacon's *idola tribus*.

The idea of glands, as such, in the tubes is an entirely foreign and imported one, not derived from observation, but from analogy with other secreting structures in the body. What is the necessary antecedent of mucous secretion? Obviously, cells specialised for such function: *the arrangement of secreting cells in pockets (glands) bearing no necessary relation to the function of secretion*, but bearing a very distinct relation to the extension of surface requisite for the massing of secreting cells in sufficient number. How are the secreting elements in mucous membranes usually placed? They are stored away in crypts, glands or pockets, partly for protection, partly to reduce the surface area of membrane to a workable minimum. How are secreting cells arranged in the Fallopian tubes? Here no protection from transmitted contents is necessary, and the requisite extension of surface area is obtained by the device of plicæ. What glandular crypts are to ordinary mucous membranes, plicæ are to the Fallopian tubes, and the diagnostic criterion of secreting cells, packed in a tract of squamous epithelium, is that they differ in epithelial type from those cells that merely line. The cells in the Fallopian tubes in and out of plicæ are perfectly homo-

geneous in character, and no differentiation into lining and secreting elements is here found.

III.—*Functions of the Fallopian Tubes.*

Until quite recently, our knowledge of tubal functions was scant; and had the further character of being nearly entirely erroneous. Before abdominal sections with their opportunity for observation on the human female took the place of vivisections and other investigations on animals, our conjectures as to the functions of these ducts were entirely deduced from facts derived from the lower animals in a feral or a mutilated state. For human female, read dog, or cow, or pig, and the observations stand on their own basis; but here as elsewhere, the bold reading of similar functions from structures that only resemble, and in conditions that are not even similar, has been prohibitive to progress.

The institution of Fallopian tubes as oviducts to a uterus begins only in mammalia. The fusion of the Müllerian elements to form single uterus and single vagina is quite a late feature in comparative embryology. A break in continuity is established between ovary and oviduct; a single uterus is present, and the Fallopian tubes, bent at a right angle to the uterus, are only in occasional contact with the ovary. These facts seem to be mainly relative to the erect posture, and further to limit the prolific character of female organisms so notable lower in the scale.

At the time of the period the Fallopian tubes undergo such muscular movements as eventuate in their application to about a third of the surface of the corresponding ovary. The fimbriæ are spread out and turgid with blood, and the contact is thus very exact. This has actually been seen in the living human subject. The ovary may not have a follicle sufficiently ripe to burst and discharge its ovum; or the tube may not grasp the ovarian area where such follicle exists. Both these facts also have been observed in the living human subject.

Should an ovum be successfully dehisced into the tubal lumen, the cilia of the epithelium propel it down the tube into the uterine cavity. How long this takes we do not know; and conjectures as to the exact period are not founded on sufficiently precise evidence to be accepted. The same direction of motion of the cilia pro-

elling the ovum, also is said to tend to prevent the access of sperm elements into the tube. Probably this is so. The muscular elements of the tube can take but little part in the propulsion of the ovum; for a very little consideration of the complex foliations of the tubal lining will show this to be impossible. Obviously, if the ciliary mechanism in whole or in part be destroyed by disease, the ovum remains *in situ*, the ingress of sperm elements is not obstructed, fertilisation takes place in the tube, and a tubal pregnancy with all its lethal issues results. To complete the picture, in tubes sealed by adhesion or impacted by inflammation, no conception occurs, for no ovum is transmitted.

Does this sketch environ the functions of the Fallopian tubes? Until the last few years, the reply would have been yes; but recent progressive work has revealed an area of influence not yet fully worked out, of quite as extensive and important a nature as oval propulsion.

The common but quite erroneous assumption has been that the ovaries initiate and condition menstruation. The work of recent years has incontestably proved that the ovaries have little or nothing to do with menstruation; that this function is solely and wholly that of the uterus and tubes. To discuss this question would require more limits than time can afford, and I must perforce content myself by making the following serial statements; each and all of which are legitimate deductions from observed facts:—

1. Menstruation has no analogue in the lower animals, and no similar function exists even in the higher apes; it is essentially the outcome of textural conditions strictly relative to the erect posture, and becomes accentuated as civilisation advances.

2. The periodicity of menstruation bears not the least necessary relation to the periodicity of ovular dehiscence; and being rhythmic, is probably ganglionic in origin; bearing some relation to the time-limit of existence of the exuviated uterine material.

3. Entire destruction of the ovaries by disease, or complete removal by operation, in many cases has not the slightest influence on the regular performance of the menstrual function.

4. Entire removal of the tubes alone permanently arrests menstruation in 90 per cent. of operation cases;

lesion of the tubes very frequently causes increased menstrual flow.

5. The maturation and rupture of ova from Graafian follicles goes on before puberty, in cases of primary or secondary amenorrhœa, and during lactation; that is, in cases where menstruation has never been established or has become suppressed.

6. Menstruation commences in the tubes; is most profoundly affected by removal of this starting point; but certainly is not caused by tubal presence.

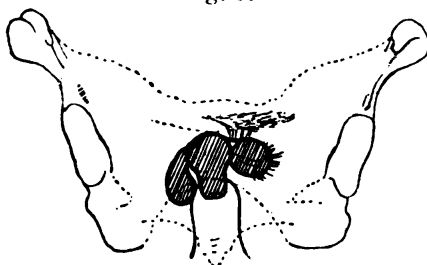
To summarise, all we can say is that removal of the ovaries alone has little influence on menstruation, that removal of the tubes alone has a very considerable influence on menstruation, and that in some cases removal of ovaries, tubes, and great part of the uterus itself does not arrest the regular performance of this periodic function. This proven occasional independence of organic integrity, and its rhythmic character, tend to turn our investigation to the nervous centres for its initial impetus; and if one may forecast, it is possible that like the vaso-motor filaments round an artery regulating its functions, there are nervous plexuses in and around the tubes and ovaries and uterus conditioning the monthly flow; but that the uterine and tubal filaments and centres have a preponderating influence over the ovarian ones in relation to the performance of menstruation.

Tumours, Neoplasms and Inflammatory Lesions of the Fallopian Tube.

First in the order of frequency come inflammatory lesions of the tube. These have been observed, figured and described by the older pathologists at intervals for the last two centuries, and yet so little were their observations considered, that these had fallen into oblivion until the revival of successful abdominal sections. Even so recently as 1881, the existence of such conditions, except as extreme rarities, was publicly scoffed at by the then leading English gynæcologist. All the standard text books, up to a couple of years ago, spoke of them as insignificant, uncommon or unknown. And yet a mass of literature and exact observation was accumulating in Europe and America during the decade, demonstrating to conviction the frequency and the

gravity of these pelvic disorders. The real secret of so much ignorance and so much baseless denial was the inability to perform an accurate bi-manual. I have seen, while in Vienna, the professor, after a careful bi-manual, sketch in each case the relative position, direction and contour of the whole pelvic contents. Such developed *tactus eruditus* as this would have saved many reputations in and out of England. And only among those who by the most painstaking assiduity have achieved a degree of perfection in this mode of procedure are the secrets of the pelvic excavation cognisable.

Fig. 3.



Transverse-vertical section of pelvis with chronic inflammatory deposit and tubal lesion.

Lesions of the tube, the direct result of acute or chronic inflammatory processes, begin in the vast majority of cases in the inner mucous lining of the tube. And curiously, some form of specific inflammatory process is usually the initial feature. The septic inflammation of post abortional or post parturient lesions travels up the mucous lining of the tube, in continuity with the inflammation of the uterine inner coat; the lining epithelium is destroyed, the subjacent tissues are affected to a varying depth, and the process extends by direct continuity through the open end of the Fallopian tube into the peritoneum of the pelvis. Many exanthemata are characterised by pelvic lesions of a precisely similar nature, especially small pox and scarlatina, and many an obscure pelvic trouble, or an early climacteria may be traced to an overlooked pelvic complication occurring in an exanthem after puberty. But by no diseased process is tubal inflammation so certainly or so constantly caused as by gonorrhœa. Often with no very marked early symptoms the tubes finally become the permanent seat of gonorrhœal

crippling. Beginning with a catarrhal inflammation of the tubal lining, the epithelial coat is cast off and the proliferation of granulative tissue underneath predisposes to adhesion of the tubal walls at different sites. The infiltration of leucocytes into the muscular layer eventuates in a loss of tone which arrests the vermicular movements of the tube. The loss of peristaltic muscular movements, the irregular adhesion of opposed walls of the tube, together with the presence of the catarrhal process necessarily terminate in the formation and retention of secretion, the distension of the tube, and the establishment of a cystic tumour.

The extension of the process through the open end of the Fallopian tube brings about an inflammation of the pelvic peritoneum, whose clinical features mainly agree with pelvic peritonitis not beginning in the tube, but starting as a primary serous affection. One marked clinical point may be mentioned : that inflammation of the pelvic peritoneum secondary to inflammatory affections of pelvic viscera, very seldom causes general peritonitis ; the virulence is almost always limited to the pelvic serous membrane.

However induced, whether primarily or secondarily, inflammation of the serous covering of pelvic viscera is even more disastrous in its results than the same process beginning in the mucous membrane. What is the natural history of the process? From the primary irritation of tubercle or the poison of acute rheumatism, or the secondary sepsis of gonorrhœa or abortion, an active inflammation is excited in the serous membrane, a large quantity of plastic effusion with or without pus is poured out, and all the pelvic organs are fused, matted, welded together as though plaster of paris had been poured among the organs in the pelvic excavation. Vaginal examination shows the floor of the pelvis as rigid as a deal board, the uterus fixed in the middle immovable, the functions of bladder and rectum attended by constant urging and a persistent pain, the floating contents, *i.e.*, tubes and ovaries fused and fixed in just that position in which the exudation found them. As the inflammation subsides, the exudation shrivels and contracts, the bladder and rectum constantly dilating and contracting, preserve more or less of their integrity, but the uterus, tubes and ovaries are doubled up into a

confused mass, adhering to whatever the exudation has affixed them, and finally becoming the seat of so much pain and irregularity of function that nothing short of their complete removal brings any permanent relief.

Exactly such a case as here sketched I have seen once and again in consultation with Dr. Clarke; the history in this case is conclusive, and the left ovary, fixed by adhesion to the rectal wall, is the source of constant and considerable suffering, as the tender mass projects into the calibre of the bowel. Precisely such pelvic conditions I have recently seen in a patient through the courtesy of Dr. Cooper, and although the history is not so clear, the local conditions leave no room for a shadow of doubt as to the preceding processes. And in our externæ gynæcological department I have a patient sent to me by Dr. Moir, whose pelvic involvement, induced by infection after marriage, is marked; but whose symptoms have been markedly lessened by the appropriate therapeutic measures.

Whether manifested chiefly as lesions within the tube, whose marked features are tubal degeneration and cyst, or as lesions without the tube, whose principal characters are adhesion, contraction and cicatricial distortion of the tubes, the results are the same—total impairment of function and permanent and crippling suffering.

I should like to have treated the symptoms in detail, but these are protean. I must rest content with stating that in the acute stage, if there be one, the conditions are those of acute pelvic-peritonitis, and as the state gradually becomes chronic the most strongly marked features are persistent pain with pre-menstrual aggravations, and profuse or scanty, often irregular, menstrual flow. A life of chronic invalidism is the result, and thousands of unfortunate women are now cooped up in back London drawing-rooms, bearing the imprisonment with exemplary patience and resigned to their fate, for whom nothing short of entire removal of the much impaired organs will bring permanent relief. Symptoms can be, and often are, alleviated by the indicated drugs, but the one prime element standing out in all these cases is the *persistent recurrence* from time to time of the most troublesome symptoms. The snake may be scotched: he is difficult to kill. This clinical feature of recurrence, however

well the patient may seem, is never wanting, and in an extended view of the history is always found to be existent again and again; the intervals grow shorter, the condition more permanent, until, finally, a status of constant, scarcely remediable discomfort and pain is established, from which neither poppy nor mandragora, nor all the drowsy syrups of the East, can release with a tithe of the certainty that abdominal section and removal of the affected mass can do.

Much that is palliative may, however, be accomplished by homœopathic therapeutics. These must be varied according to the stages of the case and the special symptomatic indications. In the recent acute stadium, *belladonna* will often prove most serviceable for the exudation; and vesical symptoms frequently yield to it, or to *terebinthina* or *cantharis*. Later, when the remanent lesion has to be treated, as the symptoms are protean the remedies vary also; but in my practice I have seen excellent results from polychrests like *sulphur*, *lycopodium*, *thuja*, *nitric acid*; and later, *china* and *ferrum*.

Cystic Distension of the Tubes.

When the tubal lumen is occluded from adhesion of parts of the canal, or twists, or strangulating bands from exudation and contraction on the serous surface, retention of altered secretions occurs. The cause of retention is obvious; and the alteration of the secretion is obviously probable also. If the secreting elements in the tube have not been wholly destroyed, nor the inflammation sufficiently acute to generate pus, the opposite raw inflamed areas of the narrow lumen adhere, secretion collects between the areas of stricture, and this may accumulate in some quantity till the obstructive power of the stricture gives way, or the distensible limit of the tubal cyst is reached. This forms the condition known as hydrosalpinx. This of all forms of tubal cyst is the least noxious; if it burst into the peritoneal cavity it causes no irritation, and some operators actually puncture and allow the cyst contents to dribble away into the pelvic excavation. Pressure symptoms with more or less pain are the conditions which call here for active treatment; and the exact nature of the contained fluid can usually only be diagnosed after a view of the cyst gained by abdominal section.

But inflammatory processes do not always end with the exudation of serum. When leucocytes undergo hasty proliferation, and necrosis of these "tissue elements without organisation" occurs, then is formed the unpropitious fluid pus. And pus, collecting in the lumen of the tube, discharges itself in the direction of least resistance when the tension of accumulation overcomes the resistance of obstruction. The tube in its course has a calibre not exceeding that of a probe, and inflammatory swelling causes sufficient obstruction to give rise to fluid accumulations of low tension. But acute catarrhal processes, causing destruction of superficial cellular layers, eventuate in the adhesion of opposed bared areas, and so are formed one or more loculi, containing fluid, and separated by areas of stricture, completely barring the exit of tubal secretion. While this process occurs in mild degree as an hydrosalpinx, it always exists when the local disturbance has caused the formation of pus, and to these loculated collections of pus, the term "pyosalpinx" is given. Here, as in the former condition, the tube distends more and more, until the limit of expansion is reached or some traumatic influence determines rupture. Irruption into the peritoneum under these conditions is always fatal, unless the pus be speedily removed by flushing.

The relation of gonorrhœa to pyosalpinx has so recently been ably and exhaustively dealt with by Dr. Blake that I have no intention of discussing the topic at length, only stating that I thoroughly agree with him concerning the frequency with which venereal infection in woman eventuates in pyosalpinx, and the fact that pyosalpinx is most frequently caused by gonorrhœa.

But curiously, in myomata, very frequently tubal cysts of the nature of pyo- or hydrosalpinx are found. Dr. Thomas Keith alludes to this fact, and my experience distinctly corroborates it. (Case seen for Dr. Cooper narrated.) With these myomata are often conjoined ovarian and tubal lesions, as *post or propter hoc.*, and in operating, removal of appendages for actual disease is quite as much required as removal for secondary influence on the uterine tumour.

Fig. 4.



Cystic degeneration of Fallopian tube.

Before leaving pyosalpinx, I must call attention to the well marked diathesis that often accompanies this lesion. Whether gonorrhœal or simple in initiation, a relapsing anæmia with varied local symptoms is a leading feature, and is the more pronounced in proportion as the cyst is specific in origin. (Illustrative cases cited.)

The remaining tubal distension with which the pelvic diagnostician has to treat is hæmatosalpinx, or the accumulation of blood, in various stages of retrograde metamorphosis in the tubal lumen. This, after acute catarrhal processes and the frequent erosion of the vessels coursing in the walls of the tube, is not difficult of explanation. But in the last few months an important monograph from Germany has directed attention to the frequency of hæmatosalpinx as a factor in atresia of any part of the genital canal, tube, uterus or vagina. This monograph, which I lay before you, deserves the most careful consideration. It shows that often in the frequently fatal results of incision for menstrual retention, the real cause of death is not negative pressure in the abdomen and suction through the tube, as suggested by Matthews Duncan and others; but actual tubal rupture where the oviduct together with the uterus has become enormously distended, and rupture following the altered conditions of parts after incision causes death. It also shows by frequently cited cases the prime necessity of not allowing menstrual retention to continue; inasmuch as each patient exposes herself to a sudden and disastrous end, when earlier and wiser measures would have ended more happily.

The diagnosis and the treatment of tubal cystic swellings I must treat in brief. The diagnosis can only be established by the bi-manual. Fluctuating swellings, conical in shape and twisted, inclined to one or other parametrium, and often in Douglas, together with marked

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evidence of other inflammatory pelvic affection at some time: these are the principal proofs of the existence of tubal cyst. But in the experience of the most accomplished diagnosticians, conditions of marked tubal distension with serum or pus may exist which escape altogether the usually accurate detection of the bi-manual.

Pain may be present or absent, but usually in the history the inception of pre-menstrual pain, gradually increasing in duration and often entirely ceasing during the period, is observed. (Case seen for Dr. Epps cited). Other local troubles, chiefly dragging pain, are usually observed, and almost without exception marked increase of the menstrual flow. Bladder and rectal troubles are often superadded, and radiated pains from the affected side further fill out the picture.

For treatment, the only satisfactorily worked out plan is abdominal section and complete removal of the crippled and dangerous structures. This is eminently safe and satisfactory, although relief consequent upon removal of the parts affected may be postponed for a few months before becoming complete. The medicinal treatment on the homœopathic plan has hitherto been limited to the palliation of concomitant troubles. Pain and hæmorrhage, anæmia and associated conditions, these plainly call for the oft-tried and oft-successful *simillimum*. But in my experience the tendency to recurrence, to frequent relapse after apparent relief, indicates a more radical treatment than lies within the sphere of drugs, while in undoubted pyosalpinx there is no alternative procedure to complete removal, by section, of the dangerous cyst and aversion of the otherwise necessarily fatal termination.

Tubal Gestation.

Had the "progressive epoch" comprised no brilliant successes beyond those achieved in the sphere of tubal gestation, its advent would still have been phenomenal. Anterior to this time, the whole mass of information we possessed on the subjects of its pathology and treatment was nebulous and vague. Classical descriptions of the catastrophe and its *post mortem* appearances date from the 13th century onward, and yet, through the centuries the hour and the man had not arrived. The influence of pre-potent professional authority, the inability

to see or interpret facts, except through the mental medium of others, produced the usual unblushing and persistent professional copyist. Erroneous and incomplete observations were handed down with a faithfulness and tenacity suggestive rather of the library than of the bedside, of the plagiarist than of the original observer. Even down to times so recent as those of Matthews Duncan and Emmet, the distinction between intra and extra peritoneal hæmatocele, and the frequency or rarity of peritoneal encystment after intra peritoneal hæmorrhage were confused and confounded. Authorities, such as Barnes in England, Emmet in America, Schroeder in Germany, even these spoke with limited information and an uncertain sound on the nature and relations of tubal gestation and pelvic hæmatocele. But the work of the true scientific observer, which reduces complexity to simplicity, and unifies ideas similarly based, but divergently developed, has of late given a coherence and serial relation to a vast but amorphous mass of facts, the product of previous work. To fully grasp the enormous advance thus made in the last decade, we will consider in detail the subject of tubal gestation.

A.—The Causes of Tubal Gestation.

When a ripe ovum, extruded from its follicle, enters the pavilion of the Fallopian tube, its arrest whilst in the duct is a contingency fraught with danger, in that fertilisation and development may occur *in situ*, the fertilised ovum adhering to the lining membrane as in the uterus. A bald statement such as this requires elaboration, for were no mechanism at work to ensure the extrusion of the ovum, before fertilisation, from the duct, tubal pregnancies would be as common as uterine ones. The sole adequate mechanism is that of the cilia of the superficial cell layer in the tube; for these fulfil the double and equally necessary function of extrusion of the ovum and barring the progress of the fertilising element. Therefore any process causing destruction of the ciliated lining of the tubes places these ducts in exactly the same position as the uterus for embryonic development. Clinically this is verified; for the previous history of tubal gestation usually indicates some prolonged uterine affection of a catarrhal nature, and sterility for some years, finally eventuating in ectopic gestation. Parry, whose work I

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lay before you, insists on this serial connection; and places great stress on the prolonged reproductive inertia preceding ectopic gestation. Either some time elapses after marriage before embryonic development, or a parturition is followed by a prolonged history of uterine trouble and sterility, finally terminating in some form of non-uterine gestation, usually tubal. Any cause of desquamative salpingitis, specific or simple, after delivery, or as a sequel of catarrhal lesion extending to the tubes, or as most frequently, associated with a sub-acute pelvic peritonitis of obscure origin, any causes such as these may place the subject of these ravages in a most critical condition as concerning the great pelvic function. To sum up, *tubal gestation can never occur in perfectly normal and healthy tubes; that any cause of tubal lesion involving the loss of the ciliated lining places the tubes on the level of the uterus for embryonic development; and that usually a prolonged history of pelvic trouble and sterility precedes the abnormal gestation.*

B.—The Clinical History of Tubal Gestation.

As already stated, a prolonged uterine or pelvic lesion, with catarrh of the tubes, or desquamative salpingitis, is the necessary precedent for this form of ectopic gestation. If not a primipara, a history of some past puerperal trouble, dragging its weary length over years, with concomitant sterility, are usually the elements in the history. At length the scene changes, the period ceases for two or three months, and the process of gestation may continue unmarked by any symptom in any way, shape or form indicative of the impending catastrophe. Suddenly, at any time from the first to the fourth month, the patient is seized with violent abdominal pain, becomes rapidly collapsed, and presents all the classical signs of internal hæmorrhage. The further progress of events depends entirely upon the direction of rupture, which, as we shall see later on, is again conditioned by the aspect of the tube on which the placenta is growing. If, and here I must anticipate a little, if the site of rupture of the tubal gestation sac is opposite that part of the tube not covered by peritoneum, *i.e.*, the part in contact with the cellular tissue of the broad ligament, the contents of the cyst, and the free bleeding from the placental sinuses ruptured,

issue into the broad ligament cavity. Now, as this is but a potential cavity, and its layers capable of but limited distension, the bleeding is soon checked, and the chief risk incident to rupture averted. Now that the embryo lies between the layers of the broad ligament, three possible issues confront it. It may, freed from all connection with uterus or appendages, continue to develop as in normal gestation, expanding the broad ligament over it, and going on to term, at which date a viable child may be removed by abdominal section. On the other hand, the embryo thus violently perturbed by rupture may die, the amniotic fluid be absorbed, the foetus and placenta disappear, and the blood clot undergo the well-known series of changes eventuating in resolution. Or suppuration of these materials may occur, a true broad ligament abscess, and the pus seek vent in one of the following situations: oftenest through the rectum; frequently, through the posterior *cul de sac* of the vagina; less frequently, through the bladder; and very rarely, through the umbilicus.

Or after a variable period of development between the layers of the broad ligament, the pseudo-cyst thus formed may rupture, the contents be discharged into the peritoneal cavity, and the issue of events be either death from hæmorrhage or peritonitis.

To recapitulate, the conditions preceding rupture of the tubal gestation sac are:—(1) Previous uterine and tubal catarrh, causing loss of the ciliated epithelium of the tube; (2) In the married state, a prolonged antecedent period of sterility; (3) A periodic discharge persisting, but irregular and profuse, only occasionally either normal in nature or entirely absent; (4) Usually an entire absence of pain or discomfort, the patients frequently believing that gestation has not begun; (5) From the fourth to the twentieth week a sudden and violent change, caused by rupture of the gestation sac, and which most frequently causes the death of the embryo; occasionally, however, with survival and continued growth of the latter.

The events at the time of rupture and ensuing therefrom are:—

1. Primary rupture of the tubal gestation sac into the free peritoneal cavity, with almost certain death from

hæmorrhage; or into the broad ligament, with a rapid cessation of serious symptoms.

2. Rupture into the broad ligament may eventuate in—

- (a) *Death of the embryo*, with absorption of embryo, blood clot, amniotic fluid, and placental tissue.
- (b) *Death of the embryo*, with partial absorption of material, resulting in suppuration, pus opening into rectum, vagina, bladder, or umbilicus.
- (c) *Continued development of the embryo* in the pseudo-cyst formed in the broad ligament, a viable child being removed at term by abdominal section.
- (d) *Continued development of the embryo* for an indefinite time in the broad ligament, terminating in

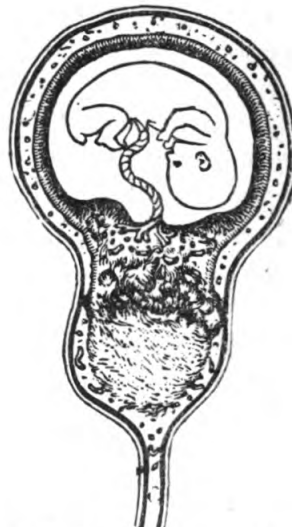
3. Secondary rupture of this distended broad ligament cyst into the free peritoneal cavity, with the risks and results of primary rupture.

Fig 5.



Tubal gestation rupturing into peritoneum.

Fig. 6.



Tubal gestation rupturing into broad ligament.

C.—The Results of Tubal Gestation.

These have been incidentally reviewed in the preceding section. The necessary result of this form of ectopic development is rupture of the tubal sac at some period between the fourth and the twentieth week of pregnancy; and the most usual result of this rupture is death from

intra-peritoneal hæmorrhage. To show the possible amount of bleeding, I cite the following case from Tait: "In November, 1887, Mrs. A. was seized with pain in the abdomen, followed by vomiting and faintness. An opiate relieved pain, but collapse followed, and death ensued the same evening. At the *post-mortem* the abdomen was found full of clots, estimated at from 70 to 80 ounces. The left Fallopian tube had ruptured and was full of clot; an ovoid swelling of it proved to be a tubal pregnancy." Primary rupture of the gestation sac into the peritoneal cavity is almost uniformly fatal. The same authority remarks: "I have never seen a case of suspected rupture, or one in which we suspected an intra-peritoneal effusion of blood, recover if left alone."

Rupture into the broad ligament is not nearly so serious an occurrence. The majority of cases with this termination constitute the bulk of broad ligament hæmatoceles. The contents of the sac and the products of rupture are absorbed, and nothing beyond some cicatricial tissue remains to indicate the occurrence, or the traumatism may be too severe to pass off thus lightly, and suppuration may ensue, constituting a broad ligament abscess, finding vent into some hollow viscus, or appearing externally. These cases drag on a weary length, and frequently drainage by abdominal section offers the only certainty of a radical and permanent cure. Or again, the effusion of blood at time of rupture may be insufficient to kill the embryo, which develops in the cellular contents of the broad ligament, and may go on to term, giving rise to much misgiving on the part of the accoucheur as to the exact condition of matters. Or again, the pseudocyst may become too distended for its further expansion and may rupture into the peritoneal cavity, of course carrying with it all the fatal possibilities of primary rupture of the tube directly into the peritoneum.

D.—The Causes of Rupture of the Gestation Sac.

Primarily, the Fallopian tube does not seem to be capable of indefinite distension, and usually reaches its limit of expansion early in the history of gestation. The increasing tension of contents therefore ensures its rupture at the point of least resistance. This is almost always determined by the site of the placenta. The villi

of this rapidly growing body cause thinning and almost perforation of the sac wall, the vascularity of the parts increases, and some temporary increase of intra-abdominal pressure is the final element in the induction of rupture.

E.—The Treatment of Tubal Gestation.

(a). *Before rupture.*—It is not at all expectable that treatment of tubal gestation before rupture of the sac can be generally applied, on account of the entire absence or frequent ambiguity of the symptoms and physical signs. The symptoms may exactly simulate those of ordinary pregnancy, and rupture be the first event indicating the actual state of things, or the physical signs may be those of tubal occlusion, for which tubal gestation has been mistaken by the most competent diagnosticians. When, however, it happens to be diagnosed anterior to rupture, three alternative methods of procedure present themselves, (1) Arrest of foetal life by electro-puncture; (2) Arrest of foetal life by morphia injections; (3) Abdominal section and removal of the sac and contents *en masse*. The first and second methods are entirely inadvisable, because the balance of evidence is in favour of the placenta continuing to grow after foetal death, and so very little is gained by these proceedings. Considering the mortal risks hourly run by the gravida in these circumstances, and the certainty of rupture at some date, and at the longest abdominal section for removal of a viable child at term, there is no room for difference of opinion on the subject of ablation of the gestation sac as the safest and wisest plan.

(b). *After rupture.*—If rupture into the peritoneum has occurred, section for tying the torn vessels and removal of masses of clot from the peritoneum is the procedure imperatively called for, without this a fatal result almost inevitably ensues. If rupture has occurred into the broad ligament, *quieta non movere* is the obstetrician's rule, as most of these ruptures with effusion spontaneously heal. Those that go on to suppuration may be dealt with afterward.

Such are some of the facts and generalisations which the adoption of methods of precision in modern gynæcology enables me to lay before you to-night. The harvest truly is plenteous, but the labourers are few. Until we

know much more of the secret of processes which eventuate in gross lesions, until we have fuller acquaintance with the laws of heredity, of environment, of disease, we cannot reach the high ideal of our art: To prevent as well as to cure—to plan a *restitutio in integrum* rather than a regrettable, if necessary, mutilation. But the laws of therapeutics cannot be most usefully applied until this rich field of knowledge has been explored much more extensively; and it is to homœopaths in particular, who probably hold in their hands the key of the situation, to play that part in modern progress which their traditions and their methods so distinctly mark out for them.

DISCUSSION.

Dr. MOIR thanked Dr. Burford for his paper, and for the clear way in which he put the subject before the Society. It was quite true that within the last ten years all this subject was new. He heard nothing of it in lectures during his studentship.

Mr. CAMERON said it was with the greatest pleasure and satisfaction that he had listened to Dr. Burford. The paper was admirably put together, and the subject well worked out and illustrated.

Dr. WOOD (of Ann Arbor) reiterated the remarks of other speakers as to the value of the paper. He could hardly agree with the opinion that the function of menstruation was more dependent on the tubes than the ovaries. He cited the statistics of ovariectomy as showing that after the ovaries are removed menstruation generally ceased. He quoted a case of his own in which the removal of tubes did not result in cessation of menstruation. He was not able from his own practice to trace the majority of cases of pyosalpinx to gonorrhœal infection. He did not think dragging pains were pathognomonic of tubal affection. Regarding tubal gestation, he was not sure that it was not possible to have tubal pregnancy without tubal disease. In one case of his own there was an entire absence of any history of tubal disease. Regarding the advisability of operation in tubal pregnancy, he thought that the difficulty of making a sure diagnosis rendered the destruction of the foetus by electrolysis the better plan. If a secondary operation had to be made, it would be under much more favourable conditions than a primary one. He related a case of extra-uterine pregnancy. There was no evidence of a cyst when he operated; it was a pure intra-peritoneal pregnancy. The patient made a good recovery. He thought

Mr. Lawson Tait deserved great credit for insisting on opening the abdomen in these cases. He had found in a second-hand library a work by Stephen Rogers, of New York, of twenty-five years ago, which insisted on operation as emphatically as did Mr. Tait. He had sent the book to Mr. Tait, who had asked to see it.

Dr. DAY expressed his indebtedness to Dr. Burford for his clear way of putting the case. He mentioned one case illustrating the conservative method. There was a pregnancy which suppurated and passed per rectum, the fœtus passing in parts. There were no bad symptoms, and the patient made a good recovery.

Dr. DYCE BROWN had much pleasure in listening to Dr. Burford's paper. He could not, however, agree with Dr. Burford in considering that the Fallopian tubes were the real cause of menstruation. In most cases menstruation ceased when the ovaries were removed; and it must still be considered an open question, what is the ultimate cause of menstruation? As to the causes of salpyngitis, though gonorrhœa may cause it, he feared that the careless and rough way in which the old school injected irritating fluids into the uterus, and introduced irritating ointments, &c., into the cervical canal, was frequently to blame for setting up inflammation in the tubes. The less homœopaths adopted this practice the better. He agreed with Dr. Burford, as against Dr. Wood, that tubal pregnancy was frequently caused by inflammation of the tubes. The symptoms of this inflammation might be slight, hardly noticed by the patient, and consequently difficult to trace back. The cause of tubal rupture after the operation for atresia vagina had not been, so far as he was aware, explained. The only explanation that occurred to Dr. Dyce Brown was that while the tubes were distended into blood, the walls must be so thinned that when muscular contraction occurred, forcing the blood backwards as well as forwards, the tube gave way at its most attenuated point, unable to resist the pressure. An interesting fact, which Dr. Burford had not noticed, was the invariable existence of tubal cysts on the uterine side only of the obstruction. He could not admit with Dr. Burford that dragging pain was pathognomonic of tubal disease. This symptom was common to a variety of forms of pelvic disorder. Dr. Dyce Brown considered that operation was justifiable in tubal disease when all medicinal treatment had failed, and when the patient's life had become a burden to her; and certainly when pyosalpinx had been diagnosed—usually a difficult matter. When tubal pregnancy was followed by rupture, he agreed with Dr. Burford that operation was necessary.

Dr. CLARKE expressed the pleasure it had given him to listen to Dr. Burford's masterly paper.

Dr. DUDGEON said it was a great pleasure to hear two gentlemen of the experience of Drs. Burford and Wood discuss the question brought forward in the paper, and to find that they could not entirely agree. That saved others the necessity of forming an opinion until they did agree. He knew of a case where a lady suffered from most profuse menorrhagia every month. The two ovaries were removed, and she remained as bad as before. A consultation was held, and it was proposed to remove the uterus and appendages. But the husband, himself a medical man, happened to be acquainted with a homœopathic doctor, who gave a few doses of *apis* and the menorrhagia disappeared. He thought the discussion was one of the most learned and useful which he had heard for a long time.

Dr. CARFRAE said that Dr. Wood had anticipated most of the remarks he intended to make. He did not endorse Lawson Tait's opinion as to the relation of the ovaries to menstruation. He referred to the baneful use of strong injections, whether for medicinal or preventive purposes. He had a case of pelvic abscess from the latter cause. He thought dragging pains were not peculiar to tubal affections. He had thoroughly enjoyed the paper of the evening.

Dr. BURFORD, in reply, expressed his indebtedness to Dr. Blackley for distributing the syllabus, and to Mr. Wright for his assistance in preparing the diagrams. He was obliged to Dr. Wood for the admirable way in which he had criticised his paper, though he could not say that he had changed his opinions. He criticised adversely the opinion that when menstruation did not cease after oöphorectomy a small portion of the gland must have been left. He still believed that in tubal lesions dragging pains were in the ascendant. If electrolysis was a permissible means of destroying a tubal pregnancy, he did not see that the hypodermic injection of morphia might not also be permitted. Electrolysis had no effect on the placenta. If the foetus were left, there always remained a possible source of disease and danger, which a section would have cleared away. He thought that the ovaries could no longer be regarded as the essentials of menstruation. Dr. Day's case showed the desirability of bold operation at first, as all the pain and danger of a passage in segments was avoided. He thought it was very necessary and desirable to have complete histories of cases before operation, with the diagnosis definitely recorded beforehand. He urged this on homœopaths especially.

PRESIDENTIAL ADDRESS FOR THE SESSION
1889-90.

By GEO. M. CARFRAE, M.D.

GENTLEMEN,—In considering briefly the work of the past session, I shall make a slight departure from the usual practice of reviewing the papers that have been read chronologically. I propose to some extent to reverse this, and shall begin by saying a few words on the paper we had the pleasure of listening to last evening, that, namely, read by my colleague Dr. Burford. This may be said to be an epitome of our *present* knowledge of the embryology and physiology of the *Fallopian Tubes*, and of the pathology and therapeutics of the diseases thereof. And nothing could better illustrate than this dissertation the rapid *progress* gynæcology has made in the present day.

In my student days, Churchill's work "On Diseases of Women" was considered one of the best text books extant. One meagre chapter exhausts all that was then known on the subject, and one or two quotations will suffice to show how vague was the knowledge of that day.

Writing of the Fallopian tubes, he says: "From their proximity to the latter (uterus and ovaries) and their continuity of tissue with the former, they participate in the more acute disorders of each. There is no doubt that they may and often are diseased independently, but it is scarcely recognisable during life." Again he says, speaking of chronic inflammation of the tubes: "The exact diagnosis is very difficult. We must be content with the conviction that some of the pelvic viscera are affected, and direct our *treatment* to the relief of the prominent symptoms" (p. 413).

The treatment recommended is, I need hardly add, as vague and unsatisfactory as the diagnosis, and when we contrast this with Dr. Burford's clear exposition of the diagnosis and treatment of such conditions as hydro-, pyo-, and hæmato-salpinx, and tubal pregnancy, we cannot, I

think, withhold the conclusion that immense strides have been lately made in this branch of medicine.

The first paper of the session 1889-90 was read by Dr. Neatby. It is entitled *A Contribution to the Study of Remedies for Diseases of the Nervous System*. And although the opening chord is in the minor key, so to speak, and has a somewhat saddening effect, as is the nature of minor chords generally, there is much that is suggestive, interesting and instructive in the paper. "Intensely interesting as is the study of diseases of the nervous system for its own sake," says Dr. Neatby, "it must be acknowledged, even by the enthusiast in neurology, that to the therapist it is one of the most depressing in the whole range of medicine." Nevertheless he furnishes a tolerably large list of remedies more or less useful in such diseases. It must be confessed that the indications for their use are sometimes somewhat vague and general, but that is due to our imperfect knowledge of drug action in this class of disease on the one hand and the vastness of the field of observation to be covered in the limited time at the reader's command on the other. We may reasonably hope that Dr. Neatby's paper will serve as a stimulus for future workers to fill up the gaps that exist in our armamentarium. While it may be true that the therapeutics of diseases of the nervous system are still in a backward state, it is subject for congratulation that increased physiological knowledge of brain functions especially has led to great advance in the *surgical treatment* of lesions of that organ. This is specially due to increased knowledge of "cerebral localisation." A certain group of symptoms enable us, *e.g.*, to determine that there is an abscess in the brain. The researches of modern physiologists and physicians—most prominent among whom in this country are Ferrier, Horsley, and Hughlings Jackson—enable us strictly to localise this abscess. By the application of the trephine its purulent contents are evacuated, and the patient cured. This ideal sketch, as we all know, can be converted into a reality by a study of recent works on "Brain Surgery." But although we have immensely increased our knowledge of the differentiation of the faculties of the brain, the *idea* of "cerebral localisation" is by no means one that *originated* in our day. It is as old as the days of Aristotle. "Inner senses are *three* in

number, so called because they be within the brain pan, as common sense, phantasie and memory," of common sense he says, "the fore part of the brain is his organ or seat; of phantasie or imagination, which some call estimative or cogitative, that his organ is the middle cell of the brain; and of memory that his seat and organ is the back part of the brain."

"In the thirteenth century a head divided into regions according to these opinions, was designed by Albert the Great, Bishop of Ratisbon; and another was published by Petrus Mentagnand in 1491."* Another, somewhat similar but more elaborated, was published at Venice by Ludovico Dolce. "In the British Museum is a chart of the Universe and the elements of all sciences, in which a large head so delineated is conspicuous. It was published in Rome so late as 1632."† In the latter half of last century Gall and Spurzheim, as is well-known, elaborated the theory of cerebral localization to an altogether unprecedented extent. In regard to the former, Dr. Ferrier writes:‡ "To Gall, however, let us in passing pay the tribute that in his analysis he followed strictly inductive methods, and made many observations of enduring value; though his synthesis of the brain as a congerie of separate organs, each autonomous in its own sphere, and all mysteriously inherent in some unifying, immaterial substratum, has failed to commend itself to the scientific world." Since Gall's day experiments on the lower animals and pathological investigations have confirmed the doctrine of *cerebral localisation*, although the exact localisation attempted to be established by him, by observation of the external configuration of the head, has been proved to be wrong. The practical application of recent investigation on this subject has eventuated in some of the most brilliant successes of modern surgery, only to be rivalled by the giant strides made in our day by abdominal surgery. But here I would strike a note of warning. The advance in surgery has been so rapid, and its brilliant achievements have been such that the tendency, especially among the younger members of the profession, is to undervalue *medicinal*, and to trust too much to surgical treatment.

* *Phrenology*.

† p. 29, *ibid.*

‡ July 7th, 1890. *British Medical Journal*.

We should ever remember that the best surgery of all is *conservative surgery*, and that only when the resources of the *Materia Medica* have been exhausted ought we to resort to operative treatment.

We must also bear in mind that the results of surgical operations are not always so successful as they seem. I might quote, as examples of this, the case of a patient who was in this hospital. She had diseased ovaries. I need not detail the case to you further than to say that life was almost intolerable to her, so great was her suffering. I had her domiciled in a suitable lodging and the ovaries were removed. She made a good recovery so far as the operation was concerned; but I have frequently been consulted by her since, and am sorry to say she still suffers almost as acutely as before. I may add that we found both ovaries very much diseased—in a state of cystic degeneration—and we might therefore quite reasonably hope for relief of the patient's suffering after recovery from the operation. But our hopes were doomed to disappointment. I shall just quote one other case. I was sent for in consultation with one of our brethren to see a patient who had all the train of neurotic symptoms associated with a split cervix, and which Emmet declares can be cured by the operation he inaugurated. I performed the operation accordingly, and with perfect success so far as the uterine lesion was concerned, but the neurotic symptoms remained, and so far as I know, do so to this day.

As an illustration of the tendency I have referred to, I may mention that the British Gynæcological Society—which is one of the youngest of our medical societies in the metropolis, and which includes among its members many, I think I may say the greater number, of our most prominent gynæcologists—has not during the whole of its existence had more than one paper read on a purely therapeutic subject; and, strangely enough, that paper was one extolling the virtues of *hydrastis canadensis*. I need not tell my present audience that that drug is not to be found either in the *British* or *American Pharmacopœia*, but was introduced into the *Homœopathic Materia Medica* by Dr. Hale so long ago as 1858. We are now so well accustomed to these *discoveries* of the virtues of our remedies, that this special *discovery* would hardly merit notice except for the fact that we, in

our turn, may learn something from it. The lesson is this: Hitherto the use of this drug in our school has been pretty much confined to cases of cancer, but Dr. Rutherford—the author of the paper I have referred to—declares that he has had excellent results from its use in cases of hæmorrhage due to fibro-myonia. He quotes some illustrative examples.* If, as seems probable, this medicine has some curative influence over neoplasms of a malignant kind, may it not also act in this way on non-malignant growths? Dr. Rutherford believes it does, and it certainly is worthy of a further trial in this direction. That this one solitary paper on a therapeutic subject should be the outcome of *five sessions'* work is the more surprising when we note that more than one of the Presidents of the Gynæcological Society have dwelt on the importance of devoting more attention to this branch of their speciality. Dr. Edis, indeed, made it the theme of his inaugural address when he was elected President. He entitles his paper, *On the Relations of Gynæcology to General Therapeutics*. And a very interesting dissertation it is. Some of his remarks are so pertinent, and show such appreciation of the only way in which we can hope for therapeutic progress, that I shall risk wearying you by making a short quotation from his address. "In the interests of gynæcology" he says "it would be well if those who have had the opportunity of studying the effects of remedies upon varying conditions met with in daily practice would communicate the results of their observations. Not only does this apply to the effects of new remedies, but also to the influence exerted by well-recognised agents, the forms in which their best effects may be obtained and their deleterious action minimised. The list at our disposal is far too small, and our knowledge of their action far too inexact. Much could be done in this respect by careful clinical observation, recording minutely the symptoms, and how these were modified or relieved, *not by a combination of half-a-dozen different drugs, as is too often the case, but by some specially selected one, given with the definite idea of testing its true value under certain well-defined conditions.*"† Here we cannot fail to observe with pleasure that Dr. Edis advo-

* *British Gynæcological Journal*. Part xiv. 1888.

† *British Gynæcological Journal*. Part xiii., p. 19.

cates—first, the use of the single remedy, and his disapprobation of polypharmacy; and second, his advocacy of the search after *specific* remedies for well defined pathological conditions. I need hardly add that these are principles which were first advocated by Hahnemann, and have been strenuously carried out by all his disciples ever since his day. Let us hope that such words of wisdom may sink deeply into the brains of the members of the Gynæcological Society and the profession generally, and bear fruit accordingly.

The next paper I have to notice is that of Dr. Cooper on *The Care of the Ears, with special reference to the action of Calendula Officinalis*. As Dr. Dudgeon remarks in the discussion which followed, “Dr. Cooper’s papers were always interesting, as they always gave us an agreeable surprise; for he brings forward remedies which no one would have divined from the pathogenesis.” This remark applies to many of the important papers that Dr. Cooper has read here from time to time. His views, for example, as to the action of *lobelia*, *liquor sodæ chloratæ*, *sulphur*, &c., will be remembered as equally original, and as something apart from the generally recognised action of these drugs. But after all, the important point is—*not* whether the pathogenetic and clinical results exactly tally with each other, but whether the curative effects are such as are claimed for them; and if we are satisfied that this is so, it is our duty to use them accordingly. Let us *first* cure our patients; then we can leisurely afford to discover *how* the medicine cures.

Dr. Goldsborough’s paper, *Exceptional Cases of Acute Pneumonia*, is very interesting, and opens up so many important questions for solution that it is impossible in the limited time at my command to do more than indicate them. Is pneumonia contagious? What circumstances determine the formation of abscess, or of purulent infiltration as a conclusion to the pneumonic process? What are the indications for the use of *digitalis* in pneumonia? These, and many other important questions, are suggested by this paper. I must, however, leave them as subjects for future consideration by Dr. Goldsborough or other members of the Society. Meantime I would say that what occurs to me in reference to the cases recorded is, that I think it rather a pity to make such rapid and

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constant changes of remedy as Dr. Goldsbrough does. Dr. Fleischmann, as we know, had large experience in the treatment of pneumonia, and seldom used any remedy other than *phosphorus*, and got excellent results. It seems to me that in almost every well marked case of acute disease, while there are variations in the symptoms calling for different medicines, there is generally also one medicine which has *par excellence* a specific relation to the disease. And here it is that alternating the medicines has a useful sphere.

The *specific* medicine, so to speak, ought to be steadily persevered with, and the *incidental* remedy alternated therewith. The use of *phosphorus* in pneumonia is an illustrative example of this. We shall find another in the next paper I have to notice, that namely of Mr. Dudley D'A. Wright, on *Bronchitis, and its Complications in Children*. The general consensus of opinion of the members who took part in the discussion was that the remedy for acute bronchitis is *antim. tart.*, and I think that in a well-defined case of this disease whatever other medicine is called for intercurrently, we ought not to discontinue the specific remedy, but give it and the other as I have just said, alternately. It is very gratifying to find our house surgeon make such excellent use of the clinical material our hospital wards afford. The principal practical deductions we make from Mr. Wright's admirable paper are, first, that our sheet anchor in acute bronchitis is *antim. tart.*; second, that the warm bath and poultices are useful adjuvants in the treatment of such cases; third, that *ammon. carb.* is a better stimulant—where stimulants are called for—in children than alcohol; fourth, that for the *spasm*, which is sometimes an alarming symptom occurring in the course of the disease, *acon.*, *spongia* and *causticum* are chiefly to be relied on, and that again the hot bath is a useful adjuvant, while in extreme cases *chloroform* or *ether* inhalation are most helpful. The next paper which I ought to notice is that of Dr. Blake. But inasmuch as I was unfortunately unable to be present when it was read, and it has not yet been published in our Annals, I am unable to say anything about it, but it will be published in due course and those who are interested in the subject will be able to study it at leisure.

As has been our wont lately one meeting in the session

was set apart for purely clinical work, and interesting cases of pemphigus of conjunctiva, lupus, Raynaud's disease, myelitis, stammering, abdominal tumours, hemiplegia and sympathetic ophthalmia were exhibited, and elicited lively discussion.

Early in this year our metropolis was, as you know, visited by an epidemic of influenza. It was deemed advisable that we should have a special meeting, not only of members of this Society but of all homœopathic practitioners, to consider the best means of combating the enemy.

In briefly reviewing this subject, naturally the most important points to note are, first, whether any new light has been thrown on the nature of the disease, and second, what are the most efficacious modes of curing it.

In *May*, Dr. Byers Moir read a paper on the same subject, and it will be convenient for obvious reasons to include this along with the discussion it elicited in my remarks on the influenza epidemic. I need not occupy your time by referring to the history of this or other similar epidemics, nor with the symptomatology of the disease, as these points are sufficiently gone into in the papers referred to. Suffice it to say that the epidemic of 1889-90, so closely resembles those which are already matters of history, that Copeland's* description of the symptoms and course of the disease in past epidemics would almost exactly apply to the present one. Of course no two epidemics, nor indeed no two cases in the same epidemic are exactly alike, but the symptoms are sufficient to convince us that the same *cause* is at work in all the epidemics referred to.

What is this *cause*? It evidently is nothing in the *soil*, because the disease has manifested itself in all soils—from the arid plains of Egypt to the moist sea coast or fen country. Nor does any known peculiar *geological* formation favour its presence. Volcanic eruptions, telluric emanations, electrical conditions, and the seasons all yield negative results when interrogated as to the origin of this mysterious disease. So also with different barometrical conditions. Moist and dry, hot and cold climates have alike been the seat of different epidemics.

* Dictionary of Medicine.

The only exception to this, Sir T. Watson thinks, is that rapid thaws and heavy fogs have in past time been noticed in association with outbreaks of this disease (*Lectures on the Principles and Practice of Medicine*, vol. ii., p. 43). He also inclines to the belief that the quantity of ozone in the atmosphere has something to do with the presence of the disease. These observations do not meet with general acceptance, nor have they been corroborated by other observers.

More than one member of this Society came to the meeting doubting the *contagious* nature of influenza, but went away feeling convinced that contagion acts at all events as a cause of the spread of the disease. But there is abundant evidence to prove that it is not *the only cause* at work. "It is stated in the transactions of the College of Physicians," says Sir Thos. Watson,* "that on the 2nd May, 1782, Admiral Kempenfelt sailed from Spithead with a squadron of which this 'Goliah' was one. The crew of that vessel were attacked with influenza on the 29th May, and the rest were at different times affected, and so many of the men were rendered incapable of duty by this prevailing sickness that the whole squadron was obliged to return into port about the second week in June, not having had communication with any shore, but having cruised solely between Brest and the Lizard. This happened in one part of the fleet. In the beginning of the same month another large squadron sailed, all in perfect health, under Lord Howe's command for the Dutch coast. Towards the end of the month, just at the same time, therefore, that the 'Goliah' became full of the disease, it appeared in the 'Ripon,' the 'Princess' and the 'Amelia,' and other ships of the last-mentioned fleet, although there had been no intercourse with land. Similar events were noticed in the epidemic of 1833." He continues, "On 3rd April in that year . . . the 'Stag' was cruising up the channel, and arrived at 2 o'clock off Berry Head, on the Devonshire coast, all on board being at that time well. In half-an-hour afterwards, the breeze being easterly and blowing off the land, 40 men were down with the influenza, by 6.24 o'clock their number was increased to 60, and by 2 o'clock next day to 160. On the self-same

* Op. cit.

evening a regiment on duty at Portsmouth was in a perfectly healthy state, but by the next morning so many of the soldiers were affected by influenza that the garrison duty could not be performed by it."

The sum of our knowledge of the etiology of influenza seems to amount to this: First. That we know absolutely nothing as to how the disease originates. Second. That when it makes its appearance it spreads with remarkable rapidity, not only in the locality of its birth, but to places remote from that in which it originates. Third. That it may also be spread by direct contagion. The probable explanation of this is that the disease is due to some organism—animal or vegetable—which under favourable circumstances develops with great rapidity over vast areas; that this poison is capable of being carried apparently by aerial currents from an infected to a healthy locality. But that it may also be carried by an infected to a healthy individual. So far as we know this poison is unaffected by telluric, atmospheric, barometric, electric or meteoric conditions. All sorts and conditions of men and women seem equally liable to be affected—perhaps this may be modified by saying that the extremely young and extremely old and feeble are more likely to be *seriously* affected by it; otherwise young and old, rich and poor, alike are its prey.

I should like now to say a few words on the important question of *treatment*. We may legitimately look on this discussion as giving us the most recent ideas on the homœopathic treatment of the disease, and I shall attempt as briefly as possible to summarise this.

First, let me remark that although we see from allopathic journals a considerable mortality and serious complications occurring pretty frequently, the experience recorded by members of this Society shows an extremely small mortality and comparative freedom from complications, and therefore whatever conclusions we may be able to draw from the facts, they may be classed as referring to the *successful* treatment of the disease, and used as a guide in future epidemics. I may say *en passant* that this remark ought to apply to *all* our discussions. If this Society fulfils its mission, it ought to represent the most advanced views of our most enlightened members, and ought, therefore, to have a powerful influence of a didactic kind on the whole body of the profession. The

moral is that it behoves members to weigh well every statement made at its meetings; seeing that what is here said may have an influence for good or ill co-extensive not only with the members of the profession of to-day but to all future time.

With one exception the disease has been treated *symptomatically*. The great majority of the speakers in the discussion agree that for the first stage, when the prominent symptom is pyrexia, the remedy is *aconite*. Some, however, think that *gelsem.* is preferable. I fancy there is right on both sides. Inasmuch as *pain in the spine* was a prominent symptom in the great majority of cases in the late epidemic, we might expect *gels.* to be more helpful than *acon.*, which has not that symptom in such a marked degree. Hence may be explained the marked preference Dr. Hughes and a few others give to *gels.* in influenza generally. Probably *acon.* will still hold an important place, however, in the treatment in these cases when the symptoms are of the more purely pyrexial type.

The same explanation will apply to the preference two speakers—Drs. Drysdale and Morrison—give to *verat. vir.* This remedy might undoubtedly be more useful than *acon.* in those cases characterised by intense coldness of the limbs, as that is a prominent symptom in the pathogenesis of *ver. vir.*

So also may be explained Dr. Scriven's marked success with *camphor*. Where the attack is ushered in with intense chilliness and collapse, *camphor* would commend itself as the most appropriate remedy.

Bryonia, it is almost generally admitted, is the most useful medicine for the rheumatoid pains, restlessness, and cough, which are such constant symptoms. *Baptisia*, *actea*, *rhus*, are also indicated under these circumstances, and in some cases seem to have been very helpful.

Phosphorus Dr. Madden found specific when there is pulmonary congestion. Other speakers corroborate this statement.

Belladonna has been found very useful for the violent headache, which is such a common symptom.

So far, you, doubtless, have noticed the remedies selected have been so, "on general principles," so to speak—on the general principle of the similarity of the symptoms in any given case to the pathogenetic action

of the drug selected. But we notice in the discussion on Dr. Moir's paper, an important departure, I would say, rather, *advance* on this. Mr. Hurndall, a veterinary surgeon, read notes of his cases, as affecting *horses*. He had very successful results, and this was due, in his opinion, to the use of *one* remedy—*iodide of arsenic*. He selected this remedy because of the similarity of its symptoms, as others have selected *acon.*, *gels.*, &c. But it seems, moreover, to act as a specific antidote to the poison which gives rise to the group of symptoms known as influenza, just as it does in some suitable cases of malarial poisoning. Indeed, it may eventually be proved that the influenza is malarial poison. Some even now—Dr. Drysdale, *e.g.*—believe it to be so. "I believe fully with Dr. Hale" (*Special Therapeutics*), says Mr. Hurndall (*Monthly Hom. Review*, June, 1890, p. 331), "that this drug is the one remedy in all cases of *true* influenza, and further, that it will serve as a most successful prophylactic, and in the same degree as Hahnemann himself claims for *belladonna* as against scarlet fever."

"My friend, Mr. Henry Edgar, M.R.C.V.S., of Dartford," he continues, "who has had a larger number of cases under his care than I, and who commenced to treat cases according to the prevailing custom among allopathic practitioners, has since tested the efficacy, of course comparatively, of *iodide of arsenic*, with the result, I believe, that he never after had recourse to any other treatment." Some of Mr. Edgar's cases are recorded in the same number of the *Review*. He finishes his notes thus, "*ars. iod.* 3 was tried as a prophylactic on three horses in a stable where influenza broke out. One powder was given daily for ten days, and neither of them failed with it, and were kept at hard work continuously."

Writing of epidemic influenza, Dr. Hughes says in his *Pharmacodynamics*, p. 249, "To the typical form of this malady *arsenic* precisely corresponds, and in my hands has always proved rapidly curative of it, unquestionably cutting short its progress."

It has always appeared to me that we ought to devote more attention to the discovery of specific remedies for diseases due to a specific poison, as *quinine*, *arsenic*, *ipéc.* for ague. Here we have valuable evidence that *arsen.*

may also prove specific for influenza, and I would urge the members of this Society to put this to the test when an opportunity offers itself.

Dr. Day's paper on *Some Unusual Cases in Obstetric Practice, with Remarks on the Relation of Homœopathy to Obstetrics*, although not calculated to evoke much discussion is eminently suggestive. In the very outset of this paper we are confronted with a problem which, it has always appeared to me, is a very interesting one to attempt to solve. "While labour is," Dr. Day says, "a physiological process, the penalty of civilisation is trouble during parturition, and diseased and ill-developed women have to suffer most." The problem for solution is, *why* is this so? It seems an undoubted fact that the more highly civilised portions of the human race have greater difficulty in parturition than savage races. It is no uncommon thing," says Dr. Day, "for the Hottentot mother, suddenly feeling the onset of labour, to retire into a corner of the hut, give birth to her child, and after a short time resume her usual occupations, much as if she had simply obeyed an ordinary call of nature." Dr. Day relates a case occurring in his practice in which the patient seemed capable of acting in the same way as the Hottentot mother. I can recall another which I attended in my student days. The patient, an Irish-woman, who had what I consider a national characteristic—I hope my Irish friends will forgive me for saying so—of calling out *very lustily* when hurt—after a very noisy and, to me as well as the patient, tedious time, was safely delivered of a child about 3 a.m., so far as I can recollect. About 10 a.m. of the same day I called to see how the patient was progressing. I found the door locked. A neighbour told me that she got up shortly after I left, packed up her belongings and with her infant went away. I never saw or heard more of her. I need not say that such cases are very exceptional. I hope you will not think it irrelevant or ill-spent time if I devote a few minutes to an examination of this question. The late Sir J. Simpson did much to elucidate the point in an exhaustive and interesting paper published in the *Ed. Med. and Surg. Jour.*, Oct., 1844, p. 387, on the *sex* of the child as a cause of difficulty and danger in human parturition. In that essay he proves, I think, quite conclusively :—

becomes an impossibility. Yet the increase of size is not more than $\frac{1}{16}$ of an inch. I think, then, we may reasonably conclude that increased size of the head is a cause of increased difficulty in parturition. Then comes the further question, what is the cause of this increased size of the male head? It must be conceded, I think, that whatever may be the result of the modern agitation for the "higher education of women," in the past the principal part of the brain work of the civilised world was done by the male sex. This preponderance of brain work will give rise to corresponding increase of brain development. Hence follows increase of the size of the head. This theoretical speculation is borne out by statistical facts. The late Dr. Reid, of Edinburgh, carefully weighed 87 adult brains, and found the average weights as follows:—

Male 3 lbs. 2 oz. $3\frac{1}{2}$ dr.
 Female 2 lbs. 12 oz. $8\frac{1}{2}$ dr.

Showing 5 oz. 11 dr. more in male than female. Tiedemann found the same law to hold good at birth, only he places the difference at 8 oz. instead of 5 oz. If this train of reasoning be correct we ought to find that there is a difference between the average head of the uncultivated savage and that of civilised nations. It is not difficult to show that this is in accordance with facts. "The brains of European nations," says Combe (*Phrenology*, p. 752), "differ considerably from each other, but a common type characterises them all and distinguishes them from those now described. *They are decidedly larger* than the Hindoo, American Indian or Negro heads." "The ancient Egyptians," he continues, "appear from the stupendous works of art and science left behind them to have been highly intelligent and civilised people; and it is a striking fact that the skulls of ancient mummies almost invariably belong to the same class with those of modern Europeans." The ancient Greeks—who come under the same category so far as civilisation and intelligence are concerned—had correspondingly large skulls. Dr. Caldwell, who had very good opportunities of investigating this point, sums up thus: "The average size of the head of the Indian is less than that of the white man by the proportion of $\frac{1}{8}$ to $\frac{1}{10}$, certainly from $\frac{1}{10}$ to $\frac{1}{12}$ part of its entire bulk."

Thus we have proved, *first*, that increased size of head gives rise to increased difficulty in parturition. *Second*. That there is a marked difference in the size of civilised and savage nations; and, *third*, we may reasonably infer that no other cause can altogether account for the increased difficulty and pain during labour that is seen in civilised life.

One other factor in this important question—although a minor one—I think may be the difference in size of the pelvis in the two sections of the human race. I have not been able to get at any facts from measurements, but think it probable that the comparatively sedentary life of the civilised races will give rise to a corresponding faulty pelvic development. If there were the very smallest difference in this respect, it would, as we have seen, make a marked difference in regard to the facility of labour. Probably both causes are at work, but I believe the main cause is the *increased size of the fetal head*. The moral of all this digression is that we who have it in our power, to some extent, to mould the rising generation, so to speak, ought to use every effort to encourage physical exercises in girls. Fortunately the mothers of the present day are becoming enlightened on this point, but there is still too much tendency to push the mental and neglect the physical education.

The next remark that suggests itself to me to make in regard to Dr. Day's paper has reference to his *Craniotomy* case. First of all I may say that I don't quite understand his measurements. Those of the false pelvis show little divergence from the normal size—being represented thus :—

	Day's case.	Normal.
Between ant. sup. spines of ilium ...	9 $\frac{5}{8}$ in. ...	10 in.
Between crests of ilium ...	... 10 $\frac{7}{8}$ in. ...	10 $\frac{1}{2}$ in.

A difference of $\frac{3}{8}$ of an inch under in the one, and $\frac{3}{8}$ *above* the normal in the other. But we may dismiss this as hardly relevant, inasmuch as the size of the false pelvis does not materially affect the labour. I have always supposed that 3 inches conjugate diam. was the limit for craniotomy. In Dr. Day's case it was 3 $\frac{1}{2}$. But supposing for the sake of argument that the case was one in which craniotomy was called for, it never seems to have occurred to him, nor was it referred to by any

member of the Society in the discussion which followed the reading of his paper, that there is another alternative in such cases, *i.e.*, *Cæserian section* or *Porro's operation*. In October, 1886, the late Dr. Meadows read a paper at the meeting of the British Gynæcological Society entitled, *Ought Craniotomy to be abolished?* A lively discussion followed, and the result was an almost unanimous consensus of opinion among the members condemning the operation, and advocating the substitution of *Cæserian section* or *Porro's operation* in its place. "The whole tendency of modern midwifery practice," said Dr. Meadows, "is setting in very decidedly in the direction of absolutely and entirely abolishing this most abominable, unscientific and brutal proceeding, and I am strongly of opinion that if not in our day before another generation of gynæcologists shall have passed away, the practice of deliberately sacrificing a human life will be regarded as wholly unwarrantable, and not to be contemplated for a single moment in the face of other more scientific, more humane and far more successful modes of treatment." The then president of the Society, Mr. Lawson Tait, thus comments on Dr. Meadows' paper. "He," the president, "had the strongest sympathy with the views of Dr. Meadows in this matter. The murder of the child in this way had been a matter of consideration by those who were concerned with professional ethics for a very long time, and it was a very well known fact that according to the doctrines of the Church of Rome, such destruction of a child, save under exceptional circumstances, was not permissible. He did not feel very much influenced by this consideration, but he did by another, in that the child had no one to look after its interests, and that it was the only person in the relations whose vote concerning its presence had not been asked for or obtained. In this defenceless position it therefore was peculiarly deserving of consideration, for it was a terrible responsibility for any one to undertake its deliberate destruction, and he was perfectly certain from what he saw in publications, and what he heard from the lips of men in practice, that a perfectly unjustifiable amount of child murder by craniotomy was practised."

But, after all, theoretical objections go for comparatively little if we cannot show that by the substitution of the

operations suggested in lieu of *craniotomy* there is a saving of life. Fortunately we have satisfactory statistical proof that such is the case. There is no gainsaying the fact that there is an immense saving of foetal life, inasmuch as all the children are sacrificed in craniotomy cases, and almost all are saved by the alternative operations. Dr. Meadows quotes in his paper some statistics collected by Drs. Harris and Sanger, which show the following results:—Out of 31 operations, the maternal mortality was a little over 21 per cent., 24 out of the 31 were saved, and 29 out of the 31 children were saved. Again, from July, 1885, to July, 1886, 20 operations have been recorded, 18 mothers were saved, a mortality reduced to 10 per cent. Of the children 19 were saved, a reduction to 5 per cent. With such facts before us I ask you is craniotomy a justifiable operation? Do not for a moment suppose, gentlemen, that I mention these facts by way of condemnation of Dr. Day's treatment of his case. I do so to show how strongly the tide of medical opinion is running against the old and in favour of the new method of procedure in such cases, and in the hope that it may influence members of this society accordingly. I confess I have always held the operation in abhorrence, and shall be extremely glad to see it abolished on rational grounds.

The next part of Dr. Day's paper to which I should like to refer, is that in which he puts in a plea for a maternity department to this hospital. That such a department should form part of the original institution seems probable, from the fact that if we look at the list of the medical staff in the early days of its existence (1845) we see a physician accoucheur (Dr. Partridge) and surgeon accoucheur (Mr. Leadam) among its members. But, practically, that department remained a dead letter and so long as we have our present building I am afraid it must continue so. But we are, as doubtless you all know, on the eve of a new departure in this respect; we hope very soon to see a new hospital built, and I see no reason why a maternity wing should not form part of it. And here I should like to direct the attention of members of this society to the importance of making the fact as widely known among their patients as possible, that we are about to rebuild, and that for

this purpose "funds are urgently needed," to quote the stock phrase of all beggars for charitable objects. Although we cannot claim for our little hospital a history of venerable antiquity as most of the large metropolitan hospitals can, we hope we can claim for it the vigour characteristic of youth, and the progressive-ness characteristic of the times in which we live.

In 1836 was formed a Society known as the "Homœopathic Association." It was composed of laymen who were interested in the spread of the then quite novel doctrine—homœopathy. Lord Ebury (then Lord Robert Grosvenor) the present President of the Board of Management of this hospital, was chairman. Most of the physicians who practised as homœopaths were made honorary members. That Association by the writing of papers and publishing books on homœopathy and by collecting money, did valiant service in spreading a knowledge of the new doctrine among the lay public. Having accomplished its mission it ceased to exist as a society, and devoted the funds it had collected to the formation of a "Homœopathic Hospital." Accordingly, about 1848, this, the first homœopathic hospital in London, was opened in Golden Square.

On April 10th, 1844, Dr. Quin invited some friends to dinner at his house, No. 4, Albermarle Street, to discuss the possibility of forming a purely *Medical* Society. The result was that they then founded this "The British Homœopathic Society." At a subsequent meeting, Dr. Quin submitted to the members the rules he proposed to adopt for their consideration, and the following officers were appointed :—

President—Dr. Quin.
 Treasurer—Dr. Gilioli.
 Hon. Sec.—Wm. Wood, Esq.

Soon after the formation of the Society we meet in its minutes, as taking part in its discussions, familiar and honoured names—Dr. Rutherford Russell, Dr. Drysdale, Mr. Cameron, &c. For nearly a year the attention of the Society seems to have been mainly directed to the formation of the laws. A more fitting commentary on this code, thus carefully and thoughtfully elaborated, cannot be made than by reminding you

that it remains almost unaltered to the present day. Having fixed the laws, the Society next set to work to provide papers for its meetings.

April 3rd, 1845.

BRITISH HOMŒOPATHIC SOCIETY.

ORDER OF THE DISSERTATIONS AND COMMUNICATIONS AND
SUBJECTS OF THE FORMER.

Name.	Order	Date.	Subject of Dissertation.	Communica- tion due.
		1845.		1846.
Mr. Charles	1	June 5	Glance at Symptomatology ...	5 Mar.
Dr. Massol	2	July 3	Skin Diseases	5 Feb.
Dr. Quin	3	Aug. 7	Neuralgia... ..	1 Jan.
Dr. Gilioli	4	Sept. 4	{ Rationale of Small Doses and Curative Process of Ho- mœopathic Medicines. }	1845. 4 Dec.
Dr. Mayne	5	Oct. 2	No subject announced	6 Nov.
Mr. Hering	6	Nov. 6	{ Uterine Hæmorrhage and Midwifery. }	2 Oct.
Dr. Partridge	7	Dec. 4	{ The Practical Advantages of Homœopathic Treatment in Certain Ailments connected with Gestation and Ac- couchement. }	4 Sept.
Dr. Dunsford	8	1846. Jan. 1	Schirrous Tumours	7 Aug.
Mr. Wood	9	Feb. 5	{ On the Action of Some Medi- cines on Different Organs and Tissues. }	3 July.
Mr. Cameron	10	Mar. 5	How Nature Acts by Small Means	5 June.
Mr. Engall	11			
Dr. Dudgeon	12			

I show you here the first session's work, containing the "Order of the Dissertations and Communications, and subjects of the former." If some such plan were again adopted I cannot help thinking the papers and discussions we listen to now would greatly improve. The papers would improve because their authors would have ample time for preparation, and we would have less chance of such defections as happened on the first meeting of this month, when, as you know, no paper was forthcoming. I would commend to the notice of the defaulter on that occasion a minute which appears on

the Society's books in July of this same year (1845). "Dr. Massol not being prepared with his paper was fined 10s. 6d." As I have already remarked, the popular lay Homœopathic Association having fulfilled its mission and collected some money, now ceased to exist and devoted its funds to start a hospital. Dr. Quin and his friends worked very hard and very successfully in supplementing this fund. The result was that the "London Homœopathic Hospital" was opened in 1848, in Golden Square.

I need not remind the members of this Society of the good work done for the cause of homœopathy, especially in the cholera epidemic of 1854, nor of the scandalous treatment by the Medical Council of the Homœopathic Hospital's statistics, by excluding them from the Parliamentary returns. Fortunately the supplementary returns which were sent to the House of Commons make the facts historical, and will show to the end of time the immense superiority of the treatment pursued in our hospital to that of any other. I have now before me the Blue Book in reference to the epidemic, also the "Supplementary Returns" alluded to, as well as all the correspondence on the subject, which I need not say is anything but creditable to the Medical Council. As most of you are doubtless more or less cognisant of that episode in our history, I shall not waste time by referring to it further than to repeat one paragraph of the Government inspector, Dr. McLoughlin's letter to Mr. Cameron on the subject, as there may perchance be some present who are not acquainted with it. "In conclusion, I must repeat to you," Dr. McLoughlin says, "what I have already told you, and what I have told everyone with whom I have conversed, that although an allopath by principle, education and practice, yet was it the will of Providence to afflict me with cholera and to deprive me of the power of prescribing for myself, I would rather be in the hands of a homœopathic than an allopathic adviser."

The Golden Square Hospital was soon found inadequate to the rapidly increasing number of patients. It was accordingly decided to have a new and larger one. The erection of the present building was the result of that decision. It may interest some of you to know that one of the two houses which constitute our present Hospital,

was the residence of Lord Macaulay. Our Secretary-Superintendent, Mr. Cross, has written a brief account of it in a recent publication, which I take the liberty of quoting to you.

“Macaulay resided for some time in No. 50, Great Ormond Street, now forming the east wing of the London Homœopathic Hospital. Here he wrote the essay on Milton, and some of his earliest literary essays for the *Edinburgh Review*. In August, 1857, Macaulay writes: ‘I sent the carriage home, and walked to the Museum; passing through Great Ormond Street, I saw a bill on No. 50. I knocked, was let in, and went over the house with a strange mixture of feelings. It is more than twenty-six years since I was in it. The dining-room and the adjoining room, in which I once slept, are scarcely changed; the same colouring on the wall, but more dingy. My father’s study much the same; the drawing-room, too, except the papering; my bedroom just what it was. My mother’s bedroom—I had never been in it since her death. I went away sad.’

“Within a few weeks of Lord Macaulay’s visit, the authorities of the Homœopathic Hospital, who were at that time established in Golden Square, acquired the freehold of Nos. 50—2 in Great Ormond Street. The new Hospital was publicly opened on May 12th, 1859; in his inaugural address, Lord Ebury mentioned that No. 50 had been, as the second Powis House, the home for twenty years of Philip Lord Chancellor Hardwicke.”

When I was house surgeon here, now nearly a quarter of a century ago, there was accommodation for 60 patients. The only speciality represented was “Diseases of Women,” and the nursing staff was supplied in the most promiscuous, and I must add often unsatisfactory, way possible. I do not say this by way of reflection on those who had the management of that department at that time, but merely state the fact. The *reason* why it was so is that the great development of nursing as an art hardly existed then, and good nurses were very difficult to get. I need not say that that is all altered in the present day; as we all know the name of Florence Nightingale is indissolubly linked with one of the greatest reforms of our day in regard to the management of the sick, and next to the patient the doctor owes to her an inestimable debt of gratitude.

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Personally, I feel that nothing conduces more to my comfort and confidence in the treatment of a case than a good nurse, and I am happy to add that in the institute in connection with our present Hospital we can almost always procure the services of such an one. There is a staff of 42. But not only have we improved in the matter of nursing our patients, we have added 30 to the 60 beds which were formerly our limit, so that we have now 90. Since 1870 the income of the Hospital has doubled. Instead of *one* single speciality we have now a dermatologist, an oculist, aurist, dentist, pathologist, anæsthetist, and my special department has increased so much that we were all very glad to welcome the recent addition to our staff of Dr. Burford, as assistant gynæcologist. But notwithstanding that we make the very most of our available space, the number of patients outruns our best efforts to provide for them. The rooms for seeing out-patients are miserably inadequate to the work. We have no suitable place whatever for the performance of such surgical operations as demand a separate ward; and in all our surgical work we have an undue tendency to septicæmia, probably owing to the insanitary conditions inseparable from old buildings, so that we are sadly handicapped, and our results are not so good as they might be and ought to be. In short, we find that if we are to get on at all we must have a new hospital, and again I appeal to the members of this Society who have the ear, and can to some extent work the *purse strings* of those laymen who are interested in homœopathy, to use every effort so as to bring grist to the mill. £30,000 are required for a really serviceable building, and although the scheme has been only a short time before the public I believe quite one-half (£15,000) is already subscribed. When we get our new building I hope we may be able to supply the want Dr. Day complains of. Indeed, I hope that every speciality represented in other hospitals will be supplied in ours, and that we may all live to see the day when a charter shall be obtained to enable us to open a *school* in connection with the Hospital, fully equipped with teachers for every branch of medical education required by the examining board. To do this a minimum of 120 beds is required, and I hope we shall have this in our new Hospital, and until we accomplish

this I do not see much hope of attracting many students. We all know the influence that teachers exercise over students, with the dread of the awe inspiring "exam." before them. And we know too the feeling of the teachers of the various allopathic schools towards us. We know also how fully a student's time is taken up from the day he begins his studies till he gets his degree, and so can readily understand our present difficulty in getting them to attend our clinics. But if there was a *central* examining board, and we had a complete school connected with our Hospital, I feel sure we would soon attract a fair share of students.

During the session just ended we have lost four of our members:—

Dr. Metcalfe	...	...	Elected 1847.
Dr. Meyhoffer (of Nice)	...	..	1871.
	(Corresponding Member).		
Dr. Jacob Dixon	...	..	1861.
Dr. John Roche	...	..	1861.

Dr. Metcalfe was one of the oldest members of this Society, only two others being senior to him—Mr. Cameron and Dr. Hamilton. He did valiant service for the cause of medical reform in the early days of its history, when those who espoused the despised doctrines of Hahnemann had much to suffer socially and professionally from their opponents. The obituary notice in the *Review* (March 1st, 1890, p. 190) says of him:—“Dr. Metcalfe will ever be remembered by those who knew him, not only as a sound practitioner, but as a most genial, kind-hearted friend. Few, if any, have closed a professional career possessing more thoroughly the grateful attachment of patients, or more respected and esteemed by colleagues, than our old friend Dr. Metcalfe.”

Dr. Jacob Dixon, years ago, was a well-known figure in this Hospital. He lived opposite, and in a very quiet, unostentatious way did an immense amount of work among the out-patients. He was one of the most amiable, good-natured men I have ever met.

Two members have been placed on the retired list, viz.:—

Dr. Harmer Smith	...	...	Elected 1861.
Dr. Mathias	...	..	1888.

Two more have resigned—

Dr. R. Flint	...	...	Elected 1869.
Dr. Woodgates	...	...	„ 1864.

Five new members have been elected—

Dr. H. Bennett	...	...	Elected 1890.
Dr. E. Capper	...	...	„ 1890.
Dr. Molson	...	...	„ 1889.
Dr. Morrison	...	...	„ 1890.
Dr. Skinner	...	...	„ 1889.

And now, gentlemen, it only remains for me before quitting this chair to express my thanks to you all, and especially to my fellow office-bearers, for the forbearance and kindness you have shown to me during my tenure of office, and my best wishes for the continued success of the Society. A great deal of thoroughly practical work has been done during the past session. Never since I have been connected with the Society have I seen more zeal and earnestness in its working than now, and I leave this chair with a confident hope that it has in store a brilliant future.

Annals of the Hospital.

DISEASES OF THE NERVOUS SYSTEM.

Under the care of Dr. J. GALLEY BLACKLEY.

*Chorea, Hysterical Hemi-anæsthesia.**

HETTY R——, aged 21, single, servant, was admitted into Vaughan-Morgan Ward on October 4th, 1888, after attending for a month as an out-patient for rigidity and loss of sensation of right leg and foot.

Family History.—Father died suddenly, cause unknown. Mother died of heart disease. One brother died in a fit; three other brothers living and well.

Personal History.—When fourteen years old she had chorea, which was confined at first to the face and then became general, interfering very much with her walking powers. This lasted altogether for three years. She remained well for 12 months, and then began to be troubled with "fits," which have continued up to the present time, occurring once in every eight months. During the last three months, however, she has had no less than eight of these, which she describes as beginning with headache and loss of sight; she then falls down, and frequently, though not invariably, becomes unconscious and bites her tongue.

Present illness began on October 27th last, when she was seized at 3 p.m. with severe headache and vomiting, followed by a fit, with complete loss of consciousness. On coming to herself, found herself in bed, with the right arm and leg stiff, and complete loss of sensation down right half of the body. Has not had a fit since. When seen in the out-patient room, on September 3rd, she complained of stiffness of the right knee and ankle, and loss of sensation in the foot and leg for three inches above the ankle. Was treated by Faradisation and

* From notes taken by Mr. W. L. Matthias, late Res. Med. Off.

rubbing, and was given *ignatia* internally; under these remedies the leg became less rigid, but the anæsthesia spread gradually upwards. On the occasion of her last visit as an out-patient she was suffering from choreic (convulsive) movements of the right shoulder and arm.

On admission, the patient is seen to be a pale, but otherwise healthy-looking and well-nourished girl. Thoracic and abdominal viscera appear perfectly normal, and tongue is clean. The skin of the right side of the body, and of the right arm and leg, is totally insensible to all ordinary stimuli; a needle may be pushed through a fold of skin without the patient taking any apparent notice of it. Convulsive movements of the right arm are constantly present during the day, but absent when asleep. The right knee and ankle are rigid; the ankle is kept in the flexed position. *Reflexes* are as follows:—

Plantar	...	...	...	Exaggerated.
Ankle clonus	...	...	...	Well marked.
Patellar	...	...	...	Very brisk.
Patellarclonus	...	...	...	Easily obtained.

The muscles of the leg are not wasted. There is slight ptosis of the right eyelid, and she says her sight is not so good on that side. No deafness. *R. Argent. nit.* 5 gtt. ii. ter die.

Oct. 8th.—Choreic movements not quite so violent. Anæsthesia the same. Some tenderness on pressure in the right ovarian region.

Oct. 10th.—Was ordered massage in addition to internal medication.

Oct. 12th.—Choreic movements have ceased, but return when the patient is looked at for awhile. Cannot continue to hold up her right hand when it is raised for her.

Oct. 13th.—Reflexes on right side all exaggerated. No choreic movements.

Oct. 19th.—Patient was subjected to mild Faradisation of the affected side. All the voluntary muscles contracted strongly, and cutaneous sensibility returned to the outer side of the leg, so that she could feel the prick of a pin.

Oct. 22nd.—Cutaneous sensibility remains good over a small area over the right fibula. Continue Faradisation and massage.

By the 25th she could feel the point of a pin over the previously anæsthetic area, and could feel when rubbed, and on the following day could feel the slightest touch, although still unable to say whether the object was sharp or blunt, and whether a prick or a blow was given.

Oct. 29th.—Anæsthesia has quite disappeared over the right side, *but has suddenly become absolute on the opposite side of the body.* “Metallo-thérapie” produces temporary sensibility on the anæsthetic side, but cannot feel the uninterrupted induced current.

Oct. 30th.—Total anæsthesia of left half of the body, except to Faradisation, which she feels slightly. Ankle clonus obtained in both ankles; patellar clonus well marked on right side.

At the time of her discharge the patient still walked very stiffly. The knee jerks were still somewhat exaggerated, and she was still unable to feel the current so well on the left as on the right side.

Remarks.—The case of Hetty R—affords a fair sample of unilateral anæsthesia of hysterical origin. The age, appearance, and history of the patient, the presence of tenderness on slight pressure over the right ovary, and the completeness of the anæsthesia over the affected side, all served to distinguish it pretty clearly from anæsthesia having a central origin. The treatment of such cases is usually eminently unsatisfactory, and this case is no exception to the general rule, for after slow disappearance of the leading symptoms on the right side they suddenly appeared with all their former intensity on the opposite side. In the next case I have I shall certainly try the effect of “treatment by suggestion.”

*Right Hemi-chorea.**

Ada T—, aged 14, school girl, was admitted into Vaughan-Morgan Ward on March 22nd, 1888, after having been an out-patient under Dr. Day for the previous six weeks, during which she had been treated by *ignat.* and *arsenic*, and massage.

Family history revealed nothing more than the fact that the mother suffered from fits, but the precise nature of these is doubtful.

* From notes by D. Ogden Jones, M.D., late Res. Med. Off.

History.—Three months ago the mother noticed that the child dropped things when holding them in her right hand, also that the right side of the body was constantly twitching whilst the patient was awake. Had never had a previous attack; no history of rheumatism or of a fright.

On admission the right arm and leg were seen to be constantly twitching (she was found to be perfectly still when asleep). Examination of the heart revealed a soft systolic bruit at the apex. Temperature morning and evening was normal. Appetite good; bowels regular; slept a good deal, and complained much of drowsiness. Has slight ptosis on right side. A liberal diet was ordered, but the patient was given a placebo in the shape of pilules of *sacch. lact.*

A month after admission had an attack of follicular tonsillitis, for which the house surgeon ordered *merc. biniod.* This was discontinued after three days, and with this exception no medicine was given. All the symptoms gradually subsided, and on May 30th she was discharged as quite well. The grip of the right hand was firm and quite equal to the left, and all twitching had ceased.

Remarks.—In all ordinary cases of chorea in children, separation from their usual surroundings, whether sanitary or otherwise, is so potent a factor in the cure that I now adopt the plan of leaving the patient without medicine for the first few weeks at least, with the result that four out of every five cases, even in previously debilitated children, get well with no other medicine than *sacch. lact.*

Angina Faucium. Cerebro-spinal Meningitis. Death.

Arthur B——, aged 14, under-porter in the hospital, was sent to bed on March 21st, complaining of sore throat, which came on on the previous day. Before this he had been in perfect health; had never had scarlet fever or measles, and had not been exposed to either recently. Tonsils and pharynx were red and swollen. Temperature during afternoon rose to 102.6, and pulse to 140. During the night he perspired very profusely, and was very restless.

March 22nd.—Was admitted into Hahnemann Ward in the following condition :—Temp. 100.6, and pulse 102. The lips and tongue are dry and brown. Tonsils and uvula œdematous, dry and shiny. Pharynx congested, and covered with a dirty grayish secretion. The neck is stiff, the muscles being firm and hard, and the glands swollen. Active or passive movements of the head cause him great pain. On forearms and chest are numerous large florid maculæ, about the size of a threepenny piece; these spots are discrete, having patches of normal skin between, and disappear on pressure. Face is much flushed. A poultice was ordered to be applied externally to the neck and throat, and a gargle of permanganate of potash internally. *Bell.* 1x. and *merc. biniod.* 3x. were given every two hours in alternation. During afternoon and evening complained of very severe headache, coming on apparently in paroxysms; the ice-cap was applied, and gave considerable relief. The head during this time was drawn back. At 8 p.m. temperature was 101.2, and at midnight 103.4; pulse 96, full and bounding. Slept 2½ hours by snatches during the night; talked incessantly all night. Was very thirsty, and complained of earache.

March 23rd., 9 a.m.—Temp., 99.4. Headache came on again at 7 a.m. very severely, causing him to scream out. All nourishment given during the night was vomited up immediately, the food being returned in gulps, without any apparent nausea. Face is flushed; pupils contracted; neck not so stiff as yesterday. Throat less congested; no deposit present; skin very dry and harsh; no rash to-day; urine 25 oj.; passed urine once involuntarily; tongue foul; bowels not open for three days; abdomen retracted; takes nourishment badly; slight jactitation of limbs occasionally; ice-cap to be continued. *R* *Bry.* 1x. gtt.j, *stramon.* 1x. gtt.j omni horâ alt. Evening temp., 102.6; pulse 92, softer. Had no sleep; wandering delirium all night; complained of his head very much; grew quieter after 6 a.m.

March 24th.—Temp. 102; pulse 92, softer; pupils normal; tongue and skin slightly moist; neck stiff, and acutely painful, but head seems easier; bowels have acted spontaneously, a natural stool being passed; the abdomen is distended and tender on percussion; no spots visible. He complains of feeling very cold one

minute, and very hot the next. Complains also of ear-ache in left ear. Takes nourishment fairly. Slept off and on all day, wandering as soon as he awoke. At 5 p.m. began muttering and shouting, but became quieter after being sponged with warm vinegar and water.

March 25th.—Temp., 101; pulse, 92. Upper lip and left angle of the mouth covered with herpes; lips dry. Body very hyperæsthetic; he complains very much of draughts, and of feeling cold. Takes plenty of food, which is retained. Does not complain of headache. Continue medicines and ice-cap. Between 2 and 4 p.m. became very noisy and talkative, and about 4 complained of pains in abdomen, chest and legs. Slept two hours during night, and was very noisy between 3 and 6 a.m.

March 26th.—Has difficulty in protruding the tongue and in opening his mouth; glands under chin enlarged; abdomen tympanitic; body still hyperæsthetic; he complains, too, of the least noise; skin dry and harsh; urine passed very frequently; bladder not distended; urine normal. \mathcal{R} Tr. *agaric*. 1 gtt. tert. hor. E.T. 101. Furious delirium during the night; had to be held in bed; grew quieter towards morning, and slept for two hours.

March 27th.—Complains very much of being cold; body still very hyperæsthetic; pupils normal; face sometimes flushed, and at others quite pale and cold; jaws fixed; grinds his teeth occasionally. \mathcal{R} Tr. *strych*. 3x. gtt.j. omni horâ.

March 28th.—Was very noisy all day, but opened his mouth wider. Complained much of pains in shoulders, hips and chest, of a shooting character, which were relieved by the spinal bag filled with hot water. Was quite conscious; neck not so stiff; could turn it a little; continue *strych*. in alternation. In the early morning during sleep there was considerable jactitation, especially of the right side.

March 29th.—Pupils normally dilated; react strongly to light. Urine acid, 1012, deposits phosphates on boiling. Takes nourishment very well. Still using the hot water spinal bag and ice-cap.

March 30th.—Quite conscious; slept three hours and 40 minutes during the night. Wandered a little, and cried out with pain in his head at times. Bowels

inclined to be loose this morning. Fan-like action of the *alæ nasi* evident during inspiration. Breathing is very quick and nervous in character. Slept eight hours out of the 24. When roused to take nourishment he was drowsy, and only half conscious, with eyes staring vacantly. About 5 p.m. the head began to be drawn back, the muscles of the neck becoming rigid and painful.

March 31st.—Head still drawn back; tongue protruded with much difficulty; pupils contracted symmetrically; react strongly to light. Abdomen hyperæsthetic, and exhibiting the *tache cérébrale* exceedingly well. Lies with eyes partially open, and rolling about.

April 1st.—Only half conscious; wanders constantly, talking of his work, &c., &c. Pupils do not react properly, remaining slightly dilated, even when a strong light is placed before the eyes. The head is drawn back as far as possible; trapezius muscle on either side is soft and lax at its spinal border, but rigid at its outer edge.

April 2nd.—Head still drawn back; kept jumping and starting and shouting out with the pain in the neck. Does not take the nourishment well, and is beginning to lose flesh. Has slept very little during last 24 hours; to have ʒss. of bromide of potassium at night. To have the neck poulticed, and ice-bag discontinued.

April 5th.—Temp. 98.6; slept a good deal during the night in snatches. Threw off the bed clothes constantly; in the intervals there was sighing and hiccough, which has continued. Abdomen tender to touch, and *tache cérébrale* very marked. Hyperæsthesia of whole body; pupils do not react, but there is some photophobia, and he is sensitive to noises. Takes nourishment well. Urine 1020, deposits phosphates on boiling.

April 8th.—Quite conscious; temp., 97.6; taking nourishment well. During p.m. lay with eyes open and staring; perspired very much about face and head.

April 9th.—Very lethargic and slightly deaf; respirations 24, pulse 132, has some hiccough. Urine alkaline depositing phosphates freely; passed involuntarily at times. Is becoming much emaciated. Seems to have great difficulty at times in swallowing, but takes a fair quantity of nourishment. During the night there was

great difficulty in opening the mouth, the teeth being tightly clenched.

April 10th.—When seen at 9.15 a.m. he was very lethargic, but could be roused with difficulty, and answered questions rationally. After this, cyanosis of the face was noticed, and breathing became shallower and much slower; pulse was strong and heart's action tumultuous. Sinapisms to the feet, hypodermic injections of brandy and artificial respiration were tried without avail. He gradually sank and died at 10.30 a.m., the pupils, which had previously been contracted, dilating gradually as respiration ceased.

Unfortunately no post-mortem was permitted.

Remarks.—The occurrence of a low form of inflammation about the fauces and upper part of the pharynx as an early symptom in cases of simple cerebro-spinal meningitis, has not, so far as I am aware, been noted by previous observers, and the florid character of the rash and its short duration are also unusual features. Beyond this the case affords a tolerably accurate picture of simple idiopathic cerebro-spinal meningitis, running, as happens so frequently, a downward course in spite of what might be called *symptomatic* treatment by such remedies as *stramonium* and *agaricus*, and the use of such remedies as *bryonia* and *strychnine*, which have a wider sphere of action, and which were prescribed upon *pathological* rather than *symptomatic* grounds. The absence of a post-mortem examination was much to be regretted.

*Two Cases of Pseudo-hypertrophic Paralysis.**

CASE I.

Eli A., aged 11, was admitted into Hahnemann ward on January 18th, 1888.

Family history: Father and mother both living and healthy; no history of nervous affections on either side. Family consisted of four boys and three girls, of whom the latter are quite healthy. Of the boys one died at the age of seven of enteritis, whilst suffering from some obscure nervous disease; next comes the present patient,

* From notes taken by D. Ogden Jones, M.B., late Resident Medical Officer.

who has been affected for nearly four years; then a younger brother of four years old, similarly affected, though to a less extent (see Case II.) ; and finally a boy of two, who is also beginning to show unmistakable signs of the same disease.

Personal history : Four years ago he had scarlet fever, after recovering from which he was able to walk for a short time, but gradually began to lose power in the legs. He is an intelligent lad, and says that when the disease began, and until he entirely lost the use of his legs, he was obliged, when going upstairs, to place the hands on the thighs, and, in rising from the ground, to turn round, so as to get on one leg at a time, and also to place his hands on the thighs and so force himself up; also, that he was always falling, especially if he ran. He has been quite unable to walk for nearly three years. About two years ago the legs became flaccid, and about the same time the arms began to lose power.

Present condition : The face is fat, and the body very thin. He is unable to stand or to sit upright. The spine is slightly curved with the convexity backwards, and there is a marked curvature towards the left side. The knees are flexed, and as he sits in a chair the toes point towards the floor (talipes equinus). He is unable to raise the hands to the top of the head, and in attempting this he throws up the arm by means of the deltoid, &c., until the hand reaches his face, when he carries it up to his head by a creeping motion of the fingers. As he sits in his chair he can flex the thighs upon the abdomen, this being accomplished entirely by the pelvic muscles.

The various muscles are affected as follows:—

Muscles of neck are but little affected.

Deltoids, lower fibres much hypertrophied, upper fibres atrophied.

Biceps (both) *brachialis anticus* (both) and *triceps* (both) atrophied.

Latissimus dorsi, *serratus magnus* and *erector spinæ* atrophied.

Pectoralis (major and minor) atrophied.

Supinator muscles of *forearms* hypertrophied.

Pronator muscles of *forearms* atrophied.

Muscles of thumb hypertrophied.

Glutei hypertrophied.

Extensors of knee atrophied.

Flexors of knee hypertrophied.
Calf muscles hypertrophied (10 $\frac{1}{4}$ inches in circumference).
Abdominal muscles not affected.
Masseters hypertrophied.

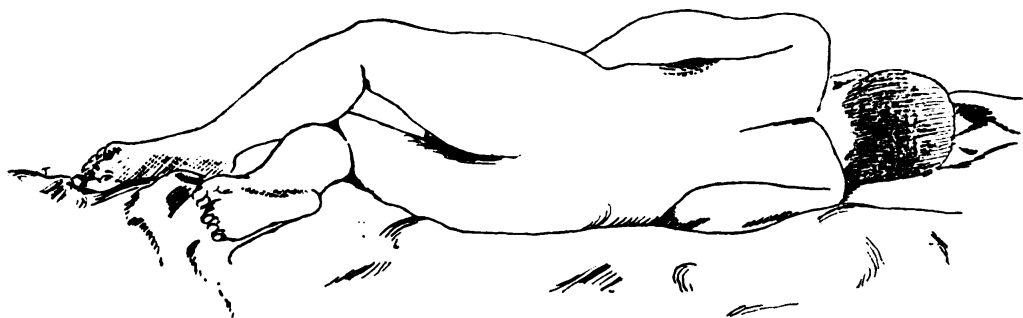


Fig. I.—Outline sketch from a photograph of Eli A., taken in the recumbent position, so as to show hypertrophied muscles. (This sketch gives the impression that the patient has a decided tendency to *embonpoint*, whereas, when seen from the front, as he sits in his chair, he is really found to be much emaciated).

Electric irritability to both forms of current is much diminished.

Reflexes are as follows :—

Patellar completely absent.

Ankle clonus absent and cannot be manufactured.

Cremasteric marked.

Abdominal, epigastric, pectoral, lumbar and *scapular* all marked.

Sensation appears to be unaffected and all the sphincters are competent. Mentally he is bright and intelligent. R̄ *Tr. curare* 3 gttj t.d. with massage to the extremities.

February 6th.—Can move the arms better, especially the right arm, which he can raise to the top of the head. The muscles are not quite so flaccid. Can straighten the legs a little.

March 8th.—*In statu quo*. R̄ *Tr. lathyrus* 3x gttj. t.d.

May 2nd.—Can move the arms better ; can also raise the feet from the bed and move them readily.

May 28th.—No further improvement having taken place he was discharged as incurable.

CASE II.

Frank A., aged 4 years, brother of Eli, admitted into Barton Ward on July 5th, 1888.

Family history. (See Case I.)

Personal history: Has had measles and scarlet fever. His mother noticed the first signs of paralysis when he was about two years old, there being frequent falls when walking, with difficulty in rising. During the last two years he has been slowly getting worse.

On admission: The patient is seen to be a well-nourished child of dull and stupid aspect. He walks fairly well, but on sitting down on the floor the mode of rising is quite characteristic of the disease, the operation of climbing up his legs being gone through in typical style. On going upstairs, too, he places his hands on the thighs and forces the body up. The affected muscles are at present solely those of the gluteal regions and the lower extremities, but neither hypertrophy nor atrophy is so marked as in the case of the elder brother. The patellar and plantar reflex are both much diminished, and there is no ankle clonus. There is diminished irritability to both forms of the electric current. R̄ *Tr. phosph.*, 3 gttj., t.d., with massage for 15 minutes, and the continuous current for 10 minutes daily to the affected muscles.

Shortly after his admission the treatment was interrupted, owing to a smart attack of bronchitis, after recovery from which he was found to have lost ground considerably. The muscles were weaker, and did not react to the continuous current. Was still able to walk, but kept the feet wide apart and the abdomen thrust forwards. On September 19th massage and galvanism were resumed. After a few days a marked improvement in his walking powers was noticed, and the muscles contracted feebly to galvanism.

October 31st.—Discharged as much improved.

Remarks.—The records of cases of pseudo-hypertrophic paralysis treated homœopathically are still too few in number for purposes of generalisation. In the elder of the two brothers the disease was so far advanced when he was admitted as to preclude much hope of checking its progress. In the younger child, however, the improvement under the use of *phosphorus* was

decided, and in a similar case, if seen sufficiently early, I should again resort to it, along with massage and galvanism.—(J. G. B.)

Acute Atrophic Paralysis.

Edward W., aged 11 years, school-boy, was admitted into "Bayes" Ward on March 20th, 1888, after being an out-patient under Dr. Day.

Family history: Father had syphilis when he married, and communicated it to his wife, who had five miscarriages, two occurring before and three after the birth of the patient. Eight children were born alive, of whom three survive, the other two, both boys, being strong and healthy. There is no history of nervous disease on either father's or mother's side.

Personal history: The mother states that he was a fine, healthy boy until seven months old, when he cut his first tooth. About this time she noticed that he had no power in his legs; did not draw them up and kick as other children did. He, however, began to crawl about early, and was rather "forward on his hands and knees." At two years old he failed very much, becoming very thin and being still quite unable to walk, whereupon he became an out-patient at the Children's Hospital, and had electricity applied to the legs twice a week for three months. He improved slightly under this treatment, and was sent away to the country. After a lapse of three months he began to walk, and at the same time improved much in general condition. Remained in the country until four years of age, by which time he managed to walk, and even run in an awkward fashion—working his arms and legs and waddling from side to side in doing so. There never appeared to be any enlargement of the muscles of legs or arms, but his mother says after the age of four these became perceptibly thinner, and his spine, which had been previously curved anteriorly became more markedly so. During the past three months the muscles have dwindled still more, walking has become more difficult, and he falls much more frequently than usual. He has attended school since the age of five, and has always been forward with his studies.

Present condition: The patient is undersized, but a bright, intelligent lad. Weight, 2 st. 9 lbs.; height,

3 ft. 10 in. The upper and lower extremities are exceedingly thin, and the muscles atrophied; the gluteal muscles, on the contrary, are hypertrophied, hard and firm to the touch. The right calf measures 7 in. and the left $7\frac{1}{4}$ in. in circumference. As he lies, in the dorsal decubitus there is a marked arching of the spine in the lumbar region; there is also a slight lateral curvature towards the left side. When walking or standing, owing to the forward curvature of the spine, the abdomen is thrust out and appears much enlarged (this is, however, mainly apparent, as measurement in its largest circumference is 22 in., that of the chest being $24\frac{1}{2}$ in.), the shoulders being thrown back; the arms work to and fro, and the whole body has a waddling motion. The feet and legs are thrown outwards together and have a shuffling gait. There is a limp on the right leg, which as he walks looks shorter than the left. The thighs seem fixed, whilst the legs work from the knees as if with a ball and socket joint. On stooping, he has great difficulty in raising himself into the erect posture, and exhibits in a very characteristic manner the operation of "climbing up his knees."

Reflexes were found to be as follows:—

Patellar entirely absent; no ankle clonus, and none can be manufactured; cremasteric, abdominal, epigastric pectoral, lumbar and scapular all present.

The irritability of the affected muscles to the two forms of electrical current was carefully tested, and it was found that all the atrophied muscles responded more freely to the continuous current than to faradisation.

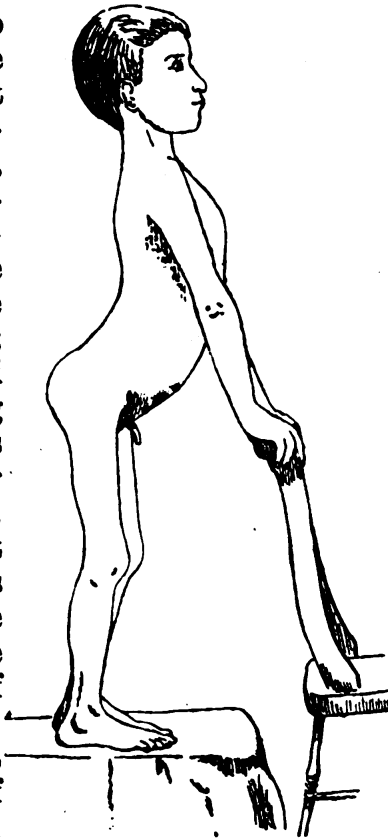


Fig. II.—Outline sketch from a photograph of Edward W., showing atrophied muscles of legs and arching forward of spine in lumbar region.

Chest was normal in every respect.

Abdomen tympanitic and walls very rigid; hepatic dulness extends below right hypochondrium almost to a level with the umbilicus; in other respects normal. Appetite and digestion good.

Treatment: The voltaic current was ordered to be applied daily for half-an-hour, beginning with that obtained from seven cells of Stöhrer's battery, the affected muscles being taken seriatim. Twenty minutes' massage to be given at another part of the day. Cod-liver oil and a generous diet were also prescribed.

The current was increased gradually up to 16 cells, and the patient, after being kept in bed for the first month, was allowed to walk about the ward.

On May 17th he was weighed and was found to have gained four pounds in weight; the muscles of the lower extremities felt firmer and his walking powers had decidedly improved.

On August 3rd measurement of the arms and legs showed that both had increased in size. He could walk and run, although still in an awkward fashion. He had increased 10 pounds in weight since admission.

Left the hospital for a convalescent home.

Remarks.—When first seen in the out-patient room by Dr. Day and Dr. Blackley, the patient's gait, the method of rising from the ground by climbing up his knees, and the arching forward of the spine in the lumbar region were all suggestive of pseudo-hypertrophic paralysis; the early history of the case, especially the sudden onset of the paralysis, the wasting confined to the lower extremities, and most of all, the electrical reaction of the affected muscles, served to make the true nature of the ailment unmistakable. The marked improvement under treatment also confirmed the correctness of the diagnosis.

SURGICAL CASES.

(Under the care of Mr. KNOX SHAW.)

Irreducible Inguinal Hernia ; Radical Cure by Barker's Operation ; Recovery.

AT the June meeting of the British Homœopathic Society Mr. Knox Shaw showed a patient upon whom he had performed Barker's operation for the radical cure of hernia. We are now able to publish the case from notes taken by Mr. W. Cox, Assistant Resident Medical Officer.

Charles K—., æt. 24, was admitted into the hospital March 12th, 1890. His family history is good and he has always been quite well and strong, with the exception of some inflammation of the bowels when he was fourteen. About six years ago patient first noticed a small lump in the groin, it caused him no pain and he joined in his usual athletic exercises. In about two years the swelling reached the scrotum. He never took any notice of the hernia till last November, when he had frequent attacks of vomiting and retching, with pain across the hypogastrium, and occasionally down into the sac. He now attended the hospital as an out-patient under Dr. Byres Moir, when he learned for the first time the nature of his illness, and was ordered a truss. But he was never able to keep the hernia up satisfactorily, any exertion easily bringing it down. It was then found that the whole of the contents of the sac were never thoroughly reduced, but that a portion of tissue remained, which was thought to be adherent omentum. Under these circumstances Dr. Moir sent the man into the hospital.

He was a very healthy young man, with a well marked right inguinal hernia, the contents of the sac not being entirely reducible. The external ring was very large and patent, and the scrotal tissue redundant and lax. Urine normal.

March 18th.—Dr. Day having administered *ether*, and the parts having been previously rendered thoroughly aseptic, Mr. Knox Shaw made an incision about three inches long, along the course of the inguinal canal, having

P 2

its centre over the external ring. The sac was then carefully dissected out, some small veins being divided between compression forceps; the neck of the sac being cleared with the handle of the scalpel. The wound was next thoroughly douched with perchloride lotion, and all bleeding arrested. An incision was now made into the sac, the wall of which was found to be much thickened, revealing a considerable quantity of adherent omentum. This was ligatured in several places with catgut and the larger portion removed, the remainder being returned into the abdominal cavity. Two long strong silk ligatures were now passed round the sac, tightly tied, and the sac divided between them. The portion of the sac between the ligatures was removed bodily, and the lower ligature was cut short and the sac dropped into the scrotum. The upper ligature was treated in the following way; the ends were passed by means of a handled needle along the inguinal canal, as high up as possible, one on each side of the internal ring and out through the tissues of the abdominal parietes, so that when tied the neck of the sac was pulled well up into the ring and at the same time the pillars of the ring were approximated. The perchloride douche was again used and the wound sewn up with silkworm gut, no drainage tube being thought necessary.

The patient took the *ether* badly, and at this point being somewhat collapsed an enema of brandy was administered. Carbolic gauze dressings were used.

March 19th.—Slept badly; has very troublesome vomiting from the anæsthetic. Ordered *ipecac.* Temp. 100°. Evening temp. 99.6°.

March 20th.—Vomiting continues. Temp. 98.2°. Taking only milk and a little brandy. Is jaundiced; has very little pain in the wound. Evening temp. 99.2°.

March 21st.—Temp. normal. Sleeping better; sickness stopped; tongue dry and furred; bowels constipated; still jaundiced. Ordered *podoph.*

March 22nd.—Temp. normal night and morning; no pain.

March 24th.—Temp. normal; taking some solid food.

March 25th.—Last night the temp. went up suddenly to 101.6°; this morning it is 99.2°. Dressings removed for the first time; the greater part of the incision is

healed; there is a little gaping at the lower part; the scrotum is œdematous and the sac distended and painful.

March 27th.—Temp. has not been higher than 100°. Wound nearly all healed; some pus from lower third of wound; scrotum much better, but there is distinctly fluid in the sac.

March 29th.—Temp. has been normal since the last note. As there was still fluid in the tunica vaginalis, a hollow needle was introduced, but the fluid was found not to be purulent.

From this date nothing worthy of note occurred; the patient made a good recovery. A little delay arose from two of the ligatures not being absorbed and making their way externally. He was discharged May 5th to a convalescent home, wearing a truss. When he presented himself for examination at the meeting he had a sound scar, and there was no attempt of the hernia to return.

*Pedunculated papilloma of the bladder; supra-pubic cystotomy; recovery.**

MRS. MARY J., aged 68, was admitted into Ebury ward on November 26th, 1889, complaining of hæmaturia, dysuria and hæmorrhoids. Her family history is good; she is a widow, and has given birth to eight children. With the exception of her present illness she has always enjoyed very good health.

About eight years ago she swallowed a piece of glass whilst drinking some beer; this was followed by a sharp attack of hæmatemesis. She is not conscious of having passed the glass per rectum. Seven years ago she first noticed that she was passing blood mixed with her urine; this lasted a day or two and then stopped. She felt, however, quite well and had no pain. Every year or two she was liable to these attacks of hæmaturia, they sometimes lasted several weeks, but were never accompanied with any pain. Eighteen months ago the hæmorrhage became more persistent, and micturition now became painful. The hæmorrhage and pain have hardly ever ceased since that time. She has never passed any

* From notes taken by Mr. Dudley Wright, Resident Medical Officer.

stone or gravel or any solid substance from the bladder, but two months ago she passed for several mornings a thick white sediment. The pain occurs just before passing water, and continues till about five minutes after the completion of the act, but is at its height during micturition; it is of a pricking character, compelling her at times to call out loudly, and is localised in the bladder. The patient has lost flesh lately. She is constipated, and sometimes passes blood with her motions.

When examined her lungs were found to be healthy; heart healthy, except a faint suspicion of a præ systolic bruit; liver and spleen normal. There was no distension of the bladder, but some tenderness on pressure over that region. A sound was passed into the bladder, but did not reveal anything. The only thing shown by a vaginal examination was a tender spot on deep pressure high up and to the left side of the anterior wall of the vagina. Examination of the anus showed a painful, florid, conical pile. The urine contained blood and albumen, but no fragments of villous growth were discoverable by the microscope. No cystitis.

Dec. 1st.—The patient complained of such acute pain on micturition that Mr. Wright used the catheter. The pain had not been relieved by the use of tincture of *hyoscyamus*.

Dec. 3rd.—The patient being anæsthetised, the urethra was dilated rapidly with Weiss' dilator and the finger was introduced into the bladder, when two good-sized, rounded tumours were discovered, one attached to each end of a short and thick Y-shaped pedicle. The growths were smooth, soft, and very vascular, and evidently were attached to the left side of the base of the bladder. The bladder was also examined by Drs. Byres Moir and Burford. As it was decided that the tumours were too large to remove by the means then at hand, and would be better dealt with by a supra-pubic operation, the bladder was washed out, and the pile having been removed, the patient was put back to bed. She soon recovered from the examination, and the bladder was ordered to be washed out night and morning. The temperature rose to 102.4° the same evening, but fell to normal the next day.

Dec. 10.—This afternoon, at three o'clock (Dr. Roberson

Day administering the anæsthetic) the bladder was well washed out with warm *boro-glyceride* solution. It was then filled with the same solution by attaching an irrigator to a catheter in the bladder; this easily distended the viscus, and by raising and lowering the irrigator the amount of distension was kept perfectly under control. A Petersen's bag was introduced into the rectum, but was not distended as it was found that the bladder was raised sufficiently by its own distension. An incision about two-and-a-half inches long was made in the mid-line above and a little below the pubes through the subcutaneous fat which in this position was of considerable thickness. The aponeurosis of the abdominal muscles was exposed and slit up on a director; a transverse incision was made at its insertion into the pubic bone. No vessels needed securing. The fat and tissues in front of the bladder next came into view, and these being pushed aside with the handle of the scalpel the bladder was exposed. A sharp hook was used to fix it whilst an incision was made into it with a scalpel and the wound enlarged with a pair of scissors. The edges of the bladder wound were then secured by two pairs of clamp forceps and held apart; the tumour immediately presenting in the opening. After washing out the bladder, the base of the tumour was seized with a pair of forceps, a second pair was placed just above the first, and one of the tumours removed by torsion. The second tumour was so soft and friable that it was removed piecemeal. There was very free hæmorrhage. Every soft portion of the growth was then scraped carefully away with a Volkman's spoon until normal tissue was reached. A free flushing of the bladder and pressure controlled the hæmorrhage. A long needle, armed with catgut, was passed so as to include all the tissues together with the wall of the bladder; this was done on each side of the wound. These were then tied so as to suture the bladder to the abdominal wall. The abdominal wound itself was sutured with silk, a small portion being left open, through which a drainage tube was passed, the other end being brought out through the urethra to drain the bladder. A large antiseptic dressing was applied.

The patient recovered the effects of the operation well,

and there was very little hæmorrhage. Evening temp. 101.6°.

Dec. 11th.—The patient had a good deal of pain during the first part of the night but slept after 5.30 a.m. The wound was dressed, but as urine was escaping through the supra-pubic opening only, the drainage tube was taken out and a catheter was introduced into the bladder. During the afternoon the patient became very flushed, the skin being hot and slightly moist. Ordered *acon.* 1x and *merc. cor.* 3x every three hours alternately. Even. temp. 101°.

Dec. 12th.—Morn. temp. 100°. Last evening there was some tympanitic distension of the abdomen. There is considerable difficulty in keeping the patient dry, owing to the free escape of urine from the supra-pubic opening; large quantities of absorbent wool are used, and the patient is dressed several times a day. Even. temp. 101°.

Dec. 13th.—Morn. temp. 100°. Had a very good night and a small action of the bowels. As the escaping urine was causing some soreness and irritation of the skin, it was rubbed over with boro-glyceride. A little urine now escapes by the catheter; it is quite free from blood and there is no cystitis. The tympanitis is much less and the tenderness of the abdomen is disappearing.

Dec. 14th.—To prevent the urine from running into the bed an ovariectomy apron was applied to the abdomen. the edge of the opening being made to adhere firmly to the skin. A quantity of absorbent wool was then placed over the wound and the apron pinned over this. This method certainly lessened the amount of the urine that escaped.

An enema administered last evening gave great relief to the patient.

From this date she made good progress, the temperature became normal and she took her food well. On December 17th she passed some urine naturally. As she was very constipated on December 20th she was ordered *nux vom.*

Dec. 24th.—Constipation still obstinate, ordered *collinsonia* ϕ . By January 11th the wound had almost contracted to a pin-point, but still permitted some escape of urine.

Jan. 16th.—The bladder now holds four ounces of urine.

Jan. 28th.—The wound is entirely closed, no urine now escapes.

Feb. 3rd.—Patient gets up every day.

Feb. 15th.—The bladder was examined to-day; no unevenness was discovered in the bladder wall by the sound; the bladder seemed roomy, and no induration was discovered on examining the bladder through the vagina. There has been no hæmaturia since the operation, and the patient has quite lost all pain on micturition.

March 4th.—Patient left the hospital to-day.

Remarks by Mr. Knox Shaw.—Modern surgery has greatly tended to increase the interest in the diagnosis and treatment of tumours of the bladder, for by its means they can now be attacked with a very reasonable prospect, in suitable cases, of a successful issue. It is only within recent years that any systematic attempt has been made to deal with this class of cases, and even now there is some division of opinion whether these tumours should be reached by a median perineal incision or by a supra-pubic cystotomy.

Sir Henry Thompson has done much to bring the former method prominently before the notice of the profession, both as an exploratory and a curative operation. Later writers, including Greig Smith and Jacobson in England, and Helmuth in America, have pronounced strongly in favour of adopting "the supra-pubic method of opening the bladder, *seeing* the growth, and removing it *in toto*, either by the scoop, the forceps, or the ligature" (Helmuth). The supra-pubic method enables the surgeon to remove all tumours that are capable of removal, in the safest and easiest manner; and is therefore preferable to the perineal route which may have to be abandoned after it has been undertaken, in favour of the high operation. The diagnosis of the actual size of the tumour and its attachment is in our present knowledge of the subject a matter of considerable difficulty, so that it is scarcely possible to decide before opening the bladder whether the growth can be easily and entirely removed by the low operation. Under these circumstances it seems better to adopt the high operation as the general mode of procedure. It is probable that a more extensive use of vesical endoscopy will materially

assist in the diagnosis of these cases. But considerable experience is needed in this method of examination so as to be able to translate successfully what is seen.

When reviewing the history of this case with a view to making a diagnosis, one is at once struck with the long period over which the hæmaturia existed, and also its intermittent character. This is quite in accord with what has been observed in these non-malignant cases, and strengthened one's opinion as to the probability of the non-recurrence of the tumour if it were removed. Further, it should be noted how in this case, as in so many others, the sound gave only negative results.

It is certainly a matter of regret that the endoscope was not used, but the female bladder is so easily accessible to a digital examination that this method was undertaken, hoping that at the examination the growth might be removed.

It is frequently possible, when the growth is of the villous variety, to detach a portion of it by washing out the bladder, and by submitting the debris to a microscopical examination, to arrive at a diagnosis. Or even self-detached portions may be found in the urine.

The tumour in this case was one of the rarer varieties. Dr. Robertson Day undertook the microscopical examination, and reported as follows:—"The tumour was distinctly pedunculated, and about the size of a good large walnut (?). It was exceedingly soft and friable, and very vascular. To the naked eye it had an irregular cauliflower-like surface. The microscope showed it to be a typical papilloma with the bulk of the growth made up of an exceedingly loose areolar tissue, the free surface being composed of branching processes covered with epithelium, which was distinctly columnar. Delicate strands of areolar tissue ran up into these processes, and in this tissue were many connective tissue corpuscles."

The *technique* of the operation was founded on the suggestions of Mr. Greig Smith as detailed by him in his very instructive work *Abdominal Surgery*. There are two points of especial interest; first, the value of hydrostatic distension of the bladder; this alone, without any distension of the rectum, sufficed to elevate the peritoneum and keep it out of harm's way. And secondly, the case proves that it is quite possible easily to remove, without

rectal distension, vesical tumours. To both these points considerable attention is given by Mr. Greig Smith, and he brings anatomical and experimental investigation to show that they are worth considering by practical surgeons.

Primary suture of the bladder wound would probably, if successful, do much to prevent a long convalescence. But unless so satisfactorily done as to ensure a water-tight organ there is a great danger of a fatal issue from perivesical cellulitis due to urinary extravasation. In this case, owing to the unavoidable bruising of the tissues from the frequent introduction of instruments and cotton wool tampons into the interior of the bladder, it was thought advisable not to attempt primary suture but to leave the wound to heal by granulation. This, however, makes it necessary that a large amount of ingenuity should be exercised to prevent the escaping urine from soiling the bed and causing bedsores on the patient.

A great deal of the success of this case is due to the unremitting attention given to the avoidance of this difficulty by Mr. Dudley Wright and the nurses.

REPORT OF IN-PATIENTS

For the Year ended March 31st, 1890.

	Cured.	Much Im- proved.	Improved.	Unimproved.	Discharged at own request or unsuitable.	Under Treat- ment.	Died.	Total.
<i>Diseases of the Nervous System—</i>								
Post Diphtheritic Paralysis	3	...	...	...	...	1	1	5
Delirium Tremens	5	...	...	...	...	...	...	5
Chorea	12	...	...	...	...	1	...	13
Sciatica	2	1	1	...	...	1	...	5
Infantile Paralysis .....	...	4	...	1	...	...	...	5
Hysteria	2	...	1	1	1	...	...	5
Tubercular Meningitis .....	...	...	...	...	...	...	2	2
Tubercular Tumour of Brain ...	...	...	...	1	...	...	...	1
Hemiplegia .....	...	...	2	...	...	...	...	2
Disseminated Sclerosis .....	...	...	2	1	...	...	...	3
Chronic Meningitis .....	...	...	1	...	...	...	...	1
Spina Bifida .....	...	...	...	1	...	...	...	1
Cephalalgia	1	...	1	...	...	...	...	2
Epilepsy .....	...	...	1	...	...	...	...	1
Convulsions	4	...	...	...	...	1	1	6
Hysterical Hemiplegia	1	...	...	...	...	...	...	1
Facial Paralysis	2	...	...	...	...	...	...	2
Campo-Pedal Spasm	2	...	...	...	...	1	...	3
Hydrocephalus (chronic) .....	...	...	1	...	...	...	...	1
Cerebral Abscess .....	...	...	...	...	...	...	1	1
Ataxic Paraplegia .....	...	...	1	...	...	...	...	1
Laryngismus Stridulus	2	...	...	...	...	...	...	2
Myelitis Acuta .....	...	...	...	...	...	1	...	1
Pseudo Hypertrophic Paralysis	...	...	...	...	...	1	...	1
Ménière's Disease .....	...	...	...	...	...	1	...	1
Raynaud's Disease .....	...	...	1	...	...	...	...	1
<i>Diseases of the Eye—</i>								
Distichiasis .....	...	...	2	...	...	...	...	2
Acute Conjunctivitis	1	...	...	...	...	...	...	1
“Essential Atrophy of Con- junctiva” .....	...	...	...	1	...	...	...	1
Strumous Ophthalmia	1	...	...	...	...	...	...	1
Ulcer of Cornea	3	...	...	...	...	...	...	3
Keratitis	1	...	...	...	...	...	...	1
Staphyloma of Cornea .....	...	1	...	...	...	...	...	1
Wounds of the Eye	2	...	...	...	...	...	...	2
Iritis	3	2	...	...	...	...	...	5
Sympathetic Ophthalmia .....	...	...	...	...	...	1	...	1
Subacute Glaucoma .....	...	...	1	...	...	...	...	1

	Cured.	Much Im- proved.	Improved.	Unimproved.	Discharged at own request or unsuitable.	Under Treat- ment.	Died.	Total.
<i>Diseases of the Eye (continued)—</i>								
Chronic Glaucoma .....	...	...	2	...	...	...	...	2
Senile Cataract	2	1	...	...	...	...	...	3
Congenital Cataract .....	...	1	1	...	...	...	...	2
Strabismus	1	1	...	...	...	...	...	2
Ophthalmoplegia Externa	1	...	...	...	...	...	...	1
Ciliary Blepharitis.....	...	2	...	...	...	...	...	2
<i>Diseases of the Ear—</i>								
Otitis Media Chronica .....	...	1	...	...	...	...	...	1
Abscess of Mastoid Cells .....	...	...	...	...	...	1	...	1
<i>Diseases of the Circulatory System—</i>								
Anæmia	7	8	3	...	...	3	...	21
Venous Thrombosis	2	3	...	...	...	...	...	5
Ulcerative Endocarditis	1	...	...	...	...	...	1	2
Chronic Valvular Disease.....	...	6	8	...	...	2	...	16
Arterial Degeneration .....	...	...	...	...	...	...	1	1
Exophthalmic Goitre.....	...	1	...	...	...	...	...	1
Acute Pericarditis	1	...	...	...	...	1	...	2
Varicose Veins	2	...	...	...	...	...	...	2
<i>Diseases of the Respiratory System—</i>								
Pleurisy	12	...	...	...	...	...	...	12
Acute Croupous Pneumonia.....	21	...	...	...	...	...	...	21
Subacute Phthisis .....	...	10	3	2	1	4	...	20
Fibroid Phthisis .....	...	...	4	...	...	...	...	4
Acute Bronchitis	22	...	...	...	...	2	1	25
Acute Phthisis	1	1	...	...	...	1	...	3
Syphilitic Laryngitis	1	...	...	...	...	...	...	1
Acute Bronchitis and Catarrhal Pneumonia	12	...	...	...	...	...	3	15
Empyema	1	...	...	...	...	...	1	2
Chronic Bronchitis.....	...	4	2	...	...	1	...	7
Croup	4	...	...	...	...	...	...	4
Bronchiectasis.....	...	3	...	...	...	...	...	3
Epistaxis	1	...	...	...	...	...	...	1
Post Nasal Polypi	1	...	...	...	...	...	...	1
Acute Laryngitis	1	...	...	...	...	...	...	1
<i>Diseases of Alimentary System—</i>								
Perineal Fistula	5	2	...	...	...	...	...	7
Fæcal Obstruction	1	...	...	...	...	...	...	1
Cirrhosis of the Liver .....	...	...	...	...	...	...	1	1
Ischio-rectal Abscess.....	3	1	...	...	...	...	...	4
Acute Gastritis	26	4	...	...	...	...	...	30
Melæna.....	1	...	...	...	...	...	...	1
Gastric Ulcer	7	...	...	...	...	...	...	7
Chronic Gastritis	1	2	...	...	...	...	...	3

	Cured.	Much Im- proved.	Improved.	Unimproved.	Discharged at own request or unsuitable.	Under Treat- ment.	Died.	Total.
<i>Alimentary System (continued)—</i>								
Acute Peritonitis	1	...	...	...	...	...	1	2
Hæmorrhoids	5	...	...	...	...	...	...	5
Hepatic Colic	3	...	...	...	...	...	...	3
Prolapsus Recti	2	...	...	...	...	...	...	2
Tabes Mesenterica .....	...	3	2	...	...	3	...	8
Chronic Peritonitis .....	...	1	...	...	...	...	...	1
Epithelioma of Pylorus .....	...	...	...	...	1	...	...	1
Chronic Constipation.....	1	...	...	...	...	...	...	1
Umbilical Abscess	1	...	...	...	...	...	...	1
Acute Enteritis	7	...	...	...	...	...	...	7
Carcinoma of Liver .....	...	...	...	2	...	...	...	2
Acute Tonsillitis	8	...	...	...	...	...	...	8
Amyloid Degeneration of Liver	...	1	...	...	...	...	...	1
Fissure of Anus	2	...	...	...	...	...	...	2
Subacute Gastritis	4	...	...	...	...	...	...	4
Chronic Enteritis .....	...	2	...	...	...	...	...	2
Stricture of Oesophagus .....	...	1	...	...	...	...	...	1
Inguinal Hernia.....	...	...	...	...	...	1	...	1
Cylindrical Epithelioma of Rectum .....	...	...	...	...	...	1	...	1
Hare Lip	1	...	...	...	...	...	...	1
Chronic Tonsillitis	1	...	...	...	...	...	...	1
<i>Diseases of the Genito-urinary System—</i>								
Phimosi s	8	...	...	...	...	...	...	8
Chronic Nephritis .....	...	4	...	...	...	...	...	4
Abscess of Prostate Gland	1	...	...	...	...	...	...	1
Sarcoma of Bladder .....	...	...	...	...	...	1	...	1
Acute Nephritis	3	...	...	...	...	2	...	5
Acute Cystitis and Stricture ...	...	1	...	...	...	...	...	1
Sarcoma of Kidney .....	...	...	...	...	1	...	...	1
Dysuria.....	1	...	...	...	...	...	...	1
Subacute Nephritis .....	...	2	...	...	...	...	...	2
Papilloma of Bladder	1	...	...	...	...	...	...	1
Stricture of Urethra	1	...	...	...	...	...	...	1
Calculous Pyelitis .....	...	...	...	...	...	1	...	1
Tubercular Pyelitis .....	...	...	...	...	...	1	...	1
Cystic Degeneration of Kidney	...	...	...	...	...	1	...	1
Vesical Calculus.....	...	1	...	...	...	1	...	1
Chronic Endometritis	5	3	...	...	...	3	...	11
Ruptured Perinæum	2	1	...	...	...	...	...	3
Metrorrhagia .....	...	...	...	...	...	1	...	1
Passive Congestion of Uterus ...	1	...	...	...	...	...	...	1
Hydrocele.....	2	1	...	...	...	...	...	3
Uterine Polypus.....	3	...	...	...	...	...	...	3
Pelvic Cellulitis (chronic).....	1	1	...	...	...	...	...	2
Urethral Caruncle	1	...	...	...	...	...	...	1
Epithelioma of Vulva .....	...	...	...	1	...	...	...	1
Ovaritis	1	4	...	...	...	2	...	7
Carcinoma of Cervix Uteri .....	...	...	...	1	...	...	...	1

	Cured.	Much Im- proved.	Improved.	Unimproved.	Discharged at own request or unsuitable.	Under Treat- ment.	Died.	Total.
<i>Diseases of the Genito-Urinary System (continued)—</i>								
Pelvic Cellulitis (acute)	5	...	...	...	...	...	...	5
Retroflexion of Uterus .....	...	1	...	...	...	...	...	1
Uterine Fibroid .....	...	4	...	...	...	1	...	5
Vaginitis	2	...	...	...	...	1	...	3
Vaginismus	1	...	...	...	...	...	...	1
Acute Orchitis.....	3	...	...	...	...	...	...	3
<i>Diseases of the Muscular System—</i>								
Lumbago	2	1	...	...	...	...	...	3
Gluteal Abscess	1	...	...	...	...	...	...	1
Abscess in Muscles of Abdomen	1	...	...	...	...	...	...	1
Abscess in Sole of Foot.....	1	...	...	...	...	...	...	1
Gumma of Calf	1	...	...	...	...	...	...	1
<i>Disease of the Cutaneous System—</i>								
Syphilitic Ulceration.....	5	...	...	...	1	1	...	7
Pemphigus	3	...	1	...	...	1	...	5
Acute Eczema	4	...	...	...	...	3	...	7
Lupus .....	...	5	2	...	...	1	...	8
Varicose Ulcer of Leg	5	2	1	...	1	...	...	9
Herpes Zoster	1	...	...	...	...	...	...	1
Psoriasis .....	...	...	3	...	...	...	...	3
Ingrowing Toe-nail	2	...	...	...	...	...	...	2
Superficial Abscess.....	5	...	...	...	...	2	...	7
Urticaria	2	...	...	...	...	...	...	2
Rupia .....	...	1	...	...	...	...	...	1
Pityriasis Rubra.....	...	...	1	...	...	...	...	1
Carbuncle	2	...	...	...	...	1	...	3
Alopecia Areata .....	...	...	...	1	...	...	...	1
Lichen Scrofulosorum	2	...	...	...	...	...	...	2
Tubercular Ulceration	1	...	...	...	...	...	...	1
Sebaceous Cyst	1	...	...	...	...	...	...	1
<i>Diseases of the Glandular System—</i>								
Strumous Glands	5	2	...	...	1	...	...	8
Lymphatic Obstruction.....	...	...	1	...	...	...	...	1
Lymphadenoma .....	...	...	2	...	...	...	...	2
Chronic Lymphadenitis	2	1	1	...	...	...	...	4
Acute Lymphadenitis	6	...	...	...	...	...	...	6
<i>Diseases of the Osseous System—</i>								
Spinal Caries .....	...	1	2	...	...	1	...	4
Necrosis of Phalanx	2	...	...	...	...	...	...	2
Alveola Abscess	2	...	...	...	...	...	...	2
Abscess in Head of Ulna	1	...	...	...	...	...	...	1
Chronic Periostitis.....	...	2	...	...	...	...	...	2
Abscess in Antrum .....	...	1	...	...	...	...	...	1

	Cured.	Much Improved.	Improved.	Unimproved.	Discharged at own request or unamenable.	Under Treatment.	Died.	Total.
<i>Diseases of the Osseous System (con.)—</i>								
Necrosis of Tibia .....	...	2	...	...	1	...	...	3
Tubercular Caries of Tarsus.....	1	2	...	...	...	...	1	4
Pelvic Abscess.....	1	...	...	...	...	...	...	1
Necrosis of Ulna.....	1	...	...	...	...	...	...	1
Genu Valgum	1	...	...	...	...	...	...	1
Rachitis .....	...	...	4	...	...	...	...	4
Necrosis of Ilium .....	...	...	...	...	...	1	...	1
Dental Caries .....	...	...	...	...	...	1	...	1
<i>New Growths—</i>								
Nævus	4	...	...	...	...	...	...	4
Carcinoma of Breast	2	...	...	2	...	...	...	4
Sarcoma of Foot	1	...	...	...	...	...	...	1
Nævo-lipoma	1	...	...	...	...	...	...	1
Fibroma of Leg	1	...	...	...	...	...	...	1
Sarcoma of Neck .....	...	...	...	1	...	...	...	1
Epithelioma of Lip	1	...	...	...	...	...	...	1
Lipoma	2	...	...	...	...	...	...	2
Adenoma of Breast.....	...	...	...	...	1	...	...	1
Sarcoma of Ilium .....	...	...	...	1	...	...	...	1
Dentigerous Cyst	2	...	...	...	...	...	...	2
Epulis	2	...	...	...	...	...	...	2
<i>Diseases of Joints—</i>								
Strumous Disease of Knee .....	...	3	...	...	...	...	...	3
Strumous Disease of Ankle	1	2	...	1	...	1	...	5
Hip Joint Disease	2	3	1	...	...	5	...	11
Chronic Rheumatoid Arthritis...	...	10	4	...	...	...	...	14
Acute Bursitis.....	7	...	...	...	...	2	...	9
Subacute Rheumatism	3	5	...	...	...	...	...	8
Lateral Curvature .....	...	...	1	...	...	...	...	1
Chronic Bursitis.....	...	...	1	...	...	...	...	1
Sacro-iliac Disease .....	...	...	1	...	...	...	...	1
Thecal Abscess	1	...	...	...	...	...	...	1
Acute Synovitis	3	...	...	...	...	...	...	3
Inflamed Bunion	1	...	...	...	...	...	...	1
<i>Specific Fevers—</i>								
Measles.....	...	2	...	...	1	...	...	3
Gonorrhœal Pyæmia	2	...	...	...	...	...	...	2
Acute Rheumatism	37	2	3	...	...	...	...	42
Diphtheria	4	...	...	...	...	1	1	5
Acute Tuberculosis .....	...	2	...	...	...	...	...	2
Scarlet Fever .....	...	...	...	...	7	...	...	7
Enteric Fever	7	...	...	...	...	1	2	10
Simple Febricula	3	...	...	...	...	...	...	3
Parotitis	1	...	...	...	...	...	...	1
Erysipelas	2	...	...	...	...	...	1	3
Influenza	28	...	1	...	...	...	1	30

	Cured.	Much Improved.	Improved.	Unimproved.	Discharged at own request or unsuitable.	Under Treatment.	Died.	Total.
INJURIES :—								
Concussion	5	...	...	...	1	...	...	6
Fracture of Tibia	1	...	...	...	...	...	...	1
Scalp Wound	5	...	...	...	...	...	...	5
Poisoned Foot	1	...	...	...	...	...	...	1
Poisoned Arm	2	...	...	...	...	...	...	2
Fracture of Humerus	1	...	...	...	...	...	...	1
Rupture of Erector Spinae	1	...	...	...	...	...	...	1
Contusion of Abdomen	2	...	...	...	...	...	...	2
Burn of Leg.....	...	1	...	...	...	...	...	1
Injury to Radial Artery	1	...	...	...	...	...	...	1
Scald of Face	1	...	...	...	...	...	...	1
Injury to Middle Ear.....	...	...	...	...	...	...	1	1
Contused Hand	1	...	...	...	...	...	...	1
Fracture of Femur.....	...	...	...	...	...	1	...	1
Rupture of Ligaments of Ankle Joint .....	...	...	...	...	...	1	...	1
Do. do. Knee Joint	1	...	...	...	...	...	...	1
Traumatic Synovitis	1	...	...	...	...	1	...	2
DISEASES NOT CLASSIFIED :—								
Struma	1	5	...	...	...	...	1	7
Diabetes Mellitus .....	...	1	...	...	...	...	1	2
Marasmus.....	3	5	...	...	...	1	2	11
Leucocythæmia .....	...	...	...	2	...	...	...	2
Debility	2	...	...	...	...	...	...	2
Delirium Tremens	3	...	...	...	...	...	...	3
Peliosis Rheumatica	2	...	...	...	...	...	...	2
Malingering.....	...	...	...	...	1	...	...	1
	477	144	66	20	19	74	30	830



	Operation Successful.	Much Improved.	Improved.	Under Treatment.	Died.	Total.
SUMMARY OF OPERATIONS :—						
Staphyloma Corneæ .....	...	1	...	...	...	1
Symblepharon.....	..	1	...	...	...	1
Iridectomy	2	...	4	...	...	6
Cataract	2	1	2	...	...	5
Fistula in Ano	5	...	...	...	...	5
Ischio-rectal Abscess.....	4	1	...	...	...	5
Hæmorrhoids	5	...	...	...	...	5
Superficial Abscesses.....	14	...	...	...	...	14
Suppurative Tonsillitis.....	1	...	...	...	...	1
Circumcision	12	...	...	...	...	12
Chronic Endometritis	4	...	2	2	...	8
Excision of Strumous Glands.....	9	...	...	1	...	10
Amputation of Breast	2	...	...	...	...	2
Hydrocele.....	1	2	...	...	...	3
Lupus .....	...	1	1	...	...	2
Enlarged Bursa Patellæ	2	...	...	...	...	2
Polypus of Uterus.....	3	...	...	...	...	3
Tracheotomy	1	...	...	...	1	2
Removal of Epulis.....	1	...	...	...	...	1
Necrosis of Finger.....	2	...	...	...	...	2
Amputation of Foot	1	...	...	...	1	2
Amputation of Leg	1	...	...	...	...	1
Sacro-iliac Disease.....	...	...	1	...	...	1
Dentigerous Cyst	2	...	...	...	...	2
Lipoma.....	2	...	...	...	...	2
Ingrowing Toe-nail	2	...	...	...	...	2
Necrosis of Tibia and Ulna.....	1	1	1	...	...	3
Tubercular Tarsus.....	1	...	...	...	...	1
Abscess of Hip Joint.....	...	...	1	1	...	2
Hare Lip	1	...	...	...	...	1
Fissure of Anus	2	...	...	...	...	2
Excision of Fibroma	1	...	...	...	...	1
Excision of Nævus.....	2	...	...	...	...	2
Ligature of Radial Artery	1	...	...	...	...	1
Epithelioma of Lip	1	...	...	...	...	1
Empyema.....	1	...	...	...	...	1
Excision of Varicose Veins	1	...	...	...	...	1
Excision of Adenoma of Breast.....	1	...	...	...	...	1
Stricture of Urethra	1	...	...	...	...	1
Whitlow	1	...	...	...	...	1
Alveolar Abscess	2	...	...	...	...	2
Perineorrhaphy	2	1	...	...	...	3
Radical Cure of Hernia.....	1	...	...	...	...	1
Excision of Part of Rectum .....	...	...	...	1	...	1
Lithotrity .....	...	...	...	1	...	1
	98	9	12	6	2	127

CLASSIFIED SUMMARY

Of the Results of Treatment of 830 In-Patients during the Year ending March 31st, 1890.

	Cured.	Much Im- proved.	Improved.	Unimproved.	Discharged at own request or Unsuitable.	Under Treat- ment.	Died.	Total.
<i>Diseases of the</i>								
Nervous System	36	5	12	5	1	8	5	72
Ocular System.....	15	8	6	1	...	1	...	31
Aural System .....	...	1	...	...	...	1	...	2
Circulatory System	13	18	11	...	...	6	2	50
Respiratory System	77	18	9	2	1	8	5	120
Alimentary System	80	13	2	2	1	9	2	109
Genito Urinary System.....	42	22	...	2	1	12	2	71
Muscular System	6	1	...	...	...	...	...	7
Cutaneous System	33	10	8	1	2	9	...	63
Glandular System	13	3	4	...	1	...	...	21
Osseous System	9	8	6	...	1	3	1	28
Articular System	18	23	8	1	...	8	...	58
TUMOURS	16	...	...	4	1	...	...	21
ACUTE SPECIFIC FEVERS.....	85	3	...	...	8	5	8	108
INJURIES	23	1	...	...	1	3	1	29
DISEASES NOT CLASSIFIED	11	6	...	2	1	1	4	28
Total	477	144	66	20	19	74	30	830
Death Rate, per 1,000.....	36.144							
Percentage Cured	59.03							
Percentage Much Improved.....	17.34							
Percentage Improved.....	7.95							
Percentage Unimproved	2.40							
Percentage Discharged at Own Request or Unfit for Treatment	2.28							

TOTAL NUMBER OF PATIENTS TREATED DURING THE
YEAR ENDING MARCH 31st, 1890.

In-Patients	830
Out-Patients (Renewals 4,216)	10,363
Total	11,193

RETURN OF DENTAL CASES.

From April 1st, 1889, to March 31st, 1890.

Extractions—Adults	91
Do. Children under 14... ..	50
Irregularities of the Teeth treated surgically and mechanically	2
Advice Cases	37
Total number of Patients seen	180

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[AUGUST, 1891.

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OF THE
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SOCIETY,

AND OF THE

London Homœopathic Hospital.



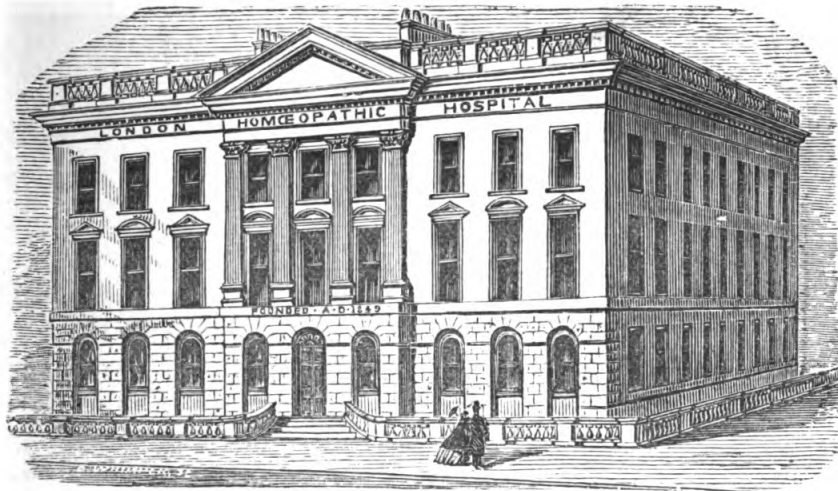
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Gilbert, Sydney, L.R.C.P., L.R.C.S. Edin.; L.A.H., L.M. Dub.; Roseneath, Reigate, Surrey	1888
Goldsbrough, Giles F., M.D., C.M. Aber., 50, Coldharbour Lane, London, S.E.	1881
Gould, E. Gardiner, L.K.Q.C.P.I., Woodlawn, Leigham Court Road, Londor, S.W.	1886
Guinness, Arthur, M.D. Glas.; F.R.C.S. and L.M. Dub.; Acacia Lodge, Oxford	1876
Hall, Edgar Atheling, M.B., C.M. Edin., Laurel Villa, Victoria Road, Surbiton, London, S.W.	1876
*†Hamilton, Edward, M.D. St. And.; F.L.S., &c.; 14, Cromwell Place, S.W.	1847
Harper, James Peddie, M.D. Edin.; L.R.C.S. Edin.; 43, Hertford Street, Mayfair, London, W.	1859

	Elected
Harris, Henry, M.R.C.S. Eng., 111, Denmark Hill, London, S.E. ...	1871
Hawkes, Alfred E., M.D. Brus. ; L.R.C.P. ; L.M. ; L.R.C.S. Edin. ; 22, Abercromby Square, Liverpool	1878
Hawkes, Edward John, L.R.C.P., L.R.C.S., L.M. Edin., 4, West Cliff Road, Ramsgate	1888
Hayle, Thomas Hahnemann, M.B. London, 154, Drake Street, Rochdale	1886
Hayward, John W., M.D. St. And. ; M.R.C.S. Eng. ; L.S.A. Lond. ; M.D. (Hon.) New York ; 61, Shrewsbury Road, Birkenhead ...	1868
Hilbers, Hermann Gerhard, B.A. Cantab. ; L.R.C.P. and S. Edin. ; L.F.P.S. Glas. ; 49, Montpelier Road, Brighton	1885
Hill, William Reid, M.B.C.M. Edin. ; 10, Crouch Street, Colchester ...	1887
*Hughes, Richard, M.D. (Hon.), L.R.C.P. Edin. ; M.R.C.S. Eng. ; 36, Sillwood Road, Brighton	1861
Jagielski, A. Victor, M.D. Berlin ; M.R.C.P. Lond. ; 54, York Terrace, Regent's Park, London, N.W.	1882
†Jones, D. Ogden, M.D. Toronto ; L.R.C.P. Lond. ; Toronto, Canada ...	1887
Jones, James, M.D. Edin. ; M.R.C.S. Eng. ; L.R.C.P. Lond. ; Friar Street, Reading	1866
Jones, T. Reginald, L.K.Q.C.P. Irel. and L.M. ; M.R.C.S. Eng. ; 24, Hamilton Square, Birkenhead	1881
Kennedy, Wm. Adam, M.R.C.S. Eng. ; M.B., L.R.C.P. Lond. ; 2, Eldon Square, Newcastle-on-Tyne	1886
Ker, Claudius Buchanan, M.D. Edin., Hadley House, Cheltenham ...	1879
†Kitching, William, M.B. Lond., Capetown... ..	1875
†Kyngdon, Boughton, Esq., M.R.C.S., Eng., Sydney, N.S.W.	
*Mackechnie, John Hamilton, M.D. St. And., 15, Catherine Place, Bath..	1850
McKilliam, Robert, M.D. and C.M. Aber., 1, Bennet's Park, Blackheath, London, S.E.... ..	1886
Mackintosh, Charles Hills, M.D. St. And. ; Ex. L.R.C.P. Lond. ; M.R.C.S. Eng. ; L.S.A. ; Morden Hall, Torquay	1868
Madden, Edward Monson, M.B. Edin. ; M.R.C.S. Eng. ; Burlington House, Bromley, Kent	1876
Marsh, Thomas Charles, L.R.C.P. Edin. ; M.R.C.S. Eng. ; L.M. ; 56, Fitzroy Street, London, W.	1885
Mason, Henry, M.B. and C.M. Glas. ; M.R.C.S. Eng. ; 73, Welford Road, Leicester	1886
†Matthias, W. Lloyd, L.R.C.P. Lond. ; M.R.C.S. Eng. ; Sydney, N.S.W.	1888
*Moir, Byres, M.B. and C.M. Edin., 4, Leinster Square, London W. ...	1882
Molson, James Cavendish, L.R.C.P. Lond. ; M.R.C.S. Eng. ; 13, Lingfield Road, Wimbledon	1889
Moore, John Murray, M.D., C.M., L.M. Edin. ; M.D. New Zealand ; 51, Canning Street, Liverpool	1877
Morgan, Samuel, M.D. St. And. ; M.R.C.S. Eng. ; L.S.A. ; 15, Oakfield Road, Clifton, Bristol	1867
Morrison, Stammers, M.D., M.R.C.S. Eng. ; L.R.C.P. Lond. ; Belgrave House, Stockwell Road, S.W.	1890
Murray, John, L.R.C.P., L.R.C.S. and L.M. Edin., 15, Trinity Gardens, Folkestone	1882

	Elected
Nankivell, Frank, M.D., C.M. Edin.; M.R.C.S. Eng.; 90, Kirkdale, Sydenham, S.E.	1888
Nankivell, Herbert, M.D. Edin.; M.R.C.S. Eng.; Penmellyn, Bournemouth	1868
*Neatby, Edwin A., M.D. Brux.; L.R.C.P. Lond.; M.R.C.S. Eng.; 161, Haverstock Hill, N.W.	1885
Neild, Frederic, M.D., C.M. Edin.; L.R.C.P. Edin.; Belvedere House, Tunbridge Wells	1885
Noble, James Black, M.R.C.S. Eng.; L.R.C.P. and L.M. Edin.; 51A, Trinity Square, Borough, London, S.E.... ..	1880
Norman, George, M.R.C.S. Eng.; L.S.A.; 12, Brock Street, Bath	1876
Pincott, James Cole, M.R.C.S.E.; L.R.C.P., L.M. Edin.; Calverley Parade, Tunbridge Wells	1886
*Pope, Alfred Crosby, M.D. Phil.; M.D. (Hon.) New York; M.R.C.S. Eng.; Watergate House, Grantham	1862
Powell, Alfred John, M.D. Erlangen; M.R.C.S. Eng.; Sewardstone Lees, Anerley Road, London, S.E.	1879
†Pritchard, Josiah, M.R.C.S. Eng.; L.S.A.; 3, Drummond Road, Bristol	1868
Purdom, T. E., M.D., C.M. Edin.; L.R.C.P., L.R.C.S. Edin.; Tregear, Park Hill Road, Croydon	1886
Pullar, Alfred, M.D. Edin., Leonard Bank, Beulah Hill, Upper Norwood, London, S.E.... ..	1884
Reed, R. Rhodes, M.D. Cleveland; M.R.C.S. Eng.; 33, London Road, Lynn Regis, Norfolk	1862
†Reid, L. Holland, M.R.C.S. Eng.; L.R.C.P. Lond.; Bowmanville, Ontario, Canada	1872
Renner, Chas., M.D. Leip.; L.R.C.P. Lond.; M.R.C.S. Eng.; 186, Marylebone Road, London, W.... ..	1885
Roche, E. B., L.R.C.P. Lond.; M.R.C.S., L.M.; Surrey Street, Norwich... ..	1878
Ross, William, L.K.Q.C.P. and L.R.C.S.I., L.M.; 86, Chapel Field Road, Norwich	1891
†*Roth, Mathias, M.D. Pavia, Villa Beaujeu, Divonne, Ain, France	1869
Sandberg, Arthur G., M.D., L.R.C.P., L.R.C.S., L.M. Edin., Liverpool Lodge, Brixton Hill, London, S.W.	1880
Scriven, William Barclay Browne, A.B. and M.B. Trin. Coll. Dub.; M.R.C.S.L.; 33, St. Stephen's Green, Dublin	1856
Shackleton, Henry, M.D. Dub.; M.R.C.S. Eng.; L.M.K.Q.C.P.I.; L.M. Rot. Hosp. Dub.; 12, West Hill, Sydenham, London, S.E.	1885
*Shaw, Charles Thomas Knox, L.R.C.P. Lond.; M.R.C.S. Eng.; 19, Upper Wimpole Street, W.	1883
Shaw, Frank Herbert, M.R.C.S. Eng., 35, Wellington Square, Hastings.	1885
Simpson, Thomas, M.D. St. And.; M.R.C.S. Eng.; Tulliallan Villa, Waterloo, Liverpool	1888
Skinner, Thomas, M.D. St. And.; L.R.C.S. and L.M. Edin.; 25, Somerset Street, Portman Square, W.	1889
†Smart, John Cass, M.D. Heid.; Ext. L.R.C.P. Lond.; M.R.C.S., Eng.; L.S.A. Lond.; Combe Hay, near Bath	1859

	Elected
Smith, Gerard, M.R.C.S., Eng.; Craigholm, Upper Clapton, London, E.	1885
†Smith, Harmar, L.R.C.P. Edin.; M.R.C.S. Eng.; L.S.A., 78, Pevensey Road, Eastbourne	1861
Stancomb, Ernest H. M., M.B., C.M. Edin.; 2, Lower Moira Place, Southampton	1890
†Stephens, S. Sanders, M.R.C.S., Eng., 54, Brook Street, W.	1866
Stonham, Thomas George, M.D. Lond.; M.R.C.S. Eng.; Claremont, Belgrave Road, Ventnor	1889
Storrar, W. M., L.R.C.P., L.R.C.S., L.M. Ed., 49, Bath Street, Southport.	1887
Süss-Hahnemann, L., M.D. Leip., 14, Highbury Crescent, London, N. ...	1877
Thomas, E. Wynne, M.D. Lond.; M.R.C.S. Eng.; L.S.A.; 8, Harborne Road, Edgbaston, Birmingham	1864
Thomas, Edward John Haynes, L.R.C.P., L.R.C.S. Edin., 18, Pepper Street, Chester	1886
Thomas, Harold Wynne, M.R.C.S., Eng.; L.R.C.P. Lond.; 19, Widmore Road, Bromley, Kent	1891
†Tuckey, Charles Caulfield, A.B., M.B., T.C.D., L.R.C.S.I., Charleville, Kew	1855
Vawdrey, Theophilus Glascott, L.R.C.P. Lond.; M.R.C.S. Eng.; 3, Wyndham Square, Plymouth	1886
†Watson, Charles George, L.R.C.S., L.K.Q.C.P. Ire.; L.M.; Hobart, Tasmania	1862
†Wagh, Dr., Brisbane, Queensland	1858
†Wheeler, Henry, L.R.C.P. Lond.; M.R.C.S. Eng.; 147, Collins Street, Melbourne	1861
Withenshaw, Charles William, L.R.C.P. and S. Edin., 12, Mayflower Road, Clapham, S.W.	1889
Wolston, Walter T. P., M.D. Edin.; M.R.C.S., Eng.; 46, Charlotte Square, Edinburgh	1877
Wood, H. Thorold, M.R.C.S. Eng., 86, Seymour Street, London, W. ...	1876
Wright, Dudley d'A., L.R.C.P. Lond.; M.R.C.S. Eng.; 21, Leinster Square, W.	1889
*Wyld, George, M.D. Edin., 41, Courtfield Road, South Kensington, London, S.W.	1854
*Yeldham, Stephen, M.R.C.S. Eng.; L.R.C.P. Edin.; Highfield House, St. Nicholas Road, Upper Tooting, Surrey, S.W.	1849

Annals of the Society.

THE TWO PATHS IN HOMŒOPATHY.

By JOHN H. CLARKE, M.D.,

Physician to the London Homœopathic Hospital.

GENTLEMEN,—There is a story told of the early days of homœopathy that illustrates a most enviable uniformity in homœopathic prescribing. It is said that a certain gentleman having consulted a number of allopaths, and having received as many different prescriptions as he consulted physicians, next gave the homœopaths a trial. He consulted eight, and from every one he received the same prescription. Like a sensible man he said to himself, “This is the medicine and the system for me”; and naturally, he was cured.

I have never ceased to admire that illustrious eight, and I very much question if the lucky patient could repeat his experience now-a-days. It seems to me that there is a great deal of drug-favouritism among us in this enlightened end of the nineteenth century, and not very much system; and I suspect that by one or two of us, perhaps, he would have had prescribed for him a “very useful tonic”; by others a variety of the syrups or tabloids prepared by certain enterprising and ingenious firms of allopathic chemists; and by another *cod liver oil*, the mother tincture of *nux vomica* and a few other homœopathic “sheet anchors” being thrown in here and there.

These, gentlemen, are my crude notions. They may, of course, be unfounded. I only regret that I have not been able to meet with a persevering patient sufficiently lavish of his time and his guineas to be persuaded to make the round. So my ideas must lack the experimental test so dear to the modern scientific mind, and you must allow me to assume for twenty minutes that there is a good deal of what I have called drug-favouritism among us.

B

When I was first led to look into homœopathy I found two sources of information open to me—the works of the Hahnemann Publishing Society, including the *Cypher Repertory*, and the works of my venerated teacher, Dr. Hughes. Acting on a principle which I once saw enunciated somewhere: “always choose the easiest”—I like to act on principle when possible—I selected Dr. Hughes for my guide. Dr. Hughes’ works have this great merit—they are readable and readily utilisable, and they don’t shock unnecessarily your allopathic feelings. My successes astonished me; my failures were not numerous enough to make me desire to retrace my steps, and so I stuck to Hughes and homœopathy.

But I did not find the homœopathic family quite so united as I had imagined. In point of fact, there was a good deal of controversy, and the combatants raised so much dust in their strivings that it was long before I was able to discover exactly what the fighting was about. I think I understand now; and it is with one of the points in dispute that I intend to deal to-night. I hope that to-night and in future we shall carry on our contests with the new smokeless gun-powder, so that we may see what we are aiming at, and slay our adversaries according to the latest rules of amiability and science.

In the realm of homœopathy there are two paths which diverge at a point and lead in widely opposite directions. The essence of the homœopathic art lies in matching corresponding things; and the essential difference between one homœopathist and another is in the mode in which they attempt this matching. On the one side are those who endeavour, when they meet with a diseased condition—say pneumonia—to find a medicine that has produced pneumonia, or whatever the disease may be named; and on the other side are those who, when they meet with disease, having satisfied themselves as to the diagnosis, prognosis, pathology and all the rest, put all these on one side when they come to select the medicine for the patient. Instead of matching disease with a drug that has produced the disease, they go to the patient, take him to pieces (so to speak) symptom by symptom, ranking the symptoms at the same time in the order of their importance, and then match the case with

the drug that has produced the same or similar symptoms in the same order.

The parting of the ways lies in the relative importance given to pathological states and nosological terms on the one hand, and to symptoms and appearances on the other, in the matter of diagnosing the remedy. The difference is one of attitude.

Hahnemann regarded symptoms—objective and subjective—as the proper expression of the state of the life-force. Beneath the material particles of our body there is an immaterial something, the loss of which leaves the material body dead. In disease this life-force is the seat of injury, the visible and sensible alterations in the patient being the expression of the nature and extent of the injury. And as the life-force pervades every part of the organism, it follows that whenever any part is affected all the rest is likely to sympathise. Hence it follows that for homœopathic prescribing it is necessary in every case to take into consideration the whole patient, and not to rest content when we have located his malady in the leg, the liver, the lung or any other part and given it a soul-satisfying name.

In my earlier and more enthusiastic days, in announcing my conversion to an eminent allopathic friend, now deceased, I mentioned that *phosphorus* was the best medicine for pneumonia. Some time after I received a reply from him to the effect that he had tried it in four cases, and he thought it had done good in one of them, but he could see no good effect in the other three. I should know better than to say any such thing now. Not that I despise pathology and nosological terms—they are indispensable in their proper place, and when used in the right way are useful as a means of grouping medicines for prescribing purposes—but when we come to make the final selection, it is the individual symptoms and signs that must be our guide. Unless we give these the chief place in our prescribing, we shall fail oftener than we succeed, as did my friend under my imperfect guidance. When once we have got the symptoms of a patient, and have matched them with like symptoms produced by a drug in the healthy, we have a foundation to build upon that nothing can shake. It is to this, the citadel of homœopathy, that the one path leads, and it is in this direction, I maintain, that we ought to set our faces.

There is another path which seems at present in no lack of travellers. In this are to be found those who will not give a drug if they can help it, in any case, that has not been known to produce the actual morbid anatomical condition of the patient they happen to be treating. In the same way are those who think that the thermometer is the most important of all medicine-indicators, and if it happens to register more than a hundred degrees, prescribe *aconite* for *that* in the first place, whatever else they may do at the same time or afterwards. In all these cases there is, it seems to me, a deposing of the actual vital symptoms and an exaltation of something else in their place. An attitude is taken up and a path entered upon the end of which (I don't say the beginning or the middle, necessarily) is something which is *not* homœopathy; and everything that is not homœopathy I take leave to call "*allopathy*"—derived from the Greek word *ἄλλος*, meaning "other," and the English word "pathy," meaning "mode of practice."

I am not saying now which kind of practice is the most successful. I have practised all kinds myself, and succeeded tolerably in all; but I know which method is the most philosophic and satisfying—which best shows you your way through a complicated case—though it is, I allow, the most troublesome. Symptoms are the only definite facts in our knowledge of disease and drug-action, and once we have got our feet on them we have a "repose that ever is the same." We may not always be able to find it, but at any rate it is worth striving after and aiming at. Any other basis for prescribing—whether morbid anatomy, pathological theories, or nosological terms—is a foundation of shifting sand.

One point to be remembered by those who might be alarmed at the multitude of symptoms some patients exhibit, and the utter hopelessness of finding a drug to cover them all, is that the discoverer of homœopathy has pointed out the relative importance of certain symptoms, and so given us a clue to solving the problem. In every case we encounter there are certain symptoms of leading importance, and these are the points by which we are to take hold of our case. First in importance are moral, mental, or head symptoms attending any bodily disorder (in mental cases as Jahr has pointed out, concomitant

bodily symptoms are often of leading importance). Next, in importance come the most *peculiar* symptoms, and then the most *severe* symptoms. Then there are the conditions of time and circumstance, which still further help to particularise every case, and suggest the appropriate medicine. In each case the leading symptoms and features must be matched first; but in all the totality must be considered. The prescribing on so-called "key-notes," without reference to the sum total of a patient's symptoms, can only lead to disappointment. There are cases, of course, in which a single symptom constitutes the whole of the disease, and if it happens to correspond with a characteristic symptom of a drug there is no need to go further.

Dr. Dudgeon has recently brought to our notice, in the *Homœopathic World* for August last, two cases of Hahnemann's own, published in the second volume of the first edition of the *Materia Medica Pura*. The cases are well known, but I may be pardoned for quoting one of them here as I cannot better illustrate the method I am trying to describe. I will take the second of the two cases:

II. "W——, a weakly, pale man of 42 years, who was kept constantly at his desk by business, consulted me on Dec. 27, 1815; he had been already five days ill.

"1. The first evening, without manifest cause, he became sick and giddy, with much eructation.

"2. The following night (about 2 a.m.) sour vomiting.

"3. The subsequent nights violent eructation.

"4. To-day also severe eructation of foetid odour and sourish taste.

"5. He felt as if the food lay crude and undigested in his stomach.

"6. His head felt wide, hollow and dark, and as if sensitive internally.

"7. Sensitive to the smallest noise.

"8. His disposition is mild, soft and patient.

"Here I may observe:—

"To 1. That several medicines cause vertigo with nausea, as does also *pulsatilla* (8), which produces its vertigo in the evening also (7), a circumstance that has been observed of very few other medicines.

"To 2. *Stramonium* and *nux vomica* cause vomiting of sour and sour-smelling mucus, but as far as is known, not at night. *Valerian* and *cocculus* cause vomiting at night, but not of sour stuff. *Iron* alone causes vomiting at night

(61, 62), and can also cause sour vomiting (66), but not the other symptoms that should be attended to here. *Pulsatilla*, however, causes not only sour vomiting in the evening (349, 354), and nocturnal vomiting in general (355), but also the other symptoms of this case not found among those of *iron*.

“To 3. Nocturnal eructation is peculiar to *pulsatilla* (297, 298).

“To 4. Fœtid, putrid (260), and sour eructation (302, 303).

“To 5. The sensation of indigestibility of the food in the stomach is produced by few medicines, and by none in such a perfect and striking manner as by *pulsatilla* (321, 322, 327).

“To 6. Besides *ignatia* (2), which, however, cannot produce our other symptoms, the same state is caused by *pulsatilla* (39 compared with 42, 94, 98).

“To 7. *Pulsatilla* produces the same state (997), and it also causes over-sensitiveness of other organs of the senses, for example, of the sight (107). And although intolerance of noise is also met with in *nux vomica*, *ignatia* and *aconite*, yet these medicines are not homœopathic to the other symptoms, and still less do they possess symptom 8, the mild character of the disposition, which, as stated in the preface to *pulsatilla*, is particularly indicative of this plant.

“The patient, therefore, could not be cured by anything more easily, certainly, and permanently than by *pulsatilla*, which was homœopathic to the case. It was accordingly given to him immediately; but, on account of his weakly and exhausted state, only in a very minute dose, *i.e.*, half-a-drop of the quadrillionth [12th dil.] of a strong drop of *pulsatilla*. This was done in the evening.

“The next day he was free from all ailments. His digestion was restored, and a week thereafter, as he informed me, he remained free from complaint and well.”

The other case, I may mention, was cured equally promptly (though after an aggravation) by a drop of the undiluted juice of *Bryonia Root*.

I quote the above case in order to show the systematic way Hahnemann went to work in recording his cases symptom by symptom, and matching them with the drugs that had produced symptoms corresponding.

I am free to confess that I think the method was easier then than it is now. There were fewer drugs, and these were known by Hahnemann and his earlier disciples with an intimate familiarity we cannot hope to attain with our “Allen,” and besides Hahnemann had experienced in his own person most of the symptoms he was dealing with. And here I venture to make a recommendation,

the value of which a small experience of my own confirms, that when we are studying a drug we should prove it at the same time. There is nothing fixes its powers in the memory so well as that.

Chief among the difficulties we have now to contend against is the immense mass of material and the difficulty of finding the symptom we require. The need of a good *Repertory*, easy to use, and sufficiently full, has long been a great want. In point of arrangement the best *Repertory* I know is Constantine Lippe's, and Lee's founded upon it, which is now being published by the editors of the *Homœopathic Physician* as part of its regular issue.

The difficulties in the way of pure homœopathising are great, but they are not insurmountable. To follow it out demands that we shall live and move and have our being to a very large extent in our *Materia Medica*s and our *Repertories*, but the results are worth it; and every man must give himself up to his profession no matter what it may be. We ought not to be *dilletanti* in the use of drugs. I am not astonished when I hear of men going aside after Matteism, Schüsslerism, and Burroughs and Welcomism, and I do not condemn them; every man must choose that which he finds himself most capable of using. Nevertheless I deplore it. It seems to me, if homœopathy is to maintain its true place in the world, if it is to fulfil the high destiny its inherent qualities entitle it to, we, who are its present representatives and stewards, must set our faces resolutely in the direction of the model I have sketched. If we do this we shall not so often hear people say that they fail to discover any difference between homœopathy and allopathy.

DISCUSSION.

Dr. HUGHES said he had listened to Dr. Clarke's paper with very mingled feelings. He heartily sympathised with any attempt to draw men from going after crude practice to pure homœopathy; but he ventured to think that Dr. Clarke had gone away from the true path, and had strayed into a byway. The practice he seemed to advocate was almost extinct in Germany and this country, and had only a small minority in America. He differed from Dr. Clarke in ranking the symptoms. The only rational basis for that which he recommended is the exploded notion of a vital force. He did

not believe in any such thing. He knew nothing in physiology to give support to this. Any unity of the body other than that of the nerves and blood-vessels modern physiology did not acknowledge. He thought in a case of pneumonia it was of far greater importance for us to prescribe on the symptoms of the chest and the inflamed lung than any peculiar symptoms or any mind symptoms. Hahnemann's cases reported are simple derangements of health, of no great importance, and these may be taken symptom by symptom. If he had given us a case of peritonitis, it would have been different. Hahnemann was not nearly such a symptom-follower as are some of his disciples. Dr. Hughes was sure Hahnemann would have approved our modern practice of limiting our treatment of pneumonia to a narrow circle of drugs. He did not acknowledge that Dr. Clarke's description of those who would only prescribe drugs that had produced actual disease was correct. He said that in the repertories recommended by the minority, symptoms were to be found which had never been produced in healthy people. He placed first in importance symptoms really pathognomonic of the disease, and not the peculiar and mental symptoms.

Dr. PULLAR said the society was much indebted to Dr. Clarke for opening a discussion on a question so vital to the interests of homœopathy. The different aspects of the subject had been so clearly set forth in his paper that we could not logically evade the issues. The two paths appeared to him essentially divergent, and he agreed with Dr. Clarke in failing to see any meeting-point. On the one hand there is the broad and well-trodden road of empirical practice, on the other the narrow and difficult path of homœopathy. It is always necessary to bear in mind that results may be obtained by widely different methods, as the curative art fulfils itself in many ways, for instance by surgical or mechanical measures, or by dietetic treatment, or even by heroic doses of medicine. *C'est magnifique mais ce n'est pas la guerre*—it is striking, but it is not homœopathy. Every man must work out his own method of practice, and be free to adopt whatever he honestly believes to be the "more excellent way." But the real question raised by Dr. Clarke is on what ground the homœopathic school is to build its stronghold, from which it may securely regard the enemy at the gate. Is it the prescribing of medicines according to physiological conceptions of disease and of drug-action? Or is it the selection of a remedy most nearly the analogue of a given aggregate of symptoms, irrespective of any physiopathological theory? The distinction is at once evident, the former being simply the method of the old school, improved, doubtless, by our more definite knowledge of the sphere of

action of drugs. To this extent Binger and the others are quite ready to utilise homœopathic work ; but they entirely reject and ridicule the principle involved in the latter method. For, according to them, " pathology alone dictates the maxims of rational practice." Here, therefore, is the crux of the whole position ; and he believed that the two methods are in reality wide asunder. The homœopathy of Hahnemann throws aside mere nosological terms and the theories of physiology as so much dust obscuring the eyes of the physician, looking upon disease as deranged vital force which is to be restored to its normal equilibrium, not by the so-called *physiological* action of drugs, but by the impact of medicinal force in quantity far too minute to act otherwise than *dynamically*. Hahnemann taught that this medicinal force, latent in inert matter, is developed by the simple process of " dynamisation," and so rendered available. Moreover, the aim of this method was entirely different from that of the physiological school. It was not to palliate or to suppress, but to eradicate by meeting the deep-seated constitutional indications of disease with the appropriate medicinal *similia*. This was the ideal of Hahnemann, and the guiding-star of his practice. There was no intermediary course, and we ought to recognise the need of some general agreement as to which of these methods is distinctively claimed by the homœopathic school. Medicinal treatment might, he thought, be fairly conducted on the one line or on the other, but never between ungrasped principle and unfronted difficulty.

Mr. HARRIS suggested a reversion to an old practice—the sending round a synopsis of the paper, to be read along with the circular. Members would then know the points they would be expected to discuss. He proposed to give his own experience. When you come face to face with a patient, you do not take either of Dr. Clarke's paths, but you mentally follow both. You translate the symptoms into their pathological meaning, and are all the time mentally seeking a drug which corresponds ; you then investigate further to find if your ideas are correct. If the patient and the drug correspond as to the pathological conditions you will cure the case. If you find a drug that will cover every symptom of a patient, you will cure your patient whether it has produced the same condition or not. It is at any rate capable of doing so. He thought Dr. Clarke's remarks regarding " Burroughs and Wellcomism " a little too smart. A drug was no less useful and homœopathic because it was in a novel form.

Dr. FERNIE criticised Dr. Clarke's use and derivation of the word " allopathy."

Dr. A. C. CLIFTON thanked Dr. Clarke for the moderate

way in which he had introduced his remarks, as he expected much severer strictures on pathological prescribing. He, Dr. Clifton, learned his earlier practice of homœopathy largely from Dr. John Epps, and for fifteen years did not look upon any physician as a homœopath who made use of pathology in prescribing; during that time, moreover, he used only attenuations of drugs from the 80th to the 200th. At the end of that time, while having good reason to be satisfied with his work, he was not entirely so, and was thus led to study pathology in connection with homœopathic treatment, and to give larger doses, viz., from the 6th down to the mother tincture. His practice was now a combination of the two paths, sometimes one path predominates and sometimes the other, and he believed that both were needful for complete homœopathic practice. He was no less careful now in selecting his medicines than he was in the earlier period, and had much more reason to be satisfied with the results on the two paths than from the one.

Mr. GERARD SMITH said Dr. Clarke's paper had done him good in stirring him out of the indolence we are all apt to get into. He would just say a word for "Burroughs and Wellcomism." He thought their preparations excellent, and more certain in their strength than some mother tinctures. In regard to the "vital force" theory, he certainly believed in the *vis medicatrix natura*. He deprecated the practice of smothering symptoms with opiates and anodynes so much in vogue at present.

Dr. MOIR thought there was a great want of care in selecting drugs. The difficulty was in getting at the symptoms. The instances in which, thanks to Ringer and others, the treatment of certain diseases is common to the two schools (*e.g.*, *merc. cor.* in dysentery) showed that where the symptoms are right the pathology also corresponds. He thought incurable cases should be recognised as such, and we should not delude ourselves or others that we are going to cure them.

Mr. KNOX SHAW said discussions on these points always made him feel sad, for he felt what a shocking homœopath he must be. He troubled little about the theory of homœopathy—he attended to the practice. He followed a pathway of his own, and it was satisfactory to himself. He referred to the dangers of the practice advocated by Dr. Clarke. He wished to draw the attention of young men to the danger of being bitten with the symptom-hunting mania. When a man questions a patient, and finds he has vertigo at six o'clock, he is apt to forget to look into his ears, where he might find a plug of wax. He just instanced this by way of warning. There was another difficulty in carrying out the practice of

symptom-hunting—the length of time that must be devoted to each case. He was more inclined to drift into a homœopathy which was more easy, and could be learned from a book written by a former speaker (Dr. Hughes).

Dr. MURRAY's feelings on hearing the paper, like those of Dr. Hughes, were "mingled." He alluded to the fewer difficulties that were in the way of the older homœopaths. It would be better if we thoroughly knew the old standard medicines. When the ordinary medicines fail us, and we cannot find a pathological equivalent, then we can go to the *Repertory* and seek for peculiar symptoms.

Dr. HUGHES said Hahnemann was not so exclusive a symptomatologist as some of his followers. He took the heads of the symptoms, and dismissed many, saying they were of no consequence or service. He selected the most important, and paid regard to them only.

Mr. CAMERON said that Dr. Hughes and others had so fully expressed his own views regarding Dr. Clarke's interesting paper, that he would refer to only two points which it suggested. He was not prepared to find the author founding a serious argument on the exploded theory of a "vital force" as a something separate from and independent of the ordinary phenomena of vital action, some substantial entity that ruled them and was separate from them. In these phenomena there was nothing mysterious and separate from themselves any more than there was in the phenomena of electricity or gravitation, which were mere *conditions* of matter, to which we gave these names, but for which no one claimed a separate entity, a something besides and independent of the phenomena themselves. Dr. Hughes in his remarks on the paper very truly said that Hahnemann was not so exclusive a symptomatologist as some of his extreme followers. Mr. Cameron had the advantage of having been his pupil for two successive winters, in Paris, during which time he attended his poor patients, and thus had ample opportunities of seeing his practice, and he could confirm Dr. Hughes' statement on this point. He often seemed to disregard symptoms altogether as an essential guide in prescribing, and to trust chiefly to the etiology of the case, more especially when *sulphur* or *psora* were in question; when they were not he generally selected the most important symptoms and treated the secondary ones with but little attention.

Dr. DYCE BROWN thought it was well that the subject should be brought forward. It was a mistake to suppose the paths were different. We all agree that the thing is to get the whole symptoms, but he thought the difference lay in what was regarded as symptoms. Some took the subjective,

and others included the pathology. There were several complaints which have no medicines that have produced the disease, *e.g.*, diphtheria. You must then go by the vital symptoms. It is the same with *belladonna* in uterine congestion. Either extreme of practice is bad: the middle course is the true one.

Dr. GALLEY BLACKLEY thought the subject which Dr. Clarke had brought before the Society a very important one, and the discussion a most useful one. He also had rather gathered from the paper that by "symptoms" was meant "subjective symptoms" merely. He was strongly of opinion that it was impossible to separate "symptoms" from the "pathological basis," and referred to the great strides which had been made of late years in unravelling the pathology of what were considered formerly to be merely psychological and neurological symptoms. He advised his younger colleagues not to follow the ultra-Hahnemannian method of prescribing, but to get together a fair number of important symptoms, then go to the *Repertory* and find the simile, and finally to the pages of the *Cyclopaedia*, where the natural history of the provings would in all probability yield a simillimum.

Dr. DUDGEON (in the chair) just wished to say one word. It was often impossible to find an exact parallel in the *Materia Medica* to the totality of the morbid symptoms. The Hahnemannians had invented a way out of the difficulty in the "Key-notes." They maintain that when they can find a key-note, all the rest of the symptoms will be present. He thought there might be other "Key-notes" of a pathological nature which were equally legitimate. Cases had lately been recorded where *phosphorus* was selected by the key-note, "diarrhoea when lying on left side." But this symptom was not to be found in the pathogenesis of *phosphorus*. He commented on a suggestion of Dr. Clarke's, that when studying a medicine we should prove it at the same time. He thought we should present a very emaciated appearance at the end of our studies. However, as Dr. Clarke had doubtless practised this method which he recommended to us, and did not look much the worse, we might venture to try it.

Dr. CLARKE (in reply) said he was afraid he could not well answer all the speakers in detail, so he would follow the example of Hahnemann described by Mr. Cameron, and take the things that struck him as of most importance and leave the rest. He first referred to Dr. Hughes' and Mr. Cameron's objection to the vital force idea. He could not, of course, make Dr. Hughes accept it if he was not willing, but, nevertheless, there was some basis of the phenomena of life, and nerves could not account for it, neither could blood-vessels.

He preferred Hahnemann's ideas of pathology and vital phenomena as immensely more philosophical and useful in giving us a practical hold on disease than the theories of modern pathology. He agreed with Mr. Harris and Dr. Clifton so far that he knew it was possible to walk between the two paths. He had himself been doing that for a long time. Where he had got to now he would leave his hearers to say. Mr. Knox Shaw had said that he followed a pathology of his own, with which he was completely satisfied. He (Dr. Clarke) would be very loth to rob him of his satisfaction. Drs. Dyce Brown and Blackley seem to gather that he sought for subjective symptoms almost exclusively. This he expressly guarded against, having mentioned both objective and subjective; the objective including all that the physician can ascertain by his senses, the subjective being the sensations of the patient. It often happened that there were no subjective symptoms, the patient being in a state in which sensation is suspended; then the objective was all that remained to go upon. Dr. Dudgeon had referred to "Key-notes." In the paper he (Dr. Clarke) stated that key-notes were not to be used without reference to the totality of the symptoms. In the *phosphorus* case to which Dr. Dudgeon referred, the drug corresponded well to the patient's state generally, as also did a number of other drugs. The symptom, "diarrhœa when lying on the left side," having been observed by some to be characteristic of this drug—whether clinically observed only or not he did not know and did not care—he chose it in preference to the others, and with the best results. The case was an exceedingly chronic one, and had no disposition whatever to get well of itself. In reference to Dr. Dudgeon's picture of the awful results that would follow if we proved drugs at the same time that we studied them, Dr. Clarke said there was no need to take the heroic doses Dr. Dudgeon took when proving *kali bichrom.* and *glonoine.* Much smaller doses would suffice to produce some of the effects of a drug and so fix its action in the memory. Hahnemann had proved more medicines than any other man ever did or was likely to do, and yet he lived to a great age with unimpaired vigour.

CASE OF HÆMATEMESIS, FOLLOWED BY COMPLETE SUPPRESSION OF URINE. DEATH; NECROPSY.

By E. M. MADDEN, M.B.,

Physician to the "Phillips Memorial" Homœopathic Hospital, Bromley.

Fanny S.—, æt. 19, had for some months been getting slightly anæmic, and menses scanty though regular and painless. Was first seen on Sept. 8th, at her home, by Mr. H. Wynne Thomas, the House Surgeon, having fainted when out in the garden. For some three or four days had had some pain after food, not severe, and headache; had vomited once yesterday, the vomit containing some coffee-ground matter; to-day had loose stools, evidently melænic. Prescribed *ham.* 1x and *arsen.* 3x alternately.

Sept. 9th.—Was brought into the hospital and fed entirely on nutrient enemata and suppositories. Bowels open once, entirely black. T. 100°; P. 80.

Sept. 10th.—Urine examined, sp. gr. 1020; no albumen. Menses due to-day; did not come on either now or subsequently. T. 99.5; P. 78.

Sept. 11th.—At 12.30 a.m. vomited blood, of which 25 ounces were measured, besides a good deal spilt over the bed. Was given at once gr. $\frac{1}{150}$ of *ergotinin* subcutaneously and *ham.* 1x and *ipec.* 1x every half hour alternately. Cold compresses applied over stomach, and ice to suck. T. normal; P. 100.

Sept. 16th.—No return of vomit; epigastric tenderness almost gone, and the reflex contraction of the right rectus abdominalis, which had been markedly exaggerated is normal. T. keeps normal, and patient is beginning to feel hungry. R̄ *uran. nitric.* 4x.

Sept. 19th.—Up till this day had seemed to be progressing most favourably, and was beginning to take a little fluid food by the stomach, though the rectal feeding was never quite given up. The bowels had only been open on the 12th and 18th by enemata, still black and solid. At 3 p.m. to-day, while turning in bed, felt a

pain in the left side, just at the upper edge of the spleen, to which hot fomentations were applied. At 5 p.m. vomited Oj of bile and mucus, and the same vomit was repeated twice during the night. This evening passed zij of urine, apparently normal (not tested). Pulse and temp. normal, and remained so till 2 days before death.

Sept. 20th.—Pain in the left side, and bilious vomiting continued all day. Passed only zij of urine to-day. A roseolous rash came out all over the chest, abdomen and knees in large patches, and continued fully out for about 24 hours, and slightly about the knees almost up to her death. R̄ *iris. v.* 1x every hour. Was given a hot bath and hot bottles round her, and hot kidney compresses, and sweated fairly well for an hour or two. Bowels open by enema.

Sept. 21st.—Vomiting of pure bile very frequent, and pain in side very severe at times. Again passed only zij urine all day. The same local and external treatment was continued, but *arsen.* 3x was substituted for the *iris*.

Sept. 22nd.—Continued very much the same, only getting weaker, passed zij urine, which on boiling became at least half solid albumen. To-day on one of the kidney compresses there was sprinkled zij. spirits of turpentine, and an enema of Oij. hot water was given, of which only zij. returned, slightly stained with fæces, not black, but no solid. She was given to-day one dose of *canth. φ* mijj., followed by mj. every hour, but as the vomiting continued constantly, it is doubtful if more than a very little was absorbed.

This evening Dr. Dyce Brown very kindly came to see her, and, while admitting that the case was somewhat obscure, believed the hæmatemesis had been vicarious for the absent menses, and the subsequent condition one of acute congestion of the liver and kidneys of neurotic origin, and in view of this aspect of the case, he advised giving *bell. φ* mj. every hour or two till the pupils, which were slightly contracted, began to dilate; besides continuing the hot sitz baths and hot compresses to the loins.

Sept. 23rd.—As the vomiting was continued, the *bell.* was stopped by the mouth and given by the rectum. No urine passed. Evening T. 99.6.

Sept. 24th.—Morning T. normal; P. 92. Not a drop of urine passed, and the skin would hardly act at all in

spite of baths given at a temperature 106° gradually raised to 112° , and two subcutaneous injections of gr. $\frac{1}{10}$ *pilocarpine*. The vomiting became more constant, with severe retching and headache, so 2 doses of *apomorphine* 3x were given by the rectum, but without any effect.

The girl was now evidently sinking, and as it appeared just possible that her symptoms might be due to some form of abdominal obstruction (beginning on the 19th, when she first had pain and vomiting, and since which time there had been no solid stool), we asked Mr. Knox Shaw to come and see her with a view to a possible operation. Mr. Shaw came the same evening, but before his arrival she had become unconscious and was having uræmic convulsions; so, as the symptoms pointing to obstruction were by no means definite, and her condition most unfavourable, he advised against it. T. this evening 99.5.

Sept. 25th.—No return to consciousness. No urine passed. Convulsions continued off and on, and she died at 10.30 a.m.

A *post-mortem* was made the same afternoon. Body well nourished. No intestinal obstruction, nor any mechanical obstruction to the flow of urine was found. The liver was congested and weighed 43 oz. The kidneys were very large and weighed $6\frac{1}{2}$ and $6\frac{3}{4}$ ozs., and were evidently large white kidneys. (The right kidney and stomach were passed round). The cardiac end of the stomach was firmly adherent to the upper part of the capsule of the spleen. The spleen was normal. At the posterior part of the stomach on its internal surface, about over the head of the pancreas and not where adherent to spleen, there were two linear cicatrices, evidently firmly healed ulcers, and across one could be traced a fair-sized blood vessel. No perforation could be discovered, nor any recent peritonitis.

The special points of interest were—

1st. The complete healing up of the ulcer, so as to form a firm cicatrix in 14 days after the acute hæmatemesis.

2nd. The cause of the suppression of urine. Was it a case of violent acute nephritis of only 7 days' duration? And if so could the kidneys have developed into the condition found in that time? Or was it a case of nephritis of some standing which had been so latent as to show

none of the usual symptoms and suddenly developing acute suppression? Either supposition involves some difficulty.

3rd. As to treatment, could anything more have been done to avert the fatal issue?

DISCUSSION.

Dr. DYCE BROWN wished to make a few remarks, as Dr. Madden had been good enough to ask him to see the case, and as the diagnosis of the case depending on a neurosis might seem peculiar. He maintained that the only thing to explain the whole case was the supposition of a reflex neurotic disturbance, the centre point being the left ovary, and the non-appearance of the catamenia. There was no history pointing to gastric ulcer, nor of scarlet fever. The girl was only nineteen, was plump, and only slightly anæmic. She had been fairly well till she fainted in the garden. Her catamenia were a week past due. The vomiting of blood and the bowel-hæmorrhage appeared at once. There was then *no* albumen in the urine, which was of normal sp. gr. The suppression of urine did not appear for three days, and then became *suddenly* almost complete. When Dr. Brown saw her, after two days of suppression, there were no head symptoms, except that the pupils were contracted and feebly sensible to light; the temperature and pulse were normal. The roseolous rash was over most of the body; there was no tenderness over the epigastrium, but somewhat over the liver, and particularly over left kidney and in a line from left hypochondrium to *left* ovary, although at the *post mortem* it was the right ovary that was diseased. Over the right ovary there was no tenderness. His opinion was, and is, that the non-appearance of the catamenia and the left ovarian irritation set up a reflex neurosis, causing—1. Engorgement of the liver, which accounted for the blood passing by stomach and bowels, and acting as a vicarious menstruation. 2. Causing great engorgement of the kidneys. 3. Causing the roseolous rash. Although at the *post mortem* the kidney was large and white, there was nothing to account for the absolute suppression of urine, nor for any secondary engorgement of liver. The facts of the case were evident. What was the cause? To his mind the reflex neurotic disturbance will alone explain all these co-existing facts. The perfect normality of the urine on admission is of the highest importance in estimating the essential cause of the malady. The treatment he recommended, *belladonna*, with hot sitz bath, met the whole features of the case.

Dr. FERNIE asked if there was any history of intemperance.

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Dr. MOIR wished to ask Dr. Madden whether any œdema was noticed, and also about the attack of faintness, whether it was at the time of the hæmorrhage or not. From the pathological specimens, he was strongly of the opinion that it was a case of chronic Bright's disease, with large white kidney. He would like to see a section of the kidney under the microscope. With regard to large white kidney occurring in three weeks, he supposed Dr. Saundby meant following in three weeks from an acute attack, but in this case there was no history of recent acute attack. He thought that the faintness was the first symptom of uræmia noticed, and that the hæmorrhage might be due to degenerative changes in the vessels of the stomach. Although albumen was not found on her admission into the hospital, that, he thought, did not exclude his view of it. He had lately under his care a case of Bright's disease, in which, on several occasions, he failed to find albumen—though generally there was a large quantity present. He did not wish to criticise the treatment, but thought that three drop doses of *cantharis* would aggravate in a condition of suppression, and would like to know if hot-air baths had been tried.

Mr. KNOX SHAW commented upon the extreme interest of the case, and the difficulty of forming a diagnosis. He had expressed the opinion that the symptoms could not be due to any intestinal obstruction, and that the case was in no way suitable for operative interference. He had inclined to the diagnosis of gastric ulcer, mentioning how frequently the first symptom shown was hæmorrhage or perforation. The specimen showed that no perforation had taken place. It had been suggested to him that the renal symptoms might have been due to thrombosis.

Dr. BLACKLEY questioned if it was not a case of pernicious anæmia. This would account for many of the symptoms, and especially the hæmorrhage. He asked if the bowel was examined under the microscope, and elicited that it was not.

Dr. MADDEN said, in reply to Dr. Moir: The fainting attack occurred after the occurrence of black stools and coffee-ground vomit. There had been no signs of dropsy at any period of the illness, but the urine was only tested once before the suppression came on, viz., on the Thursday following admission.

To Dr. Blackley: The anæmia was never very great, and certainly not of the pernicious form.

To Dr. Fernie: There was not the slightest reason to suspect intemperance.

ON THERAPEUTICS AS AN APPLIED SCIENCE.

By E. A. COOK, L.R.C.P., F.C.S., &c.

DR. BROADBENT, in his address on Therapeutics at the British Association, 1890, as reported in the *British Medical Journal*, speaks as follows:—

“The establishment of any quantitative relation between a substance introduced into the human system and the observed effects seems a hopeless task . . . and yet it must be done if therapeutics, or even physiology, is to be correlated with physical and chemical science. When we reflect that a single grain of anhydrous hydrocyanic acid, or of aconitine, or strychnine will destroy life; and try to calculate the proportion of the deadly agent present in the blood as it arrives at the nervous centre upon which it works destruction, the disproportion between cause and effect is bewildering to the imagination. . . . The consistency and constancy of the effects of smaller doses . . . points to some definite relation between the drug and the special chemical processes concerned in the evolution of nervous energy in the particular centre on which it acts. Let us think for a moment what this implies. A grain or two say of anhydrous prussic acid is swallowed; a fraction of it is absorbed: the blood by which it is carried receives a first dilution by admixture with the general portal stream from the viscera; again in the right side of the heart it is lost in the floods of blood arriving by the two *venæ cavæ*. The proportion of prussic acid, in the blood carried to the brain, must thus be incalculably minute, but it is sufficient to suspend the action of the respiratory centres, and thus destroy life within a few minutes, with the accompaniment of frightful convulsions. . . . Now we cannot admit that these effects are due to the mere contact of the blood with the nerve centres; this would be an absolute negation of the doctrine of the correlation of forces. There must be some dynamic action on the part of the drug—some evolution of energy—which interferes with the evolution of nervous energy,

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or antagonises it ; that is, there must be chemical change and dislocation of the constituent parts of the molecule."

Thus Dr. Broadbent admits the "incalculably minute" quantity needful to produce even lethal effects, and insists that this effect must be by chemical change. We have no known method of ascertaining chemical change except by the direct or indirect influence on the senses. A chemical test is such an action on one substance by another as shall lead to changes evident to the senses, and distinctive. If in applying a chemical test we *see* a change of colour, or change from liquid to solid, or the reverse, or if we *feel* an increase of heat, if we *hear* an explosion, or *smell* an odour, it is an appeal to an effect on the senses which influences our judgment and belief. Every chemical test, every physical test is an appeal therefore to physiological perception, is, in fact, a physiological test. It is true that the ordinary meaning of a physiological test is the effect of a substance applied directly to living matter, but it is equally true that no test would avail in the absence of physiological perception.

If we wish to obtain evidence of the presence of a substance, we apply certain chemical tests known to give definite reactions with that substance ; but if the substance be present in quantity so minute that chemical tests fail, we apply physical tests, and if these fail also we next apply physiological tests, if any such there be. We should never dream of rejecting the evidence offered by the physiological test because of the failure of the chemical. Naturally we should prefer, as analysts, to get the evidence of all three—chemical, physical, physiological—tests if possible. We admit then, that of all known tests the physiological is the most delicate to indicate the presence of substances which have an effect on vital force.

With certain substances there are chemical tests which will give definite and conclusive reactions with so small a quantity as one in a million or even less. With physical tests the delicacy is far greater. The spectroscope will detect very much less than 1 in 1,000,000, but for delicacy of physical test there is nothing known to indicate an inequality in the presence of a substance, or a demonstration of the effects of its presence of greater delicacy than a balanced electrical current. In the

58th Vol. of the *Chemical News*, G. Gore states the conditions of the experiment. Two couples of zinc or magnesium and platinum are immersed simultaneously in two vessels of distilled water. They are then opposed to each other through a very delicate galvanometer, so as to balance one another and cause no deflection. If now to the water of the one couple be added a proportion of hydrochloric acid equal to 1 in 23,000,000 a deflection is caused. With a magnesium and platinum couple one of bromine in 344,444,444 water is detectable, or 1 of chlorine in 17,612,000,000, and even more dilute solutions will upset the equilibrium.

Waller has demonstrated, by means of the capillary electrometer, that with every beat of the heart there is an electrical current going through the body in a line with the axis of the heart—the base being negative, the apex positive, the line of demarcation corresponding to a line drawn through the heart between the ventricles and auricles and extending through the body, all above being negative, all below positive.

It is well known that there are electrical currents in all living muscle, and it is extremely probable that each living cell has its individual currents, and it would be extremely improbable to suppose that when a cell selects a substance from the blood which all other cells have passed by, and a change takes place, that no electrical effects were produced. It would be contrary to all that is known of larger action if it were so. For instance, a bone-forming cell absorbing phosphate will be as likely to have electrical changes as does the body as a whole absorbing food from the stomach. If it be admitted probable that such electrical change is a change of electrical balance, we can see how minute a quantity would be sufficient to cause an effect.

It is notorious and universally admitted that a substance capable of producing physiological change (say lethal), if introduced into the body in mass is less capable of effecting the change than if introduced as powder. The change is quicker if it be in solution, quicker still if in dilute solution, and quickest if in the state of gas. *Arsenic* as mass, as powder, as solution, is gradually more intense in its effects, while if exhibited as As H_3 it is most deadly.

It is admitted that only certain cells take up given substances, and it is not easy to account for the increased action of As H_3 as a lethal agent, except by the fact that the particles of As , in that compound are more minute, and the minute cell can grip and absorb them quicker. At what point, then, is the influence of dilution to be supposed to be stayed? Take the case of a grain of *strychnine* present in the blood; let us take it that $\frac{1}{100}$ is absorbed by certain cells and death ensues; it is not to be supposed that were $\frac{1}{100}$ the total present in the blood of another similar subject that no absorption would take place by the similar cells; but it is universally admitted that a modified effect would take place. At what point can this modified effect be scientifically stated to cease? Broadbent states: "There must be some dynamic action on the part of the drug." The point I would urge is this; there is a dynamic action, but seeing that one grain of *strychnine* is sufficient to stop life in a 10-stone man (*i.e.*, 1,000,000 grs.) and not a fraction of it has acted, that in considering a microscopic entity there is no reason in asserting that a portion of drug $\frac{1}{1000000}$ of its weight or $\frac{1}{10000000}$ of its weight cannot act upon it. And if this microscopic entity will absorb from a solution containing 1 in 1,000,000 it will absorb so long as any minute particle exists in the menstruum. A microscopic entity will require an infinitesimal quantity of drug to produce a physiological effect, and each cell living is a microscopic entity.

At what state of dilution does the power of a cell to select cease? The blood of a new-born child contains a given number of red corpuscles and a given weight of iron. All new corpuscles must contain their due weight of iron to be healthy—the only source is the food. The food is the mother's milk and the proportion of iron in it is already infinitesimal. It is taken by the child, absorbed by the child's blood, diluted by the child's blood, yet the cells needing it—not the already perfected cells, but the few new cells—absorb it from the diluted mass, and all goes on rightly; or they fail to absorb it, and ill-health ensues. Then comes the allopath and says, "The child needs iron!" How does the child need iron; has the mother's milk less of it? Some subtle vital or electrical-balance change has taken place, and no additional amount of iron will set it right. Some

dynamic drug action will, and what that drug shall be depends on symptoms.

It is very common and usual to pour into the stomach of a patient in feeble health a quantity of medicine, which, according to all analogy of nature, is in infinite excess. Now, it has been acceptably demonstrated that one of the most important functions of the liver is to filter out and reject poisons from the portal blood. Doubtless, if the liver is up to its duties, it does filter out and reject a very large proportion of this medicinal dose. What passes the liver is dissolved in the blood, and may be absorbed by certain cells. It is possible, without killing the patient, to overpower the liver and make it let through substances into the circulation which in a more healthy or less wearied state it would never let pass; but how it can be supposed that by exhausting the natural power of one organ health can be restored to others is left for the science of medicine to explain. But the drug given in attenuation never does get to the liver direct, for it never gets to the stomach; it is absorbed through the mucous membranes of the buccal cavity and goes direct into the blood. It is possible that the amount of a given drug allowed to pass by the liver may be the same as that absorbed from more dilute solutions by the mucous membrane, and the same result be produced plus an exhausted liver.

Dr. Broadbent insists on the effects of drugs being the result of chemical change. I have tried to show the "sweet reasonableness" of minute doses. The further point I wish to deal with is, can any reasonable idea be formed of how a minute dose of a given drug can cause to disappear a set of symptoms similar to those it causes itself if administered in large doses. We can appeal to what is known and admitted of chemical change and its theory to get some insight into this. Brodie, in order to explain some peculiar effects of the elements suggested that the atoms of which they were supposed to be formed were combined among themselves. Nascent hydrogen for example has properties very different to those of ordinary hydrogen. Nascent H. consists of atoms of hydrogen uncombined. When two such similar atoms combine, ordinary hydrogen is the result, that is to say an atom of H. possessing intense energy combines with another atom possessing intense energy, the result is a substance

which, compared with its separate constituents, is powerless, actionless. He further explained this by supposing one atom to be positive the other negative, that a negative and positive combined together. He reasoned from elements to compounds, and he asserted that all compounds were atoms of compound combined with atoms of compound forming molecules. His doctrine has been received and developed down to this day. You will note that all nascent hydrogen, no matter from what source, combines with itself and forms ordinary hydrogen. A reaction may be such that you may reasonably conclude that all the H. evolved must be of one kind + or —, nevertheless, if left to itself, ordinary hydrogen is the result. Some atoms must in such a case change their state of polarity.

When a solution of potash bichromate is poured into a solution of peroxyde of barium in HCl or nitric acid a violent effervescence and escape of oxygen takes place. Apart, these two solutions are perfectly stable. Together they are both decomposed, the chromic acid passes into chromium chloride, the peroxyde to ordinary barium chloride. Both lose O. Brodie regards the oxygen itself as the true *reducing* agent; he believes that the chromic acid is decomposed (*reduced*, not oxydised) by the oxygen of the peroxyde of barium according to the same law of decomposition and for the very same reason as it would be by hydrogen itself—this reason being the polarity of the particles induced by chemical change.

Hydride of copper Cu_2H_2 with hydrochloric acid is decomposed; hydride of copper and hydride of chlorine mutually reduce each other, while $\text{Cu} + \text{HCl}$ give no reaction.

Now, who would suppose *à priori* that an oxyde could be reduced by adding an oxyde to it—a hydride by adding a hydride to it. The instances of similar decomposition are numerous. Oxydes of gold placed in hydrogen peroxyde result in metal oxygen and water; apart they are perfectly stable. No one dreams of doubting or regards this with astonishment—but you have only to state in ordinary medical circles that you believe the same kind of action goes on in living tissue and physiological action, and the absurdities of the creed you profess will, in the judgment of the elect, “be sufficient to deprive you of any right to the professional status which legally belongs to you.” (Mr. Brudenell Carter.)

It is well-known that protoplasmic matter has the power to produce chemical changes of the most extraordinary nature, witness the effect of yeast on sugar, an effect of decomposition produceable in no other way. Witness also the production of free HCl in the stomach, or the production of free soda, or its carbonate in the bile. These instances are sufficient for our purpose, for if you can realise that a protoplasmic organism has the power of separating into its elements such a stable compound as common salt, there can be no reason to assert its inability to separate them in a nascent state. The fact of the separation is undeniable, and it is equally undeniable that each atom when first separated is in the nascent state, otherwise chemistry inside the body is radically different to chemistry outside thereof. If you admit this power to protoplasmic matter in the stomach, you must admit it for vital matter everywhere in the body. How else can you account for the deposition of silica, of fluorides, or of phosphates? Now, you have only to consider the idea that *diseased* action is due to wrong chemical action of certain cells, the nascent compound acting in a wrong way. You present to it a similar nascent compound of opposite polarity—or you give neighbouring cells the means of producing such nascent compounds, and the two combine, producing normal action.

The reason why when a substance is present in the body in the crude form it should produce no medicinal effect, and yet when you give the same substance in a highly dilute form, you will get plenty of medicinal effect is not easy to find. But, although I cannot give a clear and explicit reason, I think I can indicate an analogous effect, which may throw a little light upon the matter. We know that a beam of white light thrown through a prism divides into what is called the spectrum, giving light of all colours from red to violet, and then invisible chemical rays. What has occurred to make all these differences of tint? Physicists have no proof, but have put forward the theory that the differences of colour are due to the differences of length of the waves of light, and the length of wave for each colour has been measured, but the curious fact remains, that in the same ether under similar influences so many different effects are produced. Act upon a sensitive plate by the whole spectrum, and

the differences of effect are wonderful and notorious. Place in the undecomposed sun ray a mixture of hydrogen and chlorine, and instantly you get combination. Place in the sun ray a solution of HCl or better HI and very soon you get decomposition. Place a patient mentally affected in the undecomposed ray, and nothing but good effects occur; place him in the violet rays and melancholia is produced, under the red rays fury, and under the yellow joy. These effects are so well-known, that it would be a bold man who disputed them, but nevertheless we have here an instance of no effect other than an ordinary and not remarkable effect being produced by the very agency in bulk, which, when diluted, produces so very remarkable an effect. It is simple enough to say the violet or red rays act in a subtle way on nerve endings, but there is no proof that it is so, except the physiological effects, *and they are not constantly the same in different individuals, but those in ill-health are more susceptible.*

It is generally received among scientists that certain phenomena can only be explained on the theory that between all molecules there is constant motion; that in the densest metal the molecules can only exist by constant molecular motion; that in the same metal in a fluid state or a gaseous state, equally the molecules are in incessant motion, but their range of motion is greater and greater with decrease of density. I would annex this theory. I would say that when we dilute our medicines the motion between the molecules is greater the more they are diluted; that the more of this molecular motion there is the greater is the medicinal effect, *i.e.*, the effect on living protoplasm; that it is only when the waves of motion are of a certain length that you get high medicinal effects, and the molecules act on nerve substance or cell substance very differently to the substance in bulk. There is no proof except the physiological effects, *and they are not constantly the same in different individuals, but those in ill-health are more susceptible.*

There is yet further this remarkable fact to be considered: When two substances, which will combine in bulk if solutions are mixed, are taken into a capillary tube, the one at one end, the other at the other, no combination will take place; there is a zone of contact without combination. Try to conceive what is the

difference between the mixed liquids in this zone and liquids mixed in bulk and absorbed into fine capillaries, and—added to this probable decomposing influence—there comes into play the vital influence to which we know is due so marvellous effects.

Dr. Burford, in a paper recently read before you, made the observation that “the scientific mind keeps ever before it the necessity that every observation shall be capable of continual verification.” In any science in which vital force has no part to play, continual verification of results can be easy and rigidly exact, but the greater the part played by this vital force the greater the difficulty of exact repetition of results; and when, as in physiology, you get added to the vital force element the disproportion of factors for results—the immense effect of a minute amount of dead matter on a vast amount of living—the power of measuring and exactly repeating becomes increasingly difficult, and under such conditions to evolve an exact science almost insuperable. It behoves us therefore to be very mild in our condemnation and disbelief of results we ourselves have not obtained, and having granted the probity and capacity of the observer as equal to our own, we should be at least as wary in rejecting as in accepting the results of others.

DISCUSSION.

Dr. HUGHES had rarely listened to a paper displaying more acumen, thought, and research than Dr. Cook's maiden effort that night. He commented on the statement of Dr. Cook that the arseniuretted hydrogen produced more violent effects than arsenic itself, by reason of its more minute division, as not quite sufficient, since arseniuretted hydrogen produced effects different from those of arsenic, as well as more energetic. He asked Dr. Cook what were the properties of nascent hydrogen. He inquired if Dr. Cook had any facts as to the homœopathicity of the effects of colours in insanity. The chief thought running through Dr. Cook's paper was the greater activity of substances dissolved. The difficulty was that all physiological action diminished with dilution, and finally ceased. Septicæmia has been induced by the 10-trillionth of a grain of septic material, but by nothing weaker. The same happened with diluted vaccine—a point came at which the effect ceased. Solution and dilution were different. Solution increased action; dilution in the homœopathic way diminished it.

Dr. DYCÈ BROWN thanked Dr. Cook for his extremely interesting paper. He thought, differing from Dr. Hughes, that solution and dilution were essentially the same, and though the pathogenetic effect ceased to be visible after a certain degree of dilution, there was no doubt that, though not visible or demonstrable in the healthy body, yet action did go on all the same, and hence the curative effect visible in disease from infinitesimal doses, which caused no visible action in the healthy body.

Dr. HUGHES explained that he had no idea of suggesting that medicinal action did not go far beyond observed physical and physiological action. He gave 30ths and knew that they acted. He only wished he had some clear scientific basis to found his use of them upon.

Dr. PULLAR thought this one of the most valuable papers, inasmuch as it presented a scientific study of homœopathy. It was the treatment of the subject in this spirit that would do much to advance our position by affording support from collateral sciences. He agreed with Dr. Cook's deductions as to the delicate nature of the physiological test in regard to the action of infinitely minute quantities. But even this test was insufficient to explain all the phenomena. There was a region beyond the crude physiological effect of medicines. He could not agree with Dr. Hughes in looking upon vital force as an "exploded idea." In dealing with living matter there was a something which physiology had not explained, and that was the subtle element often determining the effects of medicinal force.

Dr. CLARKE said it was unnecessary for him to repeat the praises that had been bestowed on Dr. Cook's paper. He thoroughly endorsed them all. The *modus operandi* of the higher attenuations was a most fascinating subject, and no one was better qualified to deal with one aspect of it than Dr. Cook, from his chemical knowledge. In his interesting work on Alcoholism (of which an English translation has recently been published in America), Dr. Gallavardin, who largely used the higher attenuations, had some interesting remarks pertinent to the paper. The author stated that matter can exist in four forms—solid, liquid, gaseous, and radiant. The "radiant" state, said Dr. Gallavardin, corresponds to the "subtile" state of Aristotle and the "infinitesimal" state of Hahnemann. Crooks had described it as the limit where matter and force seem to shade off into each other. Hering had a somewhat different view. He imagined that by the process of trituration, or attenuation, the force which held the material particles together was liberated. But, interesting and important as these questions were, there was a prior

question, and that was, Did these highly attenuated substances act—did they respond to their indications? Dr. Clarke thought that question was already settled abundantly in the affirmative. Dr. Hughes, he believed, had vouched for the 200th on the strength of Carol Dunham's belief in them. Dr. Dyce Brown had related the case of a patient in whom arnica 200 would produce erysipelas. Dr. Cooper had reported before the Society cases cured with 200th. If the 200th would act in this way, he could not see why higher attenuations should not act. It was no more difficult for him to conceive the power of the 200-millionth than it was that of the 200th. There was only one way of settling this point, and that was not by argument, but by experiment; and the time had come when the only testimony that could be received on the point was from those who had used the higher attenuations, and were ready to produce their results. In order to do this, he had procured from various sources supplies of the highest attenuations made—from London chemists, from Boericke and Tafel in America, and especially from his friend Dr. Skinner. He had found these all answer to their indications. With the experience of some years to support him, he had no doubt whatever of the power of the higher and highest attenuations. Another question was, Do the higher attenuations act more powerfully than the lower? This was a question he had been investigating practically, and the answer of his experience was in a large number of cases, Yes. Dr. Hughes had told us that he used 30th, and found them act. No doubt he used them because he found them in some way more efficacious than the lower. If this is so with the 30th, there is no logical reason why it should not be still more the case with higher attenuations. Whether it was so in all cases he could not from his experience decide; but he did not think it was. Every attenuation represented a different degree of power, and there were cases, he had no doubt, where the lower were more appropriate. He hoped some day a rule for their different use would be discovered. As yet he knew of none.

Dr. Morr did not think our homeopathic attenuations represented a change of state similar to the change from liquid to gaseous.

Dr. Burford thought that the weakness of homœopathy in the past was its isolated position. A paper like that of Dr. Cook's was calculated to keep us in touch with outside science. We must be swayed more by facts than by atomic and other theories. It is well known that 200ths have produced effects, even though the atomic theory cannot, according to Dr. Hughes, take us beyond the 15th attenuation. *Ex nihilo nihil fit*; there must be some power in the 200th or

the result could not come—the atomic theory notwithstanding. Moreover, there is much in the chemistry in the body that is quite different from chemistry outside. Something has been said to the effect that the physiological effects of a drug are in proportion to the amount used. The very reverse is often the fact. Why should drugs act differently in health and disease? We have been taught to regard the whole body in disease as in unstable equilibrium, and so much more easily to be influenced. Referring to vital force, Professor Huxley had said recently you could take protoplasm and analyse it, and then take the elements separately and try to combine them, but you cannot get the entity. Out of protoplasm only, can protoplasm come. This showed that Huxley was not so very averse to something like the vital force idea. The whole tendency of molecular reaction is in favour of infinitesimals. Now that the tyranny of the atomic theory has been overthrown, we are free to accept the testimony of careful, reliable observers when they tell us their results from 30th, 200th, 1000th, and higher potencies.

Mr. GERARD SMITH mentioned osmosis as one of the methods by which higher attenuations get into the blood more quickly than the lower ones, and that the crude doses of old medicine could not pass in at all. The paper was a new departure and a good one. When asked for scientific theories of our system by our allopathic brothers we have always had an answer ready—Show us the good results of *your* scientific theories—which was sufficient to silence them; but it was well to have the support of collateral sciences as well. He had never heard before of these experiments with coloured lights.

Dr. McLACHLAN : Between the physiological and the dynamic action of drugs there was a *neutral* point where the action was neither physiological nor dynamic, just as there is a point in the dosage of *ippecac.*, that will neither cause nor cure vomiting. This being the case, the further one goes from this neutral point towards the side of the higher potencies the more marked should the dynamic action become; in fact, it would seem the dynamic action only *begins* where the physiological *ends*.

Professor ALDRICH said the experiments with the action of light were new to him, and he would like to know where he could read about them. There was once a prevalent theory in the United States regarding the value of blue glass, and for a time almost every house had its blue windows. Now they are all gone.

Mr. KNOX SHAW added his high approval of the paper to that expressed by other speakers.

Dr. EDWIN A. NEATBY read from *The Monthly Homœopathic Review* (vol. xxxiii., p. 176) a record of experiments with glass of various colours in an asylum in Italy.

Dr. GALLEY BLACKLEY praised the paper, and hoped that the reader of it (who was only a visitor) would become a member of the Society.

Dr. DUDGEON (in the chair) said the subjects that Dr. Cook had brought forward were only analogies, not proofs, though, no doubt, they are calculated to impress the general public. But we ought not to regard them as scientific testimony. They give a sort of *side* corroboration to the truth of homœopathy, but they cannot be regarded as proofs. Regarding the saying quoted by Dr. Hughes, that substances could not act except when dissolved, there was a long discussion in some of the journals between Dr. C. Wesselhoeft and Dr. Buchmann as to the solubility of metals, the former maintaining that they were not, the latter that they were dissolved in our triturations. A solution is a mere dissolving. A dilution is a diminution. Dr. Clarke alluded to Gallavardin's idea of matter disappearing, and force atoms remaining. Force is a quality of matter, and he would like to know whether its quality could exist separated from a substance. A force must have a material substance in order to display itself at all. Ivory is elastic, but you cannot have its elasticity without the ivory. About those high dilutions he might just say one word. All the high dilutions, Dr. Clarke said, acted well. This seemed to him a *reductio ad absurdum*, since they were all made in different ways, and with ordinary impure water instead of spirit, as enjoined by Hahnemann.

Dr. HUGHES wished to explain, in reference to remarks made about vital force, that he was a strong vitalist; but he regarded vitality not as an entity but as a property of protoplasm.

Dr. COOK (in reply) said he could not expect them to absorb all the results of his thoughts for many months in the short space it took to read his paper. When read quietly afterwards, he thought the paper would be seen to have a thread of unity running through it, though it might seem somewhat disjointed at the first hearing. Referring to the President's remark that the arguments of the paper were mere analogies, he said the science of homœopathy does not stand alone, and he did not bring forward his ideas as direct arguments. There were different ways of evolving hydrogen, and hydrogen acting as it is evolved will reduce salts which ordinary hydrogen will not reduce. He showed how this applied to medicines. He had not mentioned osmosis, but he had not forgotten it. Iodide of potassium placed on the tongue had been found

within a minute in the urine: this rapid transmission had occurred by osmosis. Dr. Cook did not agree with Dr. Hughes that solution and dilution were different. We may dilute with various substances. It did not matter whether the dilution was with water or spirit or milk sugar, it was a dilution all the same. You may have capillary tubes inside the body so minute that chemical action, as ordinarily understood, cannot go on within them, and yet if the same substances be brought together in attenuation they might act even in the capillary tube. This might help us to understand the greater efficacy of high potencies in the minute cells of the body. We are far too apt to consider the physiological effect on the body as a whole. It is possible to act on certain cells to the exclusion of all others. Theories are useful, since by acting on them facts have been brought to light.

AURUM MUR. IN PHTHISIS.

By Dr. JOSEPH DRZEWIECKI.

Late Ordinary Physician in the University Clinic of the
Holy Ghost Hospital, Warsaw, Poland.

ON perusing the *Cyclopaedia of Drug Pathogenesis*, edited by Drs. Richard Hughes and J. P. Dake, my attention was drawn to the similarity of the symptoms which *aurum muriaticum* produces on the healthy organism with those of phthisis. The symptoms are the following:—

“It occasions a specific fever, more or less violent (p. 510); the pulse is more frequent, and then follows profuse and long-lasting perspiration, or a great flow of urine, or diarrhoea. The perspirations have been known so severe that the mattress was wet through; they have at times an alkaline odour, at times they are very foetid. According to Gozzi the perspirations are decidedly worse at night (p. 511).

“It occasions great heat in cheeks and ears (p. 502), and produces a cough which is more pronounced and is accompanied with heat in larynx, and expectoration, white and blood-streaked, or yellow and thick; speech is difficult, and voice hoarse and stridulous. With chest and heart symptoms there is sense of suffocation at night (p. 498).

“*Experiments on animals.*—After injection of 4 centigrammes of the chloride of gold to strong dog, the respiration was difficult and noisy, there was sighing, suffocation, and vomiting of a very small quantity of white matter floating in foam. At each expiration it made a very loud noise. Post-mortem examination showed the lungs livid, excepting a few small patches which were rose-coloured; the lung tissue was dense, hepatized, gorged with blood, and non-crepitant. Placed in water they sank, and only the rose-coloured patches floated and were slightly crepitant” (p. 511). Here is a more or less similar portrait of phthisis! As far as I know *aurum muriaticum* has not been hitherto used in

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phthisis. I have used it in my private practice, and the following are the results:—

Aurum muriaticum given to the patients every three hours in doses of gr. $\frac{1}{100}$ within five days produced a very visible effect—the temperature fell, perspiration and cough diminished, and after two weeks some undoubted amelioration could be detected by physical examination.

Out of eleven patients treated with *aur. mur.* five recovered after five weeks' treatment without interrupting their daily occupations; these patients were in the first stage of phthisis. Two with a very advanced tubercular process in the lungs, who remained in bed the greater part of the day, after two months' treatment improved considerably and are still under my care; the daily temperature now is normal, only the evening temperature is sometimes slightly raised, perspirations ceased, appetite increased, and general aspect improved: cough, although slight, remained. Four patients died, but they were *in extremis*, and had been given up by their own doctors.

After the above observations I venture to say that phthisis in the beginning stage can undoubtedly be cured with *aurum muriaticum*; where, however, the tubercular process has already produced great devastation, although it arrests the process, yet the effects of it remain.

Returning to *aur. mur.* once more I must add that this remedy should be used with caution, and not longer than five days together, after which a pause of two or three days must be made. In one case which I observed a few days ago, after three days' application of the chloride of gold, the patient had shortness of breath (dyspnœa) and sleeplessness, but the temperature was greatly diminished, which makes me suppose that the patient was intoxicated by gold. I interrupted its further use, and next day dyspnœa and sleeplessness disappeared, and the temperature did not rise. Seeing such beneficial effects from *aur. mur.* on the patient, I prescribed it in 3x dilution, five drops every three hours, and the patient could not sleep during the night, had shortness of breath, and fear of death. In this manner I was obliged to stop the further application of *aur. mur.*, and only 6x dilution was well supported by the patient.

This fact I state in order to show how cautious we must be in the exhibition of this drug; in one case 2x dilution.

produces good effects, in the other the 3x dilution occasions symptoms of intoxication.

As mercury in syphilis arrests the further growth of gummata and effects their absorption, so gold acts in the same way on tubercle. Perhaps *platina* or *palladium*, which belong to the same group as gold, might prove still more efficacious in phthisis.

It is a pity that the pathogenesis of these drugs has not yet been fully explored. That *platina* may be useful in phthisis, I infer from the published statement of a manufacturing electroplater in Vienna, who asserts that the health of his workmen affected with phthisis was ameliorated in spite of non-hygienic conditions, whenever they were, for any length of time, employed in the galvanoplastic section. He ascribes the beneficial effect to the vapour of prussic acid; I suppose that the improvement of the health of the patients must be ascribed to the action of gold or *platina*.

CLINICAL EVENING, DECEMBER 4TH, 1890.

Inversion of Uterus.

DR. CARFRAE reported a case of the above condition, and showed the patient. He said:—This case I look upon as being both interesting and instructive. Interesting because of its rarity, and instructive on that account as well as because it may be looked on as a typical case, presenting all the symptoms one generally finds in such cases. In all probability the mischief dates from the last confinement, two years ago, when the patient had an instrumental delivery. Since then she has never been well, has had copious menstrual periods lasting ten days, and causing great prostration, as well as sickness or diarrhœa.

On examination a body, which felt extremely like a large polypus, was felt, as recorded in the notes of the case, but with this peculiarity—it was attached all round the cervix. I may add here that bi-manual examination was very difficult on account of the spasmodic rigidity of abdominal muscles.

Dr. Burford also casually, as it were, examined and found a growth protruding into vagina.

Some time after, as the notes record, we had the patient anæsthetized, and could then make a thorough bi-manual examination. Then we found the characteristic absence of the uterine body. We found, moreover, the absolute impossibility of getting the sound to pass beyond a very short distance into the cervical cavity. One finger in rectum and a sound in bladder confirmed this fact, and we came to the conclusion that we had to do with a case of inversion of the uterus.

After the patient had recovered from the effects of this ordeal, we again had her anæsthetized, and attempted to reduce the displacement, but without success. We then applied Lawson Tait's repositor with complete success. The patient is now perfectly cured so far as the inversion is concerned. It will take some time before her general health is restored.

The moral attached to this case is, in all cases where there is a growth in the vaginal canal be careful to

ascertain its exact nature. Such cases as this under consideration have frequently been mistaken for polypus and the uterus has been amputated, almost always with a fatal result. Even such an astute and experienced gynæcologist as Lawson Tait records a case in which he made this mistake. But, inasmuch as it was complicated with epithelioma, the treatment was the best that could be adopted, and the result perfectly satisfactory. The patient recovered.

Sero-Sanguineous Cyst.

Mr. KNOX SHAW showed a little boy, aged nineteen months, then a patient in the hospital, suffering from a large tumour in the right axilla. When six months old a tumour was first noticed under the arm, which very slowly increased in size until Midsummer last, when the increase became very rapid. On admission the tumour was the size of a cocoa-nut and occupied the right axilla, reaching from the level of the nipple to above the clavicle. It was soft, semi-fluctuating, freely movable, non-adherent to the skin, and became tense when the child cried. There were some enlarged veins over the surface, and when tense it had a bluish colour. Pressure was first applied but did no good. It was then tapped and some ounces of blood-stained serum removed, but the tumour did not materially diminish. Tapping was repeated without much benefit, so the patient was now being treated with electrolysis. Three applications had already been made, of ten minutes each, passing 50 milli-ampères through the tumour. A very marked change had taken place, the tumour having considerably diminished and having become much harder. The last application was accompanied with considerable reaction. The treatment was now interrupted as the child had had an attack of measles. Further electrolytic treatment would be undertaken. Mr. Knox Shaw considered the tumour to be a sero-sanguineous cyst arising from the degeneration of a blood nævus. Photographs of the child taken by Mr. W. S. Cox on its admission were exhibited.

Mr. WRIGHT said Mr. Owen had described cases of cystic hygroma of the neck which were similar to this case. Only these were lymphatic. They were better left alone, as they disappeared in time, and if meddled with got erysipelas.

Sarcoma of Breast.

Mr. KNOX SHAW also presented a woman, aged 55, whose left breast he had removed in September last for a very large fungating sarcoma of two years' standing. Two capital photographs showing the condition of the breast on admission, taken by Mr. Cox, were exhibited with the patient. Though seemingly a most unfavourable case for operation, it had been undertaken at the earnest solicitation of the patient and her medical attendant, Dr. Buck, with a most satisfactory result. The patient was freed from a loathsome, offensive mass and had now a sound cicatrix. A very small gland was enlarged in the axilla, and this was to be removed at once, some axillary glands having been removed at the time of the operation.

Radical Cure of Hernia.

Mr. KNOX SHAW exhibited another patient, a woman, aged 49, upon whom, sixteen days previously, he had performed a radical cure for an irreducible femoral hernia. The contents of the sac were entirely omentum, some of which was firmly adherent. The omentum was ligatured and removed, a plug being left to fill the hernial opening. The operation had followed a perfectly aseptic course, and the wound healed under one dressing.

Insular Sclerosis without Tremors.

Dr. EDWIN A. NEATBY showed a case of insular sclerosis, in which the stress of the disease had fallen on the lower part of the spinal cord and on the cerebrum.

Fredk. B., æt. 31, complained of weakness of legs.

History.—Thinks he had convulsions as a child (teething?). When 18 or 19 years of age had a series of convulsive seizures of the left side, drawing head to one side, and affecting arm, hand and leg. These attacks extended over a period of 12 months. They then ceased. No history of syphilis. About three or four years ago had a fright, and after this he was unable to follow his occupation as an omnibus conductor.

Present condition.—*Reflexes.*—Knee jerks both exaggerated, especially the left. Ankle clonus present on both sides, more on the right. The superficial reflexes are all absent.

The tactile sensibility is slightly diminished in both feet. General diminished sensibility to heat and cold, especially the inner part of right foot and on great toe. Here he calls hot, cold. Says usually that the tests are neither hot nor cold. No rhythmical tremors of hands or arms. No urinary or pronounced sexual disturbance (both testes are undescended, they can both be felt in the inguinal canals); slow and interrupted utterance; involuntary laughter; weakness of hands; spastic gait; nystagmus. Pupillary reaction diminished, both to light and during accommodation.

Pallor of left optic disc. Can only read for a few moments at a time.

Memory poor, except for recent events.

Electrical reaction.—General diminished response to both galvanism and faradism in muscles of fingers, forearms, and in ant. tibiales; no qualitative change.

Dr. NEATBY said, in reply to Mr. Wright and Dr. Moir, the disease had been coming on three years—much more rapidly last ten months. He had never had syphilis. He had not seen similar eye symptoms in this disease before, but almost any combinations of symptoms might exist, depending on the situation of the sclerosed patches.

Enlargement of Bronchial Glands (probably syphilitic) with Chronic Dyspnoea.

Dr. GALLEY BLACKLEY showed a patient at present an inmate of the hospital, where the provisional diagnosis had been as above, rather with the view of eliciting the opinion of members present, for a satisfactory diagnosis in such cases is frequently a matter of considerable difficulty. The notes of the case were briefly as follows:—

“Emmanuel J., aged 56, gunsmith, has used brace and bit a great deal pressed very hard against epigastrium. No filings or great amount of dust in his work. Father had asthma; mother liver disease; no history of phthisis in family. Had chancre at thirty with secondary symptoms. Smokes a little. First complained ten years ago of suffocation whilst talking to a customer; this happened twice within half-an-hour, and after it he noticed his breathing permanently affected; used to sing and did for eighteen months afterwards, at end of which time he had to give it up altogether, finding his

breathing noisy and laboured whether at work or rest. Seven years ago, feeling incapable of doing work, came as an out-patient to this hospital, when his breathing was extremely noisy, and had a very loud cough, with yellow expectoration. Took him into the wards and sent him out at end of 14 days to go to a convalescent home at sea-side, where he remained three months, at end of which he could walk twelve miles. Has been working pretty steadily since this time, and has noticed nothing very unusual except that breathing has slightly improved, and he has seen for last four years at times pinky expectoration. Six weeks ago, when coughing, was seized with considerable hæmoptysis, which went on steadily for four weeks, generally very dark. Came to me a fortnight ago, presenting following symptoms:—Voice better than when last seen, five years ago. Breathing audible at some distance and stridulous.

“Chest measures $28\frac{1}{2}$ round: right side $14\frac{1}{2}$ in.; anteriorly, sinking below clavicle and in intercostal spaces; expansion very deficient, vocal fremitus ditto, percussion note beginning at median line is dull for three inches externally and down to ensiform cartilage. Heart sounds heard very plainly over this dull area, but no adventitious sounds. Inspiratory sounds exaggerated, expiration prolonged; over middle line, at episternal notch and external to it breath sounds tubular and much exaggerated (stridulous). Behind, dulness over suprascapular fossa along vertebral border of scapula and slightly below tip. A few sonorous moist rhonchi heard posteriorly and laterally, otherwise normal. Left side of chest measures 14 in. round, somewhat barrel-shaped, percussion note tympanitic especially along anterior border; superficial cardiac dulness almost obliterated. Heart's apex beats 1 in. below and 1 in. inside nipple line.

“Laryngoscopic examination shows epiglottis tilted backwards partially obstructing view of cords, has a few dilated capillaries upon it; mucous membrane covering arytenoids red and swollen; cords slightly more pink than normal, left one moves much more freely than right; immediately behind and below right cord is a small smooth swelling about the size of a horse-bean, encroaching slightly upon the lumen of the air tube. A full-sized œsophageal bougie passes without difficulty.

“Sputa nummular, flesh coloured (consisting of blood and pus intimately mingled), with some frothy mucus.

“Microscopic examination of sputa for yellow elastic lung fibres, and tubercle bacilli, gave negative results.”

Dr. Blackley said, that in attempting a diagnosis there were several different conditions that naturally suggested themselves as being possibly present: (1) aneurysm (this had been diagnosed by one medical man some years ago, but no distinct evidences of it remained); (2) displacement of the heart following pleurisy; (3) phthisis, due to his occupation; (4) scrofulous, malignant or syphilitic deposit in the bronchial glands. On the whole he leaned to the last supposition.

Dr. Moir thought there was no doubt about there being a tumour present, either a gumma or malignant. He advised large doses of *iodide of potassium*.

Dr. Blackley said it was too slow for a malignant growth. He thought it was possible there was affection of bronchial glands. He had been apparently well and at work for five years, and had only returned to Dr. Blackley a fortnight ago, so there had been little time to observe treatment. The man was now on *plumbum*; he had not had *iodide of potassium*.

Mr. Wright thought there were probably diseased bronchial glands.

Mr. Shaw suggested aneurysm.

Dr. Blackley said that had been diagnosed by one of the medical men who saw him years ago.

Dr. Moir said he had seen a case of aneurysm in which rupture took place, no symptoms of dyspnoea having been present.

Pelvic Cyst.

Dr. Burford showed a patient sent into hospital by Dr. Edwin Neatby, under whose care she had been for a short time prior to admission. The patient had been variously ailing for some three months, her troubles culminating in a severe attack of pelvic inflammation with a high degree of pyrexia. Under the care of an allopathic specialist, aspiration was, according to the history, performed through the vagina, and some quantity of sanguineous fluid withdrawn. She transferred herself to the care of Dr. Neatby, who detected a pelvic tumour concurrent with evidences of pelvi-peritonitis. He prescribed *belladonna* 30, under which the inflammation subsided, and then advised her removal to hospital. On

her admission a large cystic swelling, originating in the pelvis, occupied nearly the whole of the left iliac fossa, and recent plastic exudation into Douglas' pouch was found. The temperature was of the hectic type. The cyst was diagnosed as par-ovarian, and the patient confined to bed and treated with *hepar sulph.*, and hot douches locally to remove the plastic effusion. Under this *régime* daily progress was made. The temperature soon fell to normal, and the patient's general condition steadily improved. After about a fortnight thus spent in hospital the cyst was found to have disappeared, but curiously without the least consciousness on the part of the patient. No fresh symptom was evoked, and no hindrance offered to the continuity of convalescence. The patient left hospital with health fairly regained, and with but scanty evidence of the previous pelvic lesion.

Dr. Burford held that the cyst had slowly leaked into the peritoneum, thus discharging itself of its contents, which in broad ligament cysts are usually innocuous, and that the local inflammation, peripheral to the cyst, had undergone absorption under the treatment detailed.

Ovarian Cyst.

Dr. BURFORD also showed a large ovarian cyst, which he had removed that morning from a patient sent into hospital by Dr. Hughes. The history of the growth was that some six months ago the catamenia suddenly stopped, and had not since returned. No sign of increase in size was detected by the patient until about a month before admission into hospital, when she was seen by Dr. Hughes, who detected the neoplasm and advised its removal. A fortnight before operation Dr. Burford examined her, and during the fourteen days prior to its removal the cyst nearly doubled in size, its upper limit reaching nearly to the ensiform cartilage. On December 4th the cyst was removed. Some parietal adhesions were broken down, but there were no visceral ones. Some gallons of thick turbid fluid were evacuated by the trocar, and the solid elements of the cyst removed in the usual way.

Mr. SHAW thought the case showed the possibility of falling into error. If *apis* had been given, all would have said *apis* had cured the tumour.

Dr. CLARKE suggested that *hepar* was the indicated remedy, and *had* cured.

Dr. BURFORD said the *hepar* was indicated by the tendency to suppuration, fever, and hectic. Also *hepar* had done so splendidly in another case he had had on hand at Surbiton.

Neuritis (?)

Mr. W. S. Cox showed a case under the care of Dr. ROBERSON DAY, who was unavoidably absent. The patient, a woman, æt. 45, had for some months past complained of weakness in the lower extremities and inability to go up or down stairs without helping herself with her arms, also difficulty in going up or down an incline, and inability to rise from the sitting posture.

The right calf was half an inch larger in circumference than the left. On May 14th, 1890, the knee jerks were difficult to obtain, especially on left side, but the pupils reacted to light and accommodation. There was no staggering gait. Dr. Roberson Day requested the opinion of members present as to the diagnosis of the case. He considered it one of peripheral neuritis.

Epithelioma of Larynx.

Mr. W. S. Cox showed a larynx obtained from a patient admitted under the care of Mr. Knox Shaw for epithelioma of the left vocal cord. The disease had existed nine months, and was most easily demonstrable by the laryngoscope. Very urgent dyspnœa having set in the patient was tracheotomised, but he died four days subsequently from pneumonia.

Hysterical Paralysis (?)

Dr. CAVENDISH MOLSON sent for exhibition a patient of whose case the following are the notes:—

Mrs. C. S., æt. 50? Eight children, one miscarriage. About four years ago patient was seized with severe pains in her head, accompanied by dimness of sight and constant desire to lie down; 18 months since she became decidedly worse, and a little later lost the power of locomotion and of articulation, and became unable to feed herself.

During her illness she was seen, at intervals, by four medical men, who all agreed that patient could not recover; the last authority limiting the duration of her life to a few "weeks," or "months."

By the advice of a friend she was induced to "try" homœopathy, and was brought from her bed (where she had been for months) to the out-patient department of our hospital. On this day, Tuesday, July 29th, her symptoms were as follows:—

Viz.: 1. Dimness of sight. 2. Vacuity of mind; lack-lustre expression of countenance. 3. Inability to stand, except by holding on to something for support. 4. Inability to articulate, the attempt to speak being followed by an incoherent noise. 5. Profuse ptyalism, the saliva pouring from the mouth in a continuous stream. 6. Loss of prehensile power, and great difficulty in deglutition. 7. Epileptic (?) fits (four months). Symptoms 3 and 4 had been present for twelve months.

Treatment: R̄ *tinct. cicutæ virosæ* 1x, *tinc. ignatiæ amaræ* 1x, gtt. 5, 3 hor. alt.

Result: July 30. Vision improved. Mind clearer. July 31. Spoke, ate, walked a little, and felt generally better. August 3rd. So much improved that patient was able to ride on the *outside* of an omnibus. From this date onwards the convalescence was unbroken, and patient was discharged "cured" on 3rd Dec., no change having been made in the treatment. From other observations Dr. Molson attributed the improvement to the *cicuta* rather than to *ignatia*.

Dr. EDWIN A. NEATBY said it was probably hysterical, but there was quite a possibility that some organic disease might declare itself. Transitory slight paralyzes and other neuroses were often the precursors of disseminated sclerosis. They did not, however, usually last so long as the symptoms had done in this case, before disappearing.

Dr. MOIR thought it might be an instance of cure by suggestion.

Pressure Dyspnoea.

Dr. MOIR showed a boy who had a disorder of breathing. He might be called a "roarer." The condition had lasted four years, with short intervals in summer. There was a strong syphilitic history, and evidence of increase of size in the thoracic glands exciting pressure on the trachea. The child was much emaciated, and had a deep hollow in the epigastrium.

Dr. CLARKE agreed with Dr. Moir in supposing that the peculiar breathing was caused by pressure of enlarged glands, and he thought probably the thymus was chiefly at fault.

Mr. WRIGHT mentioned another case which had occurred in the hospital about a year ago. That case recovered under *merc. biniod.* There was a strong syphilitic history. In Dr. Moir's case the enlargement of the thymus was not so clear. The bronchial glands were often affected in these cases. There was some enlargement of the thymus, which passed round the trachea.

SOME OF THE COMMONER DISEASES OF THE
PHARYNX AND LARYNX.

BY MR. DUDLEY WRIGHT.

Assistant-Surgeon to the London Homœopathic Hospital.

I SHALL not try to deal in any great detail with the subjects I have chosen for to-night's paper, as our time is too short, and for this reason I must ask you to make allowances for the "sketchy" character of this essay. I hoped, moreover, to have brought before you patients suffering from the various diseases of which I shall treat, but in this I have been disappointed, and will therefore try in part to make up for this loss by a few coloured illustrations taken from patients who from time to time have presented themselves for treatment at this hospital.

For various reasons I shall not enter into a discussion upon acute catarrh of the naso-pharyngeal tract, but, passing this over, will commence with the extremely and often intractable disease—*chronic naso-pharyngitis*.

This disease may be present in one or both of two forms: The first consisting of a more or less uniform redness of the mucous membrane with, perhaps, slight swelling; the second, to which the name *pharyngitis granulosa* is given is characterised by the presence of the so-called granular bodies in various parts of the pharyngeal tract. They vary in size from a pin's head to a split pea or even larger, and are situated by far the most commonly in the *pars oralis*.

According to Saalfeld and Roth these bodies are due to "a circumscribed proliferation of the lymphoid tissue around the duct opening of a mucous gland," and most observers are agreed that their presence is a manifestation of the evil effects produced by irritation of one form or another applied to the mucous membrane of the pharyngeal tract.

The most common of these irritants, according to Lennox Browne, is the improper use of the voice, in which he would include not only improper voice production, but also over-exertion of the voice or straining, an act entirely controlled by the pharynx. That this is really

a common factor is demonstrated by the very frequent occurrence of the disease in clergymen and public speakers, from which fact it has obtained the name of "clergyman's sore throat." Other important causes are excessive smoking, especially if expectoration be frequently carried out during the act, and alcoholic excess. One form of the disease, which according to most English observers is uncommon in this country, is that in which the granulations are grouped more particularly at the sides of the pharynx. To this the name *lateral hypertrophic pharyngitis* has been given. In such cases inspection shows an irregular and elongated swelling of the mucous membrane behind each posterior pillar of the fauces springing forward and inwards and coming very prominently into view when the patient is made to say "a." This condition, though as before said comparatively rare in England, is by no means uncommon in parts of the Continent, and in the clinics in Vienna one could find it present to a greater or less degree in nearly half the cases of chronic pharyngitis.

This form is of importance, inasmuch as the granulations, being in close proximity to the opening of the Eustachian tubes, are more likely to obstruct the free passage of air into the middle ear and lead to ordinary "throat deafness" and other consequences of Eustachian blocking, than the form in which the granulations are situated more in the middle line of the pharynx.

A common symptom in these cases is a "sticking" pain running up in one or both ears.

If the granular pharynx is not carefully treated atrophy of the mucous membrane is very apt to ensue, and we then have the atrophic form of pharyngitis in which there is a loss of epithelium, atrophy of the glandular tissue, and thus a diminution or complete absence of secretion, the mucous membrane becoming dry and glazed.

In the vault of the pharynx is situated the mass of lymphoid tissue called after Luschka, who first accurately described it, Luschka's tonsil. This organ possesses numerous crypts, similar to those of the faucial tonsils, though larger, running into its substance.

It is the hypertrophy of this pharyngeal tonsil which forms the adenoid vegetations so commonly met with in children from the age of six years upwards.

Besides this, another form of disease is liable to be produced by certain alterations in its structure.

You will see in the illustration that at about its centre is situated a crypt which is somewhat deeper and larger than the rest, and which has been called the bursa pharyngea. This crypt is liable to be attacked by a form of chronic inflammation which causes it to be the seat of a stringy muco-purulent discharge which, issuing from its mouth, may appear trickling down the posterior pharyngeal wall behind the uvula. This process may of course occur in any of the other crypts, but its effects are much more noticeable and possibly more common in the larger central one. This disease was first described by Tornwald, of Dantzig, and has been called bursitis or catarrh of Luschka's pouch.

In order to make a certain diagnosis posterior rhinoscopic examination is necessary, and the discharge may sometimes be seen issuing from the mouth of the crypt. I have not yet myself had an opportunity of seeing one of these cases, but it should always be looked for in patients suffering from a chronic discharge from the posterior nares. In some cases examination of this region may be assisted by some form of uvula retractor, one of which I pass round. They are not often needful for examination purposes, but may be found useful when it is desirable to apply remedies locally.

With regard to the treatment of chronic catarrh we have many remedies from which to make a selection. For those cases attended with a scanty secretion and constant hawking, especially when this occurs in the morning soon after waking, *nux vomica* will generally give prompt relief. When the granular condition is marked, *sanguinaria* taken internally, or as I prefer it, locally with glycerine or in a warm spray, is as good a remedy as one could wish.

Phytolacca is useful in those cases of chronic sore throat increased by exposure to cold winds, with pains commencing in the throat, extending downwards, and exciting a paroxysmal cough with thick mucus.

Bichromate of potash is chiefly indicated in those forms attended with considerable muco-purulent discharge and involvement of the nasal mucous membrane, and should be of use in the disease described by Tornwald. One other form of medication I have found useful, especially

in chronic catarrh left after repeated acute attacks, is the inhalation of *camphor* mixed with *sulphuric ether*, in the proportion of 10 of *camphor* to 100 of *ether*.

Some forms of pharyngitis are marked by the presence of enlarged and tortuous veins beneath the mucous membrane, and often by a varicose condition of the veins at the root of the tongue. In these cases *pulsatilla* is the indicated remedy, though it is often necessary to destroy the varix by means of the galvano cautery. *Pulsatilla* is more particularly indicated in those cases of long standing pharyngitis accompanied by a characteristic train of mental and gastric symptoms.

Chronic laryngitis is one of the most common forms of laryngeal disorders with which one meets. In it one finds a more or less equally distributed injection of the mucous membrane of the larynx, with or without involvement of the true vocal cords. The redness and swelling is, as a rule, most marked when the tissues are loose in texture as over the ventricular bands and ary-epiglottic folds: but the epiglottis may become intensely injected, especially in those cases due to alcoholic excess. Bands of mucus may be seen stretching from cord to cord, which, breaking when the cords are widely separated as in taking a deep breath, leave an appearance of crenation of the free borders. Often, also, will be found a want of the power of approximation of the cords in their central parts, owing to weakness of that portion of the thyro-arytenoidens muscle, which exercises a control over the tension of the cords, and at the same time a certain jerkiness in their movements may be noticed. As in the pharynx, so in the larynx, though to a lesser degree, the glandular lymphoid tissue may become enlarged, forming the so-called follicular laryngitis.

Erosions of the mucous membrane may be present, though true ulceration seldom if ever occurs. When the loss of epithelium takes place on the vocal cords, an absence of the characteristic sheen will be noticed on the damaged parts. The treatment of chronic laryngitis is very much the same as for chronic pharyngitis, but I may mention *iodine* as a drug to be used in the follicular form.

It must, however, never be forgotten that both chronic pharyngeal and laryngeal catarrh are as often as not

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complicated with some form of nasal stenosis, and may really be the result of the stenosis. Any form of treatment, then, is useless until we remove the exciting cause from the nose. So long as the stenosis exists, the patient will breathe through the mouth, and this will invariably keep up the irritation.

Before passing on to the specific forms of inflammation, I should like to mention a case of a rather anomalous character which was under the care of Mr. Shaw in the hospital last year. A female child, age 5 years, who had previously been operated on for post nasal adenoids, was admitted with a sore throat, which had been coming on for the last four days, general weakness with a temperature of 101°. Examination showed the fauces to be much injected and the tonsils enlarged (this was old-standing trouble). On the lower half of the uvula was situated a dumb-bell-shaped bleb, the remainder of the uvula being of an intensely red colour. On the upper part of the right anterior pillar of the fauces were two other blebs, with a surrounding zone of hyperæmia.

The posterior pharyngeal wall was deeply injected and the tongue coated. On the second day after admission a rash, somewhat similar to that of scarlet fever, was noticed on the arms and shoulders, and at the same time the skin was hot and dry, but by the evening the rash had gone and the skin was moist. By the fourth day the temperature was normal, and the blebs had nearly disappeared, but at this time what appeared to be pompholyx formed on the outer side of the terminal phalanx of the right index finger. The child, however, went on well and was soon sent down to the Eastbourne Convalescent Home.

She received *bell.* whilst the acute stage lasted, and at the end *rhus tox.* The illustration was taken on her admission. From the faucial appearances I should be inclined to class this under the head of herpes of the pharynx, the attack somewhat corresponding to those cases in which a rise of temperature is followed by no other symptoms than herpes of the lips.

Cases of syphilis of the pharynx are unfortunately common enough in both its secondary and tertiary forms, and in hospital work one is constantly meeting with patients who present various features of this affection.

They are generally the most satisfactory cases we have to treat, and the results are very encouraging.

Cases of primary chancre of the pharynx or oropharynx would hardly come under the heading of this paper, so I propose to deal only with the two other forms of the disease.

The throat manifestations of the secondary stage are of the same nature as those of the skin.

A more or less symmetrical hyperæmia of the mucous membrane of the fauces and velum, together with a slight amount of swelling owing to serous infiltration of the submucosa is to be seen. The swelling is of course most marked where the tissues are loose, and hence the uvula may be considerably swollen and its edge have a peculiar semi-transparent look owing to the œdema. The posterior pharyngeal wall is not so often attacked by the inflammation, though the naso-pharynx may become involved together with the lining of the Eustachian tube. Mucous tubercles may be present, corresponding to the papular eruption of the skin, and on them "plaques" of exudation may form, but in many cases these plaques are not due so much to an exudation as to the heaping up of sodden scaly epithelium.

The illustration is taken from a typical case of secondary syphilitic sore throat in a man, aged 21 years, who was first seen here by me last May. He had a hard chancre in January and the sore throat came on at the end of February. When seen he was decidedly anæmic and the forehead and upper part of the chest was covered with a thick macular and papulo-squamous eruption, which had been present for two months. You will see that on the right tonsil and anterior palatine fold is a "plaque" of a horse-shoe shape, and on the left side is a more irregular shaped one. The mucous membrane around them is much congested and there is slight œdema of the uvula. There was an enlarged unindurated gland at the left angle of the jaw. The hearing power was only in contact with the watch in the right ear and $\frac{6}{30}$ in the left ear. He had previously been treated at the North-West London Hospital. I ordered him *merc. sol.* 3x mv. t.d.s. and *ung. hydrarg. ammoniatum*, with *lanoline* and *glycerine* in equal parts for the eruption. In a month the rash on the arms and body

and the sore throat had quite gone, but there were still a few maculæ left on the forehead.

The symmetry of the erythematous or papular eruptions of the throat are very characteristic, and Jonathan Hutchinson has given to it the name of "Dutch garden symmetry."

In the secondary form of the disease true ulceration very rarely takes place. The plaques may be mistaken for ulcers, but careful inspection will prevent this error. A certain amount of erosion of the mucous membrane may occur, but ulceration is practically limited to the tertiary stage and is then the result of breaking down of gummata.

Secondary syphilis may assert itself in the larynx in very much the same form as it does in the pharynx, though it is less frequent and its manifestations do not show the same tendency to symmetrical arrangement as in the latter seat. Another important feature about laryngeal involvement is that it does not show itself as a rule till a much later period than the pharyngeal form, indeed, it is generally only first present when the latter trouble has nearly or quite subsided.

If mucous tubercles are present they generally occur in the epiglottis, and in the larynx the same rule holds good with regard to true ulceration being rare in the secondary stage.

The voice is more markedly affected in cases of specific than of simple laryngitis. Periods in which the voice is quite lost are not uncommon, and are chiefly dependent on atmospheric disturbances, and when the voice is restored it is almost always husky for a considerable period and may become permanently so.

The treatment of the various conditions of secondary syphilis are eminently satisfactory. *Perchloride of mercury* suits most cases, and I have not seen a case which did not obtain benefit from it. For the pharyngitis a gargle of 1 in 20 *nitric acid* solution is highly beneficial. I know of nothing which so quickly removes the discomfort occasioned by the hyperæmia. The same or a little weaker lotion may be applied locally to the laryngeal mucous membranes by means of the laryngeal brush, or better, a probe covered with cotton wool. The patient must avoid eating anything which may act as an irritant to the inflamed parts, such as curries or mustard,

&c., and he should take great care that the teeth and cavity of the mouth are always kept clean.

We have seen that the pharyngeal and laryngeal lesions of secondary syphilis are similar in their pathology to those found on other parts of the body, and we find that the same order of things obtains with regard to the tertiary stage. We have the same gummatus deposit, the same loss of tissue or ulceration brought about by changes taking place in the walls of the vessels supplying the gummata, and the same tendency to heal up under suitable remedies. The soft palate and uvula is the most frequent seat in the pharynx for gummatus deposits, and it is here that the disease leaves the clearest traces of its past existence. A more or less localised hyperæmia and swelling of the part attacked is to be first noticed; death of tissue soon follows, and an ulcer forms which is generally covered with a tough yellowish slough, the remains of the necrosed tissue. If this slough be removed, the ulcer will be seen to be of a considerable depth, with undermined edges, and the mucous membrane in the vicinity of an intensely red colour. The discharge which comes away mingles with the saliva and renders that secretion offensive and highly septic. The glands at the angle of the jaw will, moreover, be increased in size.

If there is a gumma at the root of the uvula the blood supply of that appendix may become cut off, and true gangrene of the uvula results; this I have seen happen in a very severe case. In other cases the gumma is situated in the substance of the uvula itself, and the ulceration which follows results in its complete disappearance. The soft palate may become perforated, and the loss of tissue over the hard palate may cause necrosis of the bone and exfoliation.

Under treatment the healing process soon commences, the sloughs disappear and the ulcers look healthier and gradually diminish in size. Cicatrisation now takes place, and if the ulceration has been at all severe, and there has been much loss of tissue, considerable deformity will result. The first illustration was taken from a female, æt. 52, admitted to hospital for severe syphilitic ulceration of the soft palate. Two perforations can be seen, the uvula having entirely disappeared, and on the left side a bridge of tissue running up from the

anterior pillar of the fauces stretches across one perforation. The second illustration was taken from a girl aged 18 years, who acquired syphilis at 15 years. In this case the uvula has quite, and the velum almost entirely ulcerated away, and there is a considerable amount of scarring of the posterior pharyngeal wall.

Tertiary syphilis of the larynx may follow on a case of tertiary syphilitic pharyngitis, but should this be the case its ravages seldom extend below the epiglottis. It occurs, as a rule, as a very late manifestation of the disease, and often not until some 10 or 15 years after the primary stage. The gummatous deposit breaks down and a typical syphilitic ulcer is the result. These ulcers may be present in the epiglottis—which is most commonly the case—on the vocal cords or on the inter-arytenoid space. When on the epiglottis, the ulcer may be very readily seen, and its edges often acquire a peculiar mouse-nibbled contour, which is very characteristic. The process of cicatrisation of these ulcers is often attended with a good deal of contraction, and this may lead to stenosis of the larynx of extremely troublesome character. During the process of ulceration the cartilages of the larynx may become attacked, and pieces may from time to time be discharged.

Acute œdema may occur during the progress of the case, and such an accident often calls for the prompt performance of tracheotomy.

The treatment of tertiary syphilis is, as a rule, very satisfactory so long as we only have to deal with ulceration, but the after-effects produced by cicatrisation are always very troublesome. The ulcerative process is in most cases entirely stopped by the internal administration of *iodide of potash* in 3 to 5 grain doses.

Mr. Jonathan Hutchinson has given us a very good example of the homœopathicity of this drug in Vol. i., No. 1 of his admirable *Archives of Surgery*, where a case of *iodide of potassium* poisoning with the production of numerous gummatous like growths, and which were indeed mistaken for such, is well illustrated. Should the *iodide* fail, we fall back upon *nitric acid*, both internally and as a mouth wash. Any good antiseptic mouth wash may be used—preferably *permanganate of potash*—and after the sloughs have been removed the

ulcers may with advantage be painted with a 1 per cent. solution of *iodine* in *glycerine*.

During the ulcerative stages of tertiary syphilitic laryngitis, the same treatment may be adopted, but when cicatrisation has ended and stenosis is left, surgical treatment is necessary.

Schrötter, of Vienna, in these cases performs a preliminary tracheotomy, and by means of hollow tubes of gradually increasing dimensions, dilates the stricture by passing the instruments from above. The tubes are retained in position for from 15 to 30 minutes. I have seen two cases of post-diphtheritic stenosis in his clinique treated by this method with very good success.

Whistler uses a dilator and knife combined, by which the stricture is at the same time incised and dilated, and he does not perform a preliminary tracheotomy. In spite, however, of the most painstaking treatment, the results are unfortunately very discouraging, from the very great tendency for the stricture to become tight again.

A deposit of tubercle in the larynx may take place during the course of chronic pulmonary tuberculosis, or as post-mortem examination has proved, without the primary affections in the lungs.

The first pathognomonic signs of laryngeal tubercle are often preceded by a marked anæmia of the mucous membrane. The white cords do not stand out with their usual distinctness against the other coloured portions of the larynx. Marked pallor of the mucous membrane is, then, always a suspicious sign, and more especially so if to this be added a certain amount of aphonia and imperfect adduction of the vocal cords. These symptoms in delicate women with menstrual disturbance are by no means uncommon precursors of laryngeal tubercle.

Swelling of the parts in which the deposit of tubercle has taken place is the next change. This is the first characteristic of tubercular disease of these parts. It is generally localised to one particular spot, especially the inter-arytenoid space or the coverings of the arytenoids.

The tumefaction is due to a tuberculous infiltration of the sub-mucous tissues, and is not to be confounded with the swelling due to œdema which sometimes

occurs during the course of tubercular laryngitis owing to perichondritic changes.

When the deposit is over the arytenoid cartilages the swelling is very characteristic, the two pyriform bodies standing out prominently, with their larger ends meeting in the middle line and the other ends tapering outwards. The epiglottis and the ary-epiglottic folds may be likewise affected, and in the sketch taken from a patient, kindly sent to me by Dr. Cooper, you will see a good example of tubercular infiltration of the right half of the epiglottis and the covering of the right arytenoid cartilage. In this case there is considerable hyperæmia of the affected areas which is not usual, the colour, as a rule, being described as "muddy" or greyish, with a few dilated vessels crossing over the swelling. In the above case there is also some commencing ulceration of the inner edge of the swollen epiglottis and of the right ventricular band, with hyperæmia of the right vocal cord. The patient's age is 26, and he has slight evidences of phthisis at the right apex.

The swollen parts may attain an enormous size before ulcerating, but sooner or later the mucous membrane gives way and small ulcers form, which by confluence form larger ulcerated areas.

About this time, or even sooner, paralysis of one or both cords may appear, and this is due either to direct impediment to their movements owing to the swollen condition of the parts, or to pressure on some part of the recurrent laryngeal nerve, the right nerve being more commonly involved than the left owing to its anatomical relations.

One meets occasionally with cases in which there is no marked swelling of the arytenoids or epiglottis, but in which there are present on the posterior wall of the larynx some polypoid excrescences. These, at first sight, are apt to mislead, but careful examination will probably prove them to be the upper indurated border of a tubercular ulceration, which is limited to that part, the ulceration itself not being visible, owing to its irregular upper edge which, projecting forward, appears as the polypoid excrescences and thus obstructs the view. In process of time the ulceration may be seen creeping on to one or the other vocal cord or ventricular band and the diagnosis becomes no longer doubtful.

It is necessary to say a few words on the subjective symptoms of this disease, as their presence not only aids us in treatment but also in diagnosis and prognosis.

The voice is usually early affected, becoming weak and often quite aphonic. In syphilis true aphonia does not often occur, the voice being only hoarse.

Respiration is not often embarrassed, though often more frequent than natural, owing to the condition of the lungs. Stenotic suffocation is not so common as in syphilis.

Cough and expectorations are much dependent upon the condition of the lungs; and *hæmorrhages*, apart from a pulmonary origin, are rare, whereas in cancer and syphilis they are fairly common.

Pain is present when there is much cough, and especially when the epiglottis is involved, as every particle of food irritates the tender surface. Pain is a rare symptom in syphilis.

The prognosis is usually unfavourable, especially when the epiglottis or pharyngeal aspect of the larynx is involved, for, owing to the painful deglutition, sufficient nourishment is not easily taken, and the patient's end is rapidly hurried on by starvation.

When the disease is confined to the intra-laryngeal portion we may have hopes of arresting its course.

In treatment the two chief drugs we have to rely upon are *iodide of arsenic* and *iodide of mercury*. Dr. Beebe in the *Journal of Ophthalmology, Otology and Laryngology*, for October, 1890, reports three cases of this disease in rather an advanced state, receiving great benefit from the former drug, and *ferrum phosph.*, combined with local treatment of the ulcerated areas, with 20 and 50 per cent. solutions of *lactic acid*, iodoform powder being afterwards dusted on.

Bichromate of potash would be indicated when there is much ulceration and chondritic change.

To relieve the cough, which is often a very troublesome symptom, inhalations of *conium* are useful.

℞ *Sodæ carbonatis exsiccatae* ... gr. xx.
Aquæ (140° F.) fl. ʒ xx.

Solve et adde—

Succi Conii fl. ʒii.

The vapour should be inhaled once or twice a day.

(The above is from the *Throat Hospital Pharmacopœia*.)

In many cases *codeia* in $\frac{1}{8}$ gr. doses, with a drachm of *glycerine*, will be found to give great relief to the cough.

A twenty per cent. solution of *lactic acid* applied to the ulcers is a very favourite remedy, and in some cases has caused them to heal up rapidly. A form of treatment which has been lately advocated, and I myself can testify to the relief sometimes given to the patient from cough and pain, is the injection into the larynx of a 20 per cent. solution of *menthol* in olive oil. Many patients treated by this method express great relief, and often the emaciation is arrested and weight regained.

It yet remains to be seen whether Dr. Koch's method of treatment is to be relied upon in laryngeal tubercle.

DISCUSSION.

Dr. BLAKE had pointed out fifteen years ago that follicular pharyngitis was often associated with emphysema, and tricuspid insufficiency. Dissenting ministers were less liable to it than Church clergymen. Mr. Spurgeon said it was because Dissenters did not intone. Dr. Blake did not agree with this. He attributed it to the fact that Anglicans were often athletes, and subject to emphysema. Much more attention was given to the subject of naso-pharyngeal neoplasms by Americans than by others. He mentioned the best instruments for removing adenoids, the most popular being Löwenberg's forceps and Gottstein's ring-knife. Dr. Blake had adopted the surgical treatment some years ago, and found it much better than medicinal. He noticed that laryngeal symptoms disappeared when the pharynx was treated. Osteo-arthritic patients, especially pallid and anæmic, were liable to sore throat. They have pain on swallowing. It is myalgia of pharyngeal muscles, and disappears under *actæa racemosa*. There is nothing to see on looking at the pharynx. He sterilised the nose before examining, with a spray of boric acid and cocaine (5 per cent.) in camphor water. Dr. Blake showed and illustrated the use of a new nasal sound he had devised. He gave the 3x trituration of *merc. cor.* in secondary syphilis, the first centesimal in primary syphilis. The 30 c. was excellent in syphilis of the newly born. He mentioned a case of tertiary syphilis of a peculiar kind. The wife of an officer suffered from great pain in left arm and attacks of dyspnoea, hoarseness, and marked cyanosis. She had been thought to have adhesion of the pericardium to the heart. Mr. Millican and Dr. Blake had diagnosed a gummatous mass in the mediastinum pressing on the phrenic and recurrent laryngeal, and this was

confirmed by a *post mortem* examination. In reference to *iodide of potassium*, he mentioned a case in which cerebral syphilis was diagnosed, and massive doses of *iodide of potassium* administered. The patient became worse at once, developed dementia and local dropsies, and was sent to an asylum where he soon died. His brain was found perfectly healthy. There was no syphilis. The patient died of *iodide of potassium*. The case was really one of old sunstroke occurring in a guardsman; it had been steadily improving under *lachesis 6*, when unfortunately the aid of a distinguished neurologist, who evidently himself suffered from another form of syphilis on the brain, was sought with the disastrous result that has been described!

Dr. HUGHES was glad to see young members taking up specialities, but he hoped Mr. Wright would not, in his zeal for surgical measures, forget the better way. There was a danger lest the enthusiasm for the one should swallow up something better. The two were not incompatible, but the methods were very different. The old school method was analytic; the homœopathic was synthetic. We do hear of morbid growths melting away under drugs. Our first enthusiasm should be reserved for the homœopathic treatment. We must go to our *Materia Medica*—work that thoroughly before going to the other.

Dr. CLARKE was much interested in Mr. Wright's excellent paper, and he was glad to find he was devoting himself to this special study. In his own experience in the treatment of chronic pharyngitis he had not found local applications necessary. In one case, in which the catarrh had lasted for years, the patient having to clear away a greenish-yellow leathery secretion several times a day, *sulphur*, *lycopodium*, *argentum nitricum*, and *cistus*, given according to the patient's symptoms, general and local, entirely relieved the condition. *Cistus* was given because the patient complained of a "spongy" feeling in the throat, *cistus* producing a feeling of *softness*. The relief was immediate. The patient also suffered from granular inflammation of the eyelids, and every night she used to bathe the eyes with a zinc lotion in order to get relief. This condition was entirely removed at the same time as the throat symptoms. In reference to "antiseptic washes" recommended for the mouth and throat by Mr. Wright, he would remind him that the mouth absorbed very rapidly, and everything applied locally to the mouth was at once absorbed into the system. He had seen a case of severe poisoning by *borax* used for a long time as a mouth-wash for a child. There was ulceration outside the mouth as well as inside, and the characteristics of *borax*, "aggravated by downward motion,"

was most marked. The child screamed whenever the nurse attempted to put it down. He thoroughly endorsed Dr. Hughes' remarks that our *Materia Medica* should be our first enthusiasm. Homœopaths should be fully abreast of the allopaths in all surgical methods, but they should be homœopaths first and surgeons afterwards.

Mr. KNOX SHAW thought Mr. Wright's paper an excellent combination of modern surgery, with hints for the best medicinal treatment. There were, however, some remedies he had not mentioned. *Hydrastis* was one. Chronic post-nasal catarrh he had seen relieved by this, and the local application of *hydrastis* with *glycerine* was of great service. He had found *calcareea phos.* very useful in adenoid disease. Some patients, on whom it had not been convenient to operate at the time, materially improved under *calcareea phos.* But he thought operation should not be delayed too long. A vapour of *chloride of ammonium* had been useful, applied to the nose and pharynx. With many a patient with chronic hoarseness, improvement would not take place till the pharynx was seen to. *Nitric acid* 1x was useful in syphilitic ulceration, as well as *mercury*. He had long considered what was the relation between *iodide of potash* and tertiary syphilis. Mr. Wright had asserted, on Mr. Hutchinson's case, that it was a homœopathic relation, and if so, this cleared away a difficulty. Mr. Hutchinson had given good illustration of homœopathic action in showing the power of *arsenic* to cause cancer, which, as homœopaths knew, it had also cured.

Dr. MOIR said if homœopathy is to make progress, homœopaths must be on a level with the men of the old school who are doing good work in special diseases, and of this homœopaths ought to avail themselves.

Dr. DUDGEON (in the chair) said his own experience did not give him much information about the surgical diseases of the throat. He had found all those Mr. Wright mentioned were fairly amenable to homœopathic remedies. He had had several cases of the glazed pharynx so far improved that all the discomfort had been taken away by a long course of homœopathic remedies. He considered the use of *iodide of potassium* in tertiary syphilis was homœopathic, but it did not do very well in infinitesimal quantities. In one case of ulceration of the pharynx healing took place under five grain doses very rapidly. Another case of chronic affection of tonsils in a lady of 50, *phytolacca* cured rapidly, though before taking it she never could experience cold or damp weather without the greatest inconvenience. Such cases made him less anxious to resort to surgical measures. Medicines had

this advantage, that if successful they remove *tendencies* which surgical measures do not do.

Mr. KNOX SHAW said he had omitted to mention one point—the intense difficulty of swallowing in patients suffering from laryngeal phthisis. He referred to a method of feeding these patients which has been of great service to many. They should lie on a sofa the face down with the head hanging over and turned to one side, the food (being liquid) is sucked up and passes along the back of the pharynx and by the side of the epiglottis.

Mr. WRIGHT (in reply) thanked the members for the manner in which the paper was received. The glazed pharynx was not amenable to surgical means. It was only by getting drugs strictly homœopathic that any impression can be made on it. He did not think the laryngeal affection was always reflex as Dr. Blake suggested; it might be by extension of the diseased action, or from the cold air breathed through the mouth, the nose being stopped. *Cocaine* should be avoided as an application to relieve the pain in tubercular laryngitis; and for anæsthetic purposes it was better used on a plug of cotton wool than as a spray.

THE RECENT DISCOVERIES OF KOCH AND
PASTEUR AS ILLUSTRATING THE LAW OF
SIMILARS.

By W. DEANE BUTCHER, M.R.C.S., Eng.

I HAVE chosen as a subject worthy of the Society's attention "the Recent Discoveries of Pasteur and Koch as Illustrating the Law of Similar," but herein I labour under two disadvantages. The subject is one so new, so open to debate, and the time for preparation so limited, that I have been tempted to throw on the members of the Society the task for which I felt myself unequal. You will see in the notice that the question I put before you this evening is merely "matter for discussion" rather than a fully matured and elaborated paper.

In my previous paper, "The Recent Discoveries in Physical Science as Illustrating the Law of Similar," I endeavoured to perform a humble, but, perhaps, useful task, viz., to ascertain whether our school, the *liberal* school of medicine, was in touch with, and abreast of, the most recent development of other sciences; and whether our theory of pharmacodynamics was in accordance with the interpretation of the laws which govern the phenomena of molecular physics.

As you may remember, I endeavoured to prove that the law of similar was a universal law of molecular motion, governing all physical phenomena—a rule not only of pharmacodynamics, but of physics.

To-night I purpose to review the discoveries associated with the names of the two great bacteriologists, and trace the influence of their investigations on the modern conception of the law of similar.

First let me sketch as briefly as possible the researches of the great French savant.

Pasteur was born in 1822, and up to 1847 he studied chemistry. At that date his narrow conception of strictly chemical qualities associated with differences of chemical composition were troubled by the observation

of the German mineralogist, Mitscherlich, on the optical differences in two substances of the same composition, viz., the para-tartrate and the bi-tartrate of soda and ammonium.

His researches on the tartrates led him to the study of fermentation, which resulted in his world-renowned treatise on that subject.

"He who can explain the nature of fermentation," said Robert Boyle, "will give an explanation of the morbid processes of fever and other diseases," and it is to the great exponent of fermentation that we are indebted for the modern methods of research, and that scientific use of the imagination which has created a new era in the study of disease. The study of disease taken up from a new quarter—not by a healer but by an experimenter—by an enquirer trained in the rigorous methods of chemistry and physic, was destined to yield great results.

"All that lives must die," says Pasteur, "and all dead matter must be disintegrated by the action of living matter." Fermentation is this disintegration of matter that *has* lived, by matter that *is* living, this shaking to pieces of organised but dead material by the action of life.

Pasteur was the first to point out that putrefaction, like fermentation, had its origin in a living ferment.

In opposition to Liebig he showed that the phenomena of putrefaction were due to the presence of living organisms which he called *Vibrios*.

The question of spontaneous generation next took his attention.

Hitherto all the world had been of the opinion of Aristotle that "Every dry body becoming moist engendereth animals," and of Van Helmont, who says, "It sufficeth to place a dirty shirt in an open bottle containing grains of corn. The ferment of the shirt, modified by the odour of corn, engendereth a transmutation of cheese into mice in 20 or more days. This have I myself seen," says he, "the mice being fully grown both male and female." In opposition to such ideas which were supported by both Buffon and Pouchet, Pasteur showed conclusively that there was no such thing as spontaneous generation, that *omne vivum ex ovo*

was the one rule of nature which admitted of no exception.

In this connection he invented the method of sterilization, without which modern Bacteriology would be impossible.

We next find the French Government deputed Pasteur to inquire into the silkworm disease, that had created such havoc in the silk industry of the South of France. The cause of this disease, Pébrine, was found to be certain corpuscles everywhere present in diseased worms.

By a microscopic examination of the egg-bearing moth, and the destruction of all diseased eggs, he introduced an improvement in silk culture valued at many milliards of francs.

But it is his subsequent studies of septicæmia and charbon, of anthrax, fowl cholera, and hydrophobia, with which we are most interested.

It was in March, 1865, that Lister, inspired by the teaching of Pasteur, performed his first great operation under antiseptic treatment, and it was the work on the fermentation of milk that suggested to Lister the method which has revolutionised surgery.

In his studies on chicken cholera, Pasteur first published his method of pure cultivations of bacteria.

The germs are sown in nutrient broths or jellies under such conditions that only pure air is admitted to them.

Under favourable circumstances the organisms will live for years. If these cultures, however, are exposed to lower temperatures, the germs gradually lose their virulence and their power of reproducing disease.

A fowl was inoculated with the weakened or attenuated virus. It became slightly indisposed, but soon recovered. If it was then inoculated with the strong virus it escaped unhurt, although a fowl unprotected by vaccination would be killed by a smaller dose. This was a true vaccination phenomenon.

The success of this treatment was shown by the fact that, by inoculating fowls with the attenuated virus, Pasteur has succeeded in reducing the death-rate of the poultry yards over a large area of France from 10 per cent. to 1 per cent.

Pasteur next turned his attention to anthrax, a disease well known in the East, and there regarded as the direct

descendant of one of the plagues of Egypt. Here also his method of an attenuated virus was successful, and a second contagious disease was brought under control.

The bacillus anthracis was isolated by a young physician of Breslau, Dr. Koch.

Koch, moreover, showed that under certain conditions the bacillus breaks up into spores, which have the power of resisting a degree of heat which would prove fatal to the bacillus itself. He further succeeded in making artificial cultures of the germ in nutrient jellies and broths.

The greater resisting powers of the spores to heat had not escaped the attention of Pasteur, who was also working at the bacterium of anthrax, and in connection with this we read of an experiment which gives a wonderful insight into his inductive method of reasoning.

It is a well known fact that, although anthrax passes readily from one kind of animal to another, from quadruped to man and back again, it never attacks birds. Experiment had shown that a temperature of 44° C. is prohibitive to the multiplication of the germ; now birds have the warmest blood of all vertebrates, the temperature of their circulating medium being as high as 42° C. The bacillus, then, when in the body of a fowl, is at a temperature closely bordering on the prohibitive one, and further, being an ærobic microbe, it is handicapped by having to wrest its oxygen from the blood corpuscles. Under these circumstances it does not thrive, and the fowl escapes a terrible disease.

Now Pasteur said to himself, "If the above reasoning be true, and we take a fowl and keep it under such conditions that the temperature of its blood is lowered, it ought when inoculated to take the disease." He therefore lowered the temperature of a fowl to 37° C. or 38° C. by placing its feet in cold water, and then inoculated it. Within 24 hours it had died of anthrax. He corroborated this experiment by chilling another fowl, inoculating it and allowing the fever to come to a head. Then he hurried it into a warm chamber and restored its normal temperature by wrapping it in cotton wool. In a few hours the returning heat got the better of the bacillus, and the fowl was soon restored to perfect health.

Pasteur applied his discoveries of attenuated virus also in this disease, and with such success that a million

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sheep and 100,000 oxen have been vaccinated for anthrax, and the insurance companies of France insist on vaccination before they will insure cattle.

Such is the man who has spent the last nine years in the study of hydrophobia or rabies, and in an endeavour to find a means for its cure.

In this disease the virus appears to attack the nerve centres, and to be reproduced more especially in the medulla oblongata.

Pasteur experimented for years until he was able to reproduce the disease with certainty by inoculation, although he was not able to isolate the bacillus. Rabbits inoculated with the virus showed a definite latent period of incubation of seven days duration.

As the poison has not been isolated, Pasteur makes use of a trituration of the spinal cord itself.

By heating this for 14 days at 25° C. the bacteria, if any, or at all events the disease-producing cells, are killed. A small quantity of the poison remains unaltered, and this is used as a vaccine.

An animal may be injected with a virus from a 14 day old cord, then with one 12 days old, &c., till the full strength of the fresh cord vaccine can be borne.

A dog thus protected is perfectly impervious to the bite of a mad dog, bite he never so madly, as has been proved over and over again.

But a still further advantage is gained. The bite of a mad dog would take some days, or weeks, or months before it would become strong enough, by recruitment in the blood, to poison the brain.

It has to take two days at least to form the poison, and seven days, the period of incubation, for the poison to act.

If, now, the poison be injected ready made, there is an interval of nine days during which the protective power of the artificial virus may act, and these small doses of the poison gradually inure the nervous system to its presence. This, and perhaps variola, are the only diseases in which treatment by vaccination has been attempted in the human subject.

The explanation of the *modus operandi* is not easy; but in the case of hydrophobia there appears to be what we may term a Mithradatic effect, *i.e.*, the nervous system is strengthened and hardened against the impact

of a nervous excitant, by mere use and wont of a gradually increasing dose of the new poison, whereby a condition of tolerance is obtained.

We shall see in the discoveries of Pasteur's successor a still nearer approach to homœopathic methods and modes of thought.

CHAPTER II.—Koch.

We can but briefly review the career of Pasteur's compeer—the great German bacteriologist, Koch—whose name we have already met in connection with Pasteur's study of anthrax.

He was brought into prominent notice by his discovery of the bacillus anthracis, and more recently by his supposed discovery of the comma bacillus of cholera. Although it is disputed by English authorities, this organism is universally accepted in Germany to be the true cause of cholera. His latest discovery, the bacillus of tubercle, led the way to the so-called Koch cure, which excited for a time a degree of enthusiasm unparalleled in the history of scientific discovery.

Associated with broncho-pneumonia, with phthisis, in scrofulous glands, in the skin of lupus, in the pus of scrofulous joints, and lastly in the expectoration and even the breath of phthisical patients, Koch demonstrated the presence of a minute organism, the so-called bacillus tuberculosis. Whether the bacillus causes the tubercle, or whether the tubercular diathesis generates or facilitates the growth of the bacillus, is a question much debated and still unsettled.

I need not detain you with a description of the bacillus tuberculosis, a rough diagram of which I have here, and a slide of which you will find under the microscope, kindly lent by my friend Dr. Shuldham. I think that the balance of proof supports our belief in the existence of a true bacillary phthisis in which the introduction of the bacillus plays the part of the *vera causa*.

The following are Koch's postulates or conditions of proof, which must be satisfied before we can say any particular organism is the actual *causa causans* of a specific disease.

1. The organism must be found in every animal dead or suffering from the disease.

2. From this animal the organism must be cultivated through successive generations on nutritious media outside the body.

3. After going through many generations, or culture series, the cultivated organism must produce the disease afresh with all its characteristic symptoms on inoculating healthy animals.

4. In these experimental animals, before or after death, the organism must be found, and fresh cultures established therefrom.

Koch maintains that each of these conditions of proof has been abundantly manifested in the case of tubercle.

If tubercle be then caused by the invasion of pathogenic bacilli, and if they are capable of causing all the symptoms of tubercular disease by their mere presence in the body, we might naturally expect that a bacteriologist would follow the example of Pasteur, and seek for the method of cure by exhibiting an attenuated virus of the disease, as was done in anthrax in chicken cholera and in hydrophobia.

Such we find to be the case, for when, after some delay, Koch revealed the constitution and preparation of his remedy, we found it was in fact a product of the bacillary growth. It is interesting to follow the steps of the experiments which led up to Koch's discovery, and which were related at the last International Congress at Berlin, where I heard from Koch's own lips the assurance that he had discovered an agent which, at all events in the laboratory and in the guinea pig—the *corpus vile* of the experiment—had arrested the progress of tuberculosis.

Long ere this Koch had isolated the bacillus, and had cultivated it on sterilised blood serum outside the body. The bacilli were sown in this medium and produced their like, generation after generation, as surely as seed produces wheat. A pure sterilised medium—pure air and a suitable temperature—was all that was required to procure a so-called pure cultivation of bacillus tuberculosis.

A tube of sterilised blood serum was inoculated with a platinum needle dipped in the cultivation. Islands of the bacillary growth spread over the surface till the whole mass became infected.

If now a Pravaz syringe was filled with this infected gelatine and injected under the skin of a guinea pig, the animal became tuberculous. In about six weeks the whole body was infested with tubercle.

Now Koch took two animals, No. 1 healthy, No. 2 which had been rendered thus tuberculous.

If No. 1, the healthy animal, was inoculated with a syringe full of the pure cultivation of bacillus, the wound did not heal except superficially.

In ten days a hard nodule appeared, which broke down into an ulcerating sore, getting deeper and deeper, till the animal died.

If No. 2, the tuberculous animal, was inoculated with the pure cultivation of the tubercle bacillus, quite a different condition of things resulted. The wound healed with a viscid secretion. No nodule was formed, but a shallow ulcer which healed rapidly without infecting the lymphatic glands. These phenomena occurred whether the injection was made with living bacilli or with a solution of dead bacilli, and this, whether the microbes were killed by heat, by cold, or by chemical means. This proved conclusively that the poisonous results were *not* due to a growth of living bacilli.

While the local symptoms thus differed, there was a corresponding difference in the general condition.

Comparatively *small* doses of the dead bacilli, triturated in water, killed tuberculous animals in a few hours, whereas it merely rendered healthy animals tuberculous.

If, however, the dose was not large enough to *kill* the tuberculous animal, if the bacilli were diluted still further, the inoculated animal survived and began to improve.

If the injections of minute doses were continued every two days, the local ulcer healed (which it never did otherwise), the swollen lymphatic glands diminished in size, and the nutrition was improved. The animal was saved. The bacillary poison which was *fatal* to the healthy was a *cure* to the diseased animal. This, surely, is *similia similibus* with a vengeance.

But one disadvantage remained. Koch found that there adhered to the dead bacilli, with great tenacity, a poison whose peculiar property it was to set up local suppuration.

To get rid of this substance he dissolved out the active principle with glycerine, and thus produced a pure glycerine solution of the specific poison, untainted with dead bacilli and free from the substance which excited suppuration.

Koch's lymph, then, is a glycerine extract from a pure cultivation of the tubercle bacillus. The active principle can be procured as a colourless dry material, of which the ordinary lymph contains only about $\frac{1}{10}$ of one per cent.

Further on we shall find the dose to be infinitesimal as the remedy is homœopathic.

As might be expected, Koch's explanation of the *modus operandi* is not wholly satisfactory. It is too mechanical to satisfy those who have learned to look for a wider and deeper generalisation of pharmacodynamic action.

The action of the lymph according to his theory is a Nach-impfung, or after-poisoning, in which the bacillus is killed by an excess of its own poisonous excreta.

The substance thus isolated is, according to Koch, that particular product of the bacillary growth which sets up in the surrounding tissue the phenomena of tubercular caseation.

We may study its action—

1st. Locally on the tubercle.

2nd. Generally on the system.

I. The local theory.

We have in lupus or phthisis numbers of points invaded by living bacilli, and each colony is surrounded by a softened and neutral zone in which there are but few invaders, but which is already infiltrated with the poison the result of the life processes of the bacilli.

If to the nutrient fluid, *i.e.*, the blood, some of this poison be added, the inflaming and softening processes going on in this area are quickened and the bacilli are killed by the excess of a poison similar to their own excretion.

Still further the process of caseation is set up, since the tubercle bacilli produce a poison which in a certain state of concentration kills the tissue around it, and causes it to pass into the condition called by the Germans the coagulation-necrosis of Weigert.

This necrosis may extend to only a part of the cell, the remainder of which in that case, with further growth, becomes a so-called giant cell.

This process is not confined to tubercle, but seems to be Nature's universal method of setting a bound to bacillary inroads.

Here is a rough diagram of the ordinary caries disease in teeth.

A is the area of bacillary infection. On examination microscopically thousands of bacilli will be found crowding the field, but around the infected area is another lightly shaded area (B) which is softened, infiltrated with the morbid products of caries, but not as yet invaded with bacilli.

It is as though Nature, to whom nothing is great or small, who cares for bacilli as she does for men, had carefully prepared around each colony of bacilli a neutral zone—an area of political influence as it were—into which any enterprising bacillus might emigrate at its will.

At all events, this neutral territory is destined ere long to be over-run by the present inhabitants of A or by their descendants.

This diagram might serve as well for a tubercle, and illustrate the phases of tubercular invasion.

Like all over-crowded communities, the inhabitants of A will be poisoned by the products of their own retrograde metamorphosis, the bacilli secreting a poison which, from *their* point of view, is destined to set up a modified and gentle solubility in adjacent territory, but which, under certain circumstances, becomes most fatal to themselves.

Just as the Black Hole of Calcutta was poisonous to its inmates from the mere presence of carbonic acid and other death dealing exhalations of lungs and skin, so all living beings excrete products of metamorphosis which in too great concentration is fatal to themselves.

Fermentation, for instance, is a process so like bacillary disease that it may be taken as its type.

Fermentation is the growth of yeast; alcohol the excretion of yeast. When the alcohol reaches a certain strength, it destroys its progenitor, for, as you well know, alcohol, the result of fermentation, is the very best preventive and preservative against it.

To return to the lymph. In health in large doses it injures certain tissue elements, especially the white

blood cells. In very small doses it produces extensive cell-necrosis in every spot where bacilli are vegetating.

That the remedy has a very general and serious influence on the bacilli themselves, none can doubt, who have made a microscopical examination of sputa or tissue after the Koch treatment.

On the table you will see slides which show this very clearly. In the second slide you will see symptoms of degeneracy in the cell debris—the uncertain outline—and the crescent and dumb-bell shaped *bacilli*, the result of Koch's treatment.

Fever, as you know, is the first and most noticeable symptom after injection. In this respect Koch has given to us an agent of great potency. Indeed the Koch lymph is the most certain fever-producer known. A rise of temperature from 98° to 104° is not uncommon in six hours, preceded by a rigor, accompanied in certain cases by rash, nausea, drowsiness, and other symptoms of profound general nervous poisoning.

It would be an interesting study to inquire what part this rise of temperature takes in the so-called Koch cure.

When studying the effects of *antipyrine*, *quinine*, and the many agents for reducing fever, so carefully worked out on the Continent, it has often occurred to me to wish for an agent which could produce at will, a certain, moderate and easily-controlled rise of temperature in the blood, instead of the reduction of temperature so universally desiderated.

It would seem that fever is exactly Nature's mode of chemically destroying the bacillary invaders of the blood, and of neutralising the poison they set free.

For what does a chemist do if he wishes to sterilise a liquid which will not bear a high temperature? He heats it to as high a temperature as the liquid will bear without decomposition. Further, if a temperature, say, of 103° will destroy the bacteria, we know that their spores will not be destroyed, being more resistant to heat they need time to develop. In their turn they need heating to arrest or destroy them. Hence the phenomena of intermittent fever.

1. Infection. Invasion of bacilli from marshy ground, &c.
2. A period of quiescence.
3. The bacteria grow—increase in numbers.

4. They secrete their appropriate poison.
5. The poison acts on the nervous system, causing depression, rigor, &c.
6. The nervous system reacts, fever sets in, the blood is heated, the bacillary activity subsides, they degenerate.
7. One, two, or three days intervene, till spores have time to develop, secrete poison anew, and the old vicious round begins again.

It may be that in Koch's lymph we have ready to our hand such an agent for securing a rise of temperature, at least, for cases of tubercular origin.

If it be true that the nightly rise of temperature in phthisis is indeed nature's effort to throw off the disease, to destroy the invader, then we may hope that in early cases, by imitating, we may aid nature's efforts—when the resisting powers are strong, when fever would not be fatal, an artificial fever may disorganise the bacteria. At the same time, experience has already shown us abundantly the extreme danger of lighting up at the same moment the slumbering fires or foci of infection.

Dose.

I have said that the dose of Koch's lymph was as infinitesimal as the action was homœopathic.

The lymph as it issues from Koch's laboratory at the Hygienic Institute of Berlin is a straw-coloured liquid containing, according to his own estimate only a trace of the septic poison—a fraction of one per cent. Hence this would in our nomenclature be a 3x solution. A 10 per cent. solution of this is used for injection, thus reducing the strength to the fourth decimal dilution.

Now the smallest quantity of this dilution which has produced in Koch's hands a definite reaction is .001 gramme or 1,000th of this dilute solution; so that according to these somewhat rough experiments, the human organism reacts with certainty to the 1,000th of 1,000th, or one millionth of a cubic centimetre of the poison.

There is no doubt that it might usefully be used in still smaller doses, if submitted to careful proving and experiment by members of our own school.

We may hope for great results when we are able to introduce the remedy into the body by nature's own method of inhalation—and this gradation step by step, cautiously and continuously—and for dose we

may also imitate nature's methods when we can estimate accurately the dose of bacterial poison absorbed while sleeping for a single night in a marshy hollow. For this is the dose which sets up a like disease, and the curative dose must be at any rate less than this.

Perhaps some of our members can give us the results of practical experience of treatment with isopathic remedies or nosodes, of which Koch's fluid is the last and most potent.

I have here a list of more than 100 so-called isopathic medicines, including *sepsin*, *tuberculinum*, *pyrogen*, *anthracin*, *variolin*, *scarlatinin*, *syphilinum*, showing that the idea of curing disease by the exhibition of their products is a very old one.

Among these Dr. Drysdale's *tuberculinum* anticipated some ten years ago not only the remedy re-discovered by Koch, but the appropriate vehicle glycerine.

So that just as the method and the dose are in accordance with our tenets, so apparently did the idea emanate from our despised school.

I can only speak personally of the effects of *pyrogen* or *pyrexin*, the sepsin of beef, manufactured by Mr. Wyborn, which has appeared to me to be of undoubted efficacy in cases of puerperal fever, pyæmia and the like.

In conclusion, I feel I have but touched one wing of a subject of so vast and growing an importance that no medical man, and no school of scientific medicine can afford to neglect it.

Whether I have proved my thesis that these researches have an intimate bearing on the doctrine of similars I must leave to you to decide who have listened so long and so patiently to-night.

At all events, I think we may fairly take as proved, that the researches of Pasteur do support the doctrines of our school.

1. They illustrate the efficacy of vaccination both as a cure as well as a preventative—a doctrine which some of us hold in the case of variola as a necessary result of the law of similars.

2. They illustrate the use of animal poisons, which have always been favourite remedies with us, *e.g.*, *apis*, *lachesis*, &c., while neglected by other therapeutists.

3. They illustrate once again the doctrine that great results invariably spring from small causes. Indeed, the preparation of the rabies remedies and the pure cultivations, both in magnitude, in mode of dilution and preparation, and even in nomenclature, are homœopathic.

4. They confirm our belief in the selective power of remedies on certain organs and tissues.

5. They corroborate our guiding rule that the search for a cure is the search for a similimum.

My task is even easier when we turn to Koch's studies.

Indeed, his first paper, as reported in the *Times*, might well have been written by a "Liberal."

1. His dose is infinitesimal.

2. His remedy acts fiercely on a diseased organism, feebly or not at all on a healthy body.

3. The doctrines of medicinal exacerbation and medicinal tolerance, both receive support.

4. In short, he has proved in his laboratory in Berlin, in 1890, what Hahnemann, with the prescience of genius, asserted 50 years before—

"*Similia Similibus Curantur.*"

DISCUSSION.

Dr. HUGHES quite agreed with Mr. Butcher that the action of Koch's fluid was *apparently* homœopathic to the disease (tubercular phthisis) it was designed to cure. When we went below the surface, however, the case was not so clear. Koch's account of the process was that the bacilli poison the protoplasm on which they feed, making it unfit for their pabulum, and that his fluid does this more rapidly and on a larger scale, so starving them out. Naturally therefore the two agents produce similar symptoms—fever, cough, &c., but since he could not think of drugs as acting in this way, he was unable to claim any curative effects obtained by Koch's fluid as examples of the law of similars. Neither could he make such claim for Pasteur's treatment, real or imaginary, in their efficacy. A patient protected by them is like one who has already had an attack of the disease to be guarded against, and this he considered was also the probable account to be given of the power of vaccination. On the other hand, in respect of the minute quantities required, Koch's treatment was a valuable testimony to one feature of homœopathy. In this matter he (Dr. Hughes) had long ago said that science was fighting our battle, and that we might wait for her to

gain the victory for us. He asked Mr. Butcher if *omne vivum ex ovo* should not be *omne vivum e vivo*, as eggs were not always required for the process.

Dr. DYCE BROWN said Mr. Butcher's papers were always deeply interesting and instructive. Dr. Dyce Brown elicited from Mr. Butcher that the virus was taken from guinea-pigs, though the original came from the human subject. He thought in this case the treatment was and is homœopathic. If it is direct from the human subject he could not consider it homœopathic; unless the simple attenuation of the virus so altered it as to produce something different from the original. He considered the Koch treatment was similar to the hydrophobia treatment of Pasteur and vaccination. The agent is altered by being passed through different animals. He considered vaccinia and variola two entirely distinct diseases. Cows would not take variola. If infected with the poison, vaccinia results, not variola. Pasteur does not use hydrophobic virus from the dog, but from the rabbit. Rabbit rabies is different from dog rabies. The two are not identical, but like. A *tertium quid* is proved.

Dr. MADDEN said the question of the use of nosodes as homœopathic remedies was always interesting. He had tried *pyrogen* in one case of typhoid and two of puerperal fever. He found no result. He considered it proved that Koch's remedy did produce effects, and some of them satisfactory. In reference to Dr. Hughes' remarks, he said that the strong fluid did produce effects on the healthy. In one of Koch's cases the guinea-pig was cured by a smaller injection of what had before given it tubercle. He asked if the discussion was not trenching on the explanation of the homœopathic action of remedies as stated by Hahnemann. Were not the symptoms produced the result of the organism reacting against the poison?

Dr. E. B. ROCHE (of Norwich) said he had been struck as Mr. Butcher had with the thought that Pasteur and Koch had hit upon the idea of cure by similars. He agreed with Dr. Dyce Brown that the passage of the poison through other animals did produce a *tertium quid*. He found intelligent men much more open to conviction as to the power of the infinitesimal since they had become aware of the minute quantities of Koch's fluid which produce such powerful effects.

Dr. CARFRAE wished to intensify Dr. Dyce Brown's criticism of Dr. Hughes' remarks. He thought vaccination was a strong illustration of the law of similars. Dr. Hughes admits the fact that Koch's fluid produced all the symptoms of tuberculosis, but objects to its being homœopathic, because of the supposed mode of action. The one is a fact admitted by

Dr. Hughes the other a theory which is generally accepted but may turn out to be quite wrong. But right or wrong the theory must give way to the fact.

Dr. Morr was deeply interested in Mr. Butcher's paper. He thought Koch's methods were decidedly homœopathic; but the results were nothing to be proud of at present. Neither did he think Pasteur's results were so very certain. He thought much more might be done by prevention.

Dr. BURFORD felt great indebtedness to Mr. Butcher for working out the scientific side of homœopathy. The paper was fertile in ideas. If Dr. Dyce Brown's idea of a *tertium quid* was right, he thought Pasteur and Koch were decidedly homœopathic. Either it was or was not homœopathic. If not, we must be content to be swallowed up by something else. It is not so much the living bodies as the never varying chemical products of the organisms that produce the effects. The pabulum in which they are found is important, and makes all the difference to the properties of the cultures. It is not so much the living organism as its excretion, called ptomaines, that is the efficient agent. It is the careful study of ptomaines that now devolves upon us. In septic peritonitis after operation, the deaths are due to poisoning, and this not so much by the organisms as by their environment. Another point which is of interest is the theory of inheritance. Tendency to tubercle is inherited. It is open to question if the Kochian results of immunity are also heritable. In regard to Mr. Butcher's theory of self-limitation the question is—Is the pabulum present on which the germs can thrive? On Mr. Butcher's theory it would not be right to interfere with abscesses, &c., until they had killed all the germs.

Dr. GALLEY BLACKLEY said he had taken considerable interest for years past in the system of protective inoculations as practised by Pasteur and others, but had come to the conclusion, at least, in so far as concerned the inoculations with fluids still containing bacilli, that they were in no way allied to homœopathy. The successive cultivations of a bacillus did not at all resemble the dilutions of a drug, for as a matter of fact the number of the bacilli might increase to an unlimited extent, although their virulence gradually diminished and they could be tolerated when injected into the system of the animal whom it was desired to protect, as in the case of anthrax, or cure, as in the case of rabies. Dr. Dyce Brown had spoken as if the tuberculation of an animal by Koch had been accomplished with the so-called lymph: this, it need hardly be said, was not the case. The tuberculation was performed either by feeding the animals on tuberculous material or by means of injections containing bacilli. It was

curative effects alone that were claimed for the finished product known as Koch's fluid. In claiming Koch's liquid as a homœopathic specific it should not be forgotten that it did not at all fulfil the conditions laid down by Drysdale in his definition of a specific, viz. :—that its whole physiological action should be absorbed into its therapeutic effects. Replying to Dr. Hughes' suggestion that the fever produced by Koch's injections was probably that of destruction, he said this could not be maintained; the fever was undoubtedly primary: he had seen a dose of half a milligramme injected into a child with strumous dactylitis; within eight hours the temperature rose to 105.5 and was down again next morning below 100; all that there was to show in the way of local trouble being that the diseased finger joint was swollen to double its size but in no sense destroyed. Whatever might be in store for the fluid as a remedial agent there could be no doubt that in cases of lupus it had produced effects such as no other remedy, either external or internal, had ever produced in the same space of time.

Dr. CLARKE said he would not retail to members the three last leading articles of the *Homœopathic World*. They had doubtless been read already. He fully agreed with Mr. Butcher that the treatments of Pasteur and Koch, in so far as they were curative, were homœopathic. In reference to Dr. Hughes' remarks, he would say that drugs had a lofty scorn for explanations. If a substance which had the power of producing certain symptoms could also cure these when otherwise brought about, that substance acted homœopathically, no matter what the explanation. He had used *nosodes* and he found them very effective agents. He agreed with Hahnemann that the method of preparation did so alter them as to make them not identical but similar. He could not endorse all the methods and doctrines of Pasteur and Koch, nor did he rate them at so high a figure as Mr. Butcher, but they had certainly brought the doctrine of *nosodes* to the front, and it would have to be dealt with by homœopaths. He had used *tuberculinum*, the *nosode* used by Dr. Burnett, and with very good results. He had also used *pyrogen* lately, with good effect, in a case of debility after typhoid.

Dr. BURWOOD thought the profession, as well as the public, were losing their heads in connection with this matter. We had all heard of the "grape cure," and the "milk cure," and other cures; the term "cure" here really meant treatment, and the Koch treatment at present had certainly not been a "cure" in the proper acceptance of that term. He would like the Koch treatment to be tried in the early months of childhood for the *prevention* of tubercle, as vaccination was

employed for the prevention of small-pox. It might interest the Society to know that one of the earliest patients, he believed the third inoculated in London, was his patient, a lady, and had been under his care for twenty years; during this period, off and on, she had been subject to lupus in the face; as soon as it began to appear she would have the usual homœopathic remedies, the condition gradually improving and the face for two or three years remaining tolerably well. Then another outburst, and so on. The last attack or relapse no kind of treatment seemed of any use for, so Dr. B. suggested consulting an eminent specialist, who said in six months he would cure it. At the end of three months the lupus was worse than ever. She then saw Mr. J. H., who confirmed the diagnosis and advised a line of treatment, wishing to see the patient in six weeks; at the end of that time, the face being no better, he advised that the Koch treatment should be tried at once, and on the next day she had the first inoculation by Dr. H.; she had eight injections, with the usual reactionary fever. Strangely, however, the face trouble was not affected in the slightest degree, but instead an old slumbering pulmonary trouble which had been quiet thirty years was roused into activity with most distressing cough, &c., &c., and now, after eight weeks residence in a surgical home, the patient has to return to the country with her face as bad as ever, and her lung much worse. So much for the Koch cure in this case.

Dr. DUDGEON thought before we claim anything as homœopathic we should first ask, Is it successful? In reference to Pasteur's inoculation for hydrophobia there was a long list of fatalities; the death rate from hydrophobia since he began his inoculations had been raised in France instead of being lowered. Besides, Pasteur did not claim to cure hydrophobia, but only to prevent it. Homœopathy was a method of curing not preventing disease, hence Pasteur's inoculations had nothing to do with homœopathy. Dr. Carfrae said he would give up homœopathy if he was convinced that vaccination was not truly homœopathic, but as vaccination was the production of a disease in a person in order to prevent another disease attacking him, it was not homœopathy at all, so he feared Dr. Carfrae would have to renounce his allegiance to Hahnemann. Coming to Koch, not a single authentic case of cure had yet been recorded. Virchow had shown that the inoculations instead of killing the bacilli multiplied them and set up infection pneumonia. It had also been shown that in patients under the Koch treatment bacilli existed in the blood where they had never been found before. In thirteen cases of death from two-and-a-half to forty-seven years, dying in from eighteen hours up to thirty days after Koch's

injections, examined by Dr. Hansemann, the diseases were of very great gravity, mostly disseminated tubercle; and this happened not only in the advanced, but also in the early cases. We should not be in a hurry to claim any treatment as homœopathic until it had first been proved curative. Homœopathy is a curative system; Koch's has, as yet, only proved a killing system.

Mr. BUTCHER, in reply, said he simply followed Koch up to his laboratory experiments. He expressly guarded himself against saying anything about his "cure" as applied to human beings. He did not endorse fully Koch's experiments on human beings with a destructive poison. He was not speaking in a limited sense of what anyone may consider to be homœopathy, but of the law of similars—the interference of vibrations more or less like. Scientifically there can be no other demonstration of the homœopathic law. Take Koch's fluid and call it K. It is formed and fashioned by animal life, just as *aconite* is formed by vegetable life. He took it there was no difference between re-arrangement of atoms by physical, vegetable or animal forces. If you take the 1x dilution of "K" you have a certain arrangement of atoms, and it makes no difference whether this is brought about chemically or by means of animal or vegetable life. Sugar, which was once thought impossible to make, has been formed in the laboratory only the other day. Mr. Butcher takes the fluid of Koch from Koch's hands as an entity. By similarity Mr. Butcher means equality of vibrations. He had seen improvement in lupus cases, but he referred to discoveries made in the laboratory in his comparisons with homœopathy. He was not referring to cures.

OUR PUBLIC FLESH AND MILK SUPPLY IN
RELATION TO HYGIENE.

BY J. S. HURNDALL, M.R.C.V.S.

THE invitation to read a paper before your Society was accepted by me rather as a compliment to that branch of medicine of which I am a member of the mere rank and file than to myself as an individual, and at the same time a courteous advance on your part, as I believe, to institute a closer union between the two branches of the profession; and I use the term "the profession" advisedly, meaning to convey the idea, that practically I look upon the work of the medical practitioner and the veterinarian as one; certainly the pathology of the human subject and the lower animals is to all intents and purposes one, notwithstanding the fact that we find forms of disease peculiar to one class of animal from which all other classes have so far seemed to be exempt; again, there is a remarkable one-ness in our therapeutics; the remedies, which after obtaining a full list of the totality of the symptoms you rely upon, I find equally applicable under like circumstances; furthermore, coming nearer home to the subject of this paper, are not the sanitary laws which you observe and desire to see carried out for the better health of your patients as applicable to the lower animals? In claiming for my own profession so close and intimate an alliance with your own, I hope I shall not be esteemed too familiar; for my object in appearing in your midst to-night is not to breed contempt, but, if possible, to cement a closer bond of friendship between your *confrères* and my own, between you, gentlemen, and myself.

I have selected the subject of HEALTH because there we meet on common ground; it is, I am well aware, your practice at these meetings to discuss subjects of vast importance affecting the action of drugs on the principles laid down by the revered Hahnemann; and those of you who know me best are well aware that there is no more loyal follower of that great man than myself; moreover I revel in the study of therapeutics; the study of micro-organisms, fascinating though it no doubt is,

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does not, to me, compare in interest with therapeutics ; but, had I offered for your consideration some of my own poor thoughts, based it may even be on experience, respecting the pathogenetic and therapeutic actions of one or more drugs on one or more different animals, it is just possible I might have succeeded in interesting you ; it would not, however, have been even a step in the direction I have indicated as being one of the reasons of your flattering invitation to me to appear in your midst this evening ; it would have been a subject of no interest whatever outside this room, or, at all events, outside the number of the profession who follow the principles of Hahnemann.

In point of fact, I am, by your permission, proposing to reverse the order of things ; instead of discussing how to cure some form of disease, I propose to ask you to consider how best to prevent disease, so far as that is possible by protecting people from the risks they now daily incur by taking into their systems in the form of nutriment deleterious substances only too well calculated to undermine health and sow the seeds of various pathological conditions, some of which are curable and some, so far as is known at present, which can, alas, only be described as incurable.

No doubt it is against the interest of the practitioner to encourage the observance of sanitary laws, and to adopt prophylactic measures, that is, so far as the annual income is concerned. I have often heard this assertion combatted ; and glib and plausible arguments have been advanced affirming that the public gladly pays for advice that the scientific man can offer on hygiene. Does it ? Possibly in a few isolated cases ! Some great man, with his pockets already well lined, and a mighty good balance at his bankers, will perhaps receive a handsome fee for advice on some important sanitary problem affecting either a whole parish or the palatial residence of a member of the peerage ; but how about the struggling practitioner ? Will it pay him best to urge the adoption of measures to prevent diphtheria and scarlatina or to have plenty of cases, attend them assiduously and make some splendid cures ; a few losses by death only serve to intensify the value of the cures, and to prove what a clever man he is !

Again, as to the veterinary surgeon. Which pays

best, to advise measures to hinder the spread of an epidemic like influenza, or to allow it to take its course and have plenty of cases to attend, to be followed by good bold accounts at quarter-day?

I submit to you, gentlemen, it does not take long to answer these queries!

Happily, however, for the public weal, there are those in our professions who, conscientiously desirous of serving faithfully their day and generation, put on one side all personal interests, cheerfully and gladly advocating measures that tend to save this already too suffering world from unnecessary pain, and this often against strong opposition on the part of that portion of the public entrusted with its purse strings. Such being the case, I anticipate that the subject I have ventured to submit to you this evening is one that will commend itself to your judgment and approval; and imperfect though I know my effort will be, I sincerely trust it will in some measure serve to arouse in your minds an awakening interest that will stimulate each one, according to the measure of his influence, to do what within him lies to promote the establishment of such improvements and provisions in connection with the distribution of flesh and milk as the urgency of the circumstances warrant us in demanding of local authorities.

In the public interest it is of the first importance that flesh consumed as food should be wholesome; and not only wholesome, but nutritious. On whom does the public mainly rely for guarantee of good faith in this respect? Unfortunately the public has no practical knowledge of what is sound flesh and what is not; it must therefore trust to some one; and that some one is generally the butcher. No doubt a very respectable following of this trade consists of honest upright men; but is the majority so, think you? I put it to you; assuming that you were all absolutely poor men with only a few pence in your pocket to spend on the article of flesh, and with the pangs of hunger gnawing at your stomach, would you care to purchase all and everything that the majority of butchers tell you in their usually hilarious, jovial style of description, is good meat? I trow not! Furthermore, let us for the nonce assume that every butcher is an unimpeachably honest man, who would not for worlds deceive the public by selling

diseased flesh nor other horse flesh in lieu of what if the law may not the butcher himself be imposed upon for lack of that knowledge which none but the veterinary surgeon possesses? Personally, I am firmly impressed with the conviction that he can and frequently is so imposed upon. And the matter is not rendered any more satisfactory, as regards the protection of the public interest, by shifting the responsibility upon the medical officer of health or health visitor and what is not healthy, or on the other hand diseased flesh, and whether or not it is fit for consumption. I consider that those gentlemen who hold public appointments as medical officers of health, deserve a great deal of sympathy. Usually, in the majority of instances, the appointment is a valuable one, and one that it is desirable to secure. In view of the large number of applicants for such public appointments, it would not do for the candidates to open up a preliminary discussion with the local authority in order to point out that they were not qualified for certain of the duties which the authority in its wisdom included in the work required of its officers. That would be by far too risky a procedure, lest the coveted prize should slip from the grasp; and so it comes to pass that these gentlemen are, *volens volens*, compelled to undertake responsibilities, to discriminate upon which they have had no special training, and for which they possess no qualifications whatever. I reiterate, they deserve a great deal of sympathy; but only up to a certain point is this sympathy deserved, and that point is when they have served the office long enough to discover their own unfitness for these duties, when, I contend, the local authority should be apprised of the mistake; but experience serves to show that medical officers of health are intensely human, and rather than make such an admission as these circumstances would require, the duties of meat inspecting are carried out as best they may under existing conditions.

I submit, gentlemen, that so important is the subject of meat inspection, that not only ought every carcase, whether of the ox, sheep or pig, to be carefully examined, but the examination or inspection should be invariably conducted by a member of the Royal College of Veterinary Surgeons, who by special qualification, experience and character, is fitted for and officially elected to the

position of Public Inspector; and that none but veterinary surgeons should be eligible as candidates for the appointment. Moreover it is most desirable that all private slaughter houses should be abolished with a view to the thorough and complete fulfilment of the inspector's duties; this of course refers to large towns and districts where public abattoirs could be established, concerning which no theoretical sophistries could be advanced against location and public convenience; in isolated country districts, where population is not sufficiently large to warrant an expenditure of money out of local funds such as would be requisite to provide a public abattoir, it should only be legal for butchers or meat purveyors to obtain their stock from the dead meat market, which should be duly certified by the inspector as fit for food before it could be allowed to be taken from the market.

I am desirous of impressing upon the minds of gentlemen present how important it is, in view of the public well-being and general health, that legislation of a very radical character should be effected; but before there is the slightest hope of arousing an active interest in the subject to an extent sufficient to overcome all the red-tapeism that will have to be confronted in order to make anything like a practical advance in the direction I have briefly suggested, some measure must be devised to educate the public to protect itself, and I know of no better means than that of first convincing the medical profession of the importance that attaches to this subject, and relying upon its active co-operation in promulgating the teaching. But here comes in a difficulty. Your profession reads that Klein is of opinion that a scarlatinal epidemic was due to infection from cows themselves, while members of my own profession say no. The infection certainly may possibly have been conveyed from some other source through the medium of the milk, but it had nothing whatever to do with the cows. It is quite natural that many of you should attach more importance to Klein's opinion than to that of the veterinary profession, provided you do not think for yourselves, and this may result in a want of unanimity of action. Dr. Klein's conclusions were, in my judgment, altogether unwarranted and extremely unfortunate; their consideration certainly will come in more appropriately in that

portion of my paper which refers to milk, but I mention it here in passing as a proof of the danger that is likely to arise if even such an authority as Dr. Klein meddles in investigations for which he has had no special training, more especially on account of the weight attaching in the lay mind to any opinion he may advance on this and kindred subjects; indeed, I am of opinion that Dr. Klein is in no small degree responsible for any delay that may for a time take place in promulgating sanitary legislation. No doubt the doctor himself, many members of your profession, and that portion of the public which interests itself in the subject, are of opinion that he has done very much to foster wholesome sanitary legislation. I am sorry to say I think very differently.

It may be objected that the investigation which I refer to, as conducted by Dr. Klein, had nothing whatever to do with meat inspection; and I admit that directly it had not; on the other hand, it was a function properly devolving upon a veterinary surgeon having special reference to the communicability of disease between man and animals, for which reason I felt justified in commenting upon it at this stage of my paper. I have already expressed the opinion that it is dangerous in the public interest for members of the medical profession to assume responsibilities in connection with our flesh and milk supply for which they have had no training, and I quote this instance of Dr. Klein's experience as evidence in support of my argument. I shall now revert back to the consideration of various abnormal conditions which present themselves in connection with the flesh of different animals used for food, including of course a *résumé* of the diseases of which animals may be the subjects, and which in my judgment render the carcasses unfit for consumption, with a view to show how necessary it is that systematic inspection should be instituted.

In determining whether flesh should be passed as healthy and fit for consumption, there are many points which have to be borne in mind; they may be taken in the following order: colour, odour, moisture, texture and firmness as the leading features for consideration; these again may be subdivided according to the many variations which frequently present themselves; for instance as regards the colour, flesh may be extremely pallid, due

in one case to the character of the food upon which the animal has been fed, and at another time to a development of disease such as dropsy; from this it will be observed that a practical acquaintance with pathology is essential if an inspector is to perform his duties properly.

Again, the colour may be of a yellow tinge; this may be due to food or a diseased condition of the liver.

Other hues, such as magenta, scarlet, mahogany, brown, green, and even black are observed in animal flesh, each of which indicates its own peculiar condition, and has to be taken into consideration when determining the fitness or otherwise of such flesh for human food. The odour of flesh is best determined upon immediately after slaughter, as it is then most readily detected; fermentation, decomposition, food, drugs or some pathological development each in its turn, may be responsible for any deviation from the normal odour, as also is the age of the animal.

In forming a judgment as to the moisture one has to bear in mind how long the animal has been slaughtered; the state of the atmosphere, whether damp or dry, to which the carcase is exposed; the age of the animal and its general condition, and the extent to which it was bled when slaughtered.

These are but a few of the more important points that the experienced inspector has to bear in mind in the performance of his duties, though they by no means represent the full complement of knowledge he ought to possess; I leave it to you, gentlemen, to say whether you are of opinion that a medical officer of health is qualified to undertake duties of this character. But after all the inspector's chief functions are to decide whether the flesh of animals which have been the subjects of some definite form of disease is or is not fit for human consumption. Various opinions are held upon this point, I very much regret to say, even by veterinary surgeons, but I should obviate any difficulty arising out of differences of opinion thereupon by making it compulsory that the carcasses of all animals which have suffered from any of the following forms of disease should be condemned: viz., pyæmia, septicæmia, anthrax, hog cholera, small pox, trichinosis, hydatid disease, dropsy, tuberculosis, and parturient fever. Professor Walley, Principal of the Royal (Dick's) Veterinary College, Edinburgh, than whom there is no

one (whether veterinary, medical or lay) better qualified to offer an opinion upon the subject now under consideration, in his appendix to *The Four Bovine Scourges*, states, when considering what is marketable and unmarketable meat as follows:—

“About this question, as about all others connected with this subject, a vast difference in opinion exists; and it cannot be answered without including in its discussion the third question also.” The third question referred to by the Professor is as follows: “Is the inspection of meat, as a rule, in proper hands?” He then proceeds to say: “In the very great majority of instances inspectors of meat look only at the bare carcass, and that, too, after it has been dressed and hung up for a period of twenty-four or forty-eight hours; and not infrequently even after it has been quartered. If the flesh is tolerably firm, dry, devoid of unpleasant odour or flavour, is not much altered in its normal colour, and the carcass sets, it is passed as marketable and fit for food. If the reverse of these conditions obtains, it is rejected, though in some districts food is condemned which would be passed in others. Thus one inspector would reject a carcass which was dark in colour, even though otherwise all right, while another would pass it without hesitation.

“We shall see the same divergencies in opinion when we consider the second question—viz., ‘What is innocuous, what noxious?’—and I think that much might be gained if the Legislature—by aid of competent authorities—would authoritatively settle the question as to what should be considered fit for food and what unfit. It should decide too, independently of particular diseased conditions, primarily, between two principles for the guidance of inspectors. These are (a) Is the inspector to take into consideration collateral circumstances? (b) Is he simply to be guided by the condition and appearance of the carcass after it has been divested of all organs and appendages and prepared in the usual way for sale?”

Probably no single individual has given more careful or dispassionate consideration to the subject of meat inspection than has Professor Walley, and personally I look to him as a leading authority, whose opinion is deserving of the most respectful attention. In thus quoting from the Professor’s work, which treats very fully of this subject, it is my aim to draw your attention

to the fact, that while individually I claim to hold very strong views upon the urgency of legislation for the better protection of the public health, where it is affected by the flesh and milk supply, I am by no means an isolated advocate of such. Professor Walley has both in season and out of season done very much to try and arouse the authorities to a sense of their duty, and has been an earnest and conscientious worker in this direction for the public weal. I thought it would be interesting to you gentlemen who represent an important section of the medical faculty to learn that there is among the veterinary profession a goodly muster who recognise the importance of assisting your profession in its efforts to inaugurate prophylactic measures for the better protection of your patients against the ravages of devastating disease, and I hope to convince you that a systematic practice of inspection is a most important step in this direction.

My opinion is that the inspection of meat is a question that has not yet had that consideration and attention from sanitarians that its importance demands, and I hope to so fully arouse your interest in the subject that henceforward you will one and all bring your influence to bear upon it and that you will never allow an opportunity to pass of awakening influential clients and the public generally to the fact that steps are urgently required for prompt legislation, and by this means it is to be hoped that pressure may be brought upon Parliament with a view to the speedy adoption of some enlightened measure. According to Professor Walley the inspection of meat has for the most part been carried on hitherto in a very perfunctory fashion, and by men whose general training has not in any way fitted them for the office. It might seem from what one hears and sees that any person (no matter what his previous occupation) is qualified to act as a meat inspector. Thus we hear of retired tradesmen, such as shoemakers, of superintendents in the employ of public companies, of gatekeepers of slaughter-houses and other persons in a similar position being employed not only as meat inspectors, but also as superintendents of slaughter-houses, and probably there is not one in a hundred of these who has received any scientific or practical training to fit him for the office."

Professor Walley also goes on to say : “ Again we find that legislation affecting the subject is of a very diverse and unsatisfactory character—various regulations having only local effect being in force in different parts of the country : and further, that in many districts slaughter-houses are private property and not under the supervision of any official, competent or otherwise.” After hearing this statement, which is from the pen of one whose experience of the subject is second to none in the kingdom, I would ask what are your feelings about the risks you run in your own persons without considering your clients at all? When questions such as these are crying aloud for interference, and being treated as though they did not exist, there is nothing like bringing the matter home to the individual, hence I put it to you so far as regards yourselves.

But to make it more impressive I propose to deal with one form of diseased meat, which comes into the market daily in vast quantities, about which various opinions are held as to its nocuity, I refer to the flesh of animals affected with tuberculosis. I think if I deal with this one form, of what I believe to be dangerously risky food, it will suffice without going into details of the many other forms of noxious flesh that is only too often palmed off upon an unsuspecting public ; about these your acquaintance with pathology will enable you to draw your own inferences as to dangers which are imminent, and you will no doubt be able to appreciate the responsibility lying at the door of those whose eyes are open to such startling facts. Without making any attempt to define the pathological characteristics of tubercle—for before an audience like the present such an effort would be superfluous—I ask your consideration of the question of the use of the flesh of tuberculous animals for human food ; and I may as well state at once, in order to obviate the necessity of repeated reference to my authorities, that I am indebted mainly to Professor Walley’s work on Meat Inspection, and to the *Journal of Comparative Pathology and Therapeutics*, edited by Professor McFadyean, Lecturer on Anatomy at the Royal (Dick’s) Veterinary College, for evidence and cases in support of the line of argument I propose to rely upon. There is very little doubt that tons upon tons of flesh belonging to animals which are the subject of a tubercular diathesis are con-

sumed, and that without any apparent injury to the consumers; but inasmuch as it has been proved that phthisis may be introduced into the human system by consuming tubercular flesh, I contend that the risk is far too serious to be incurred with impunity, and that therefore no carcase affected with tubercular lesions should be passed for human food. Professor Walley very pertinently remarks that "it may be argued that there is no direct proof of the transmission of tubercle from animals to man by the consumption of flesh; such proof, it need scarcely be said, cannot for manifest reasons be obtained, but the mass of indirect proof in favour of such supposition is enormous, and if our arguments against the use of such flesh are based only upon analogies and deductions they are sufficient to warrant us, in view of the great gravity of the question, in prohibiting the sale of tuberculous flesh for human consumption. Very recently a most striking example of the effects of consuming the flesh of a tuberculous animal has been brought to light by a French physician in the case of a young woman who rapidly became consumptive as the result of devouring the imperfectly cooked bodies of tuberculous fowls."

Professor McFadyean has translated from a paper read by M. Arloing at the recent International Congress held in Paris the following among other experiments to show the nocuity of tuberculous flesh:—

"Let us at the outset prove very clearly the nocuity of the flesh coming from tuberculous animals. That has been demonstrated by two varieties of experiment. 1. The ingestion of the flesh of tuberculous animals having all the appearances of healthy flesh. 2. The inoculation of the juice extracted from such flesh. Of the first kind we shall content ourselves with citing a few. Those of Gerlach and of Johne with the raw flesh from animals attacked with tuberculosis 8 or 22.5 per cent. became tuberculous, and of 46 subjects fed in the same manner by Johne 13.1 per cent. contracted the disease. M. Peuch caused two young pigs to consume 5 kilogrammes of raw flesh without bone in ten days. At the end of two and three months these animals presented discrete glandular tuberculosis. Thus the passage of suspected flesh into the digestive tube can communicate tuberculosis. Moreover, M.M. Straus and A. Wurtz have shown in some experiments, *in vitro*, that the virulence of Koch's bacilli

is with difficulty destroyed by the gastric juice. "The cooking to which food is submitted can diminish the danger, but it is impossible to rely on that for the destruction of the virulence. In fact to obtain this result all the virulent particles would require to be heated to over 70° C. for half an hour. But in practice this temperature is not always uniformly attained and maintained throughout the whole thickness of the masses of flesh submitted to the cooking. Let us add, to complete the information on the *rôle* that may be attributed to cooking, that in 62 experiments in which Johne administered notoriously tuberculous flesh, after having submitted it to cooking in boiling water for ten to fifteen minutes, 35.5 per cent. of the animals were infected."

From the same source we learn that a series of experiments were performed by M.M. Nocard, Chauveau, Arloing, Galtier, Peuch and Veyssière to test the effect of inoculation with the juice of meat of tuberculous animals: first impressions concerning the expected results of such experiments would probably favour the idea that these would be more decisive than by ingestion into the digestive canal; such, however, did not prove to be the case, and one reason assigned for this is that the virulent bacilli are very irregularly distributed among the muscles, and that in many portions from which the juice for inoculation purposes might be expressed the virulent bacilli may frequently be absent. These gentlemen made 47 experiments, employing 137 animals, 13 of which became tuberculous, which gives a proportion 9.4 per cent. that were infected by inoculation, while the average number of animals infected in Gerlach and Johne's experiments by ingestion amounted to 17.8 per cent. Such results as these, whatever may be their effect upon your minds, fill me with concern, and serve to convince me that ordinary prudence dictates that effective measures should, from a sanitary point of view, be taken to prevent the consumption of tuberculous flesh. I do not mean to infer that bovine tuberculosis is alone responsible for the spread of the disease among human subjects, but that it is due to this source either through the ingestion of flesh or milk in a very large degree I am fully persuaded; hence the importance, in my opinion, of early legislation to ensure a proper system of inspection of all carcasses, and the inclusion

of tuberculosis in the schedule of the Contagious Diseases (Animals) Act. It is not improbable that some of the more sceptical among your number may be disposed to raise a doubt as to the probability of risk of infection on account of the power of resistance against infection on the part of the human subject, and the consequent minimum of risk in consuming tuberculous flesh. I have met with many such sceptics, men who are never satisfied with anything short of direct proof before they accept anything; but when I think of the large mortality due to tuberculosis, I confess to feeling that if we err at all it should rather be on the side of sacrifice than of caution. In a report of the Committee of the North of Ireland Branch of the British Medical Association, held in Belfast in December, 1889, which appears in the *Journal of Comparative Pathology and Therapeutics*, it is stated that "In man 10 to 14 per cent. of all deaths are due to tuberculosis. 150,000 it has been said die annually in the British Isles of consumption." Such a statement as this, I contend, is sufficiently serious to make the most careless ponder. The same report in dealing with the infection of man from the lower animals states: "The probability of the transmission of the disease from animal to man rests on the following points: (1) The disease is the same in man and animal; (2) Man is very susceptible to the disease; (3) Animals, which are much less susceptible than man, become affected by experimental inhalation, ingestion and inoculation. It is, therefore, a fair deduction that man may become affected by the same methods, Practically, it might be said, it must be by one or other of these methods, although not experimentally."

For my own part I cannot see that any other deduction can be drawn from experience; the wholesale condemnation of affected carcasses seems to present a serious difficulty in the minds of some to anything like effective legislation on account of the heavy pecuniary loss that would be inflicted on individual owners of cattle, so large a proportion of the bovine population being in greater or less degree the subjects of this fell disease; but surely, gentlemen, you will not allow such an insidious objection to influence you against appealing for legal protection against a disease so cruel and destructive as tuberculosis. The loss must be borne by

someone; the question is who? It certainly does not seem fair that individuals should be ruined for the country's good, hence, theoretically, the responsibility seems to devolve upon the country: but this is no part of the present argument; the conditions are so urgent, and of themselves call so loudly from a moral standpoint for effective reparation that it does not do to stop to think of consequences, at all events in the present instance; the effective method of dealing with that side of the question must be left to financiers and political economists, who can no doubt easily find a way out of the difficulty, and that without imposing any unfair burden upon the individual. Tuberculosis is only one form of disease, albeit the most terrible, that the public has a right to be protected against. I have already enumerated a number which, in point of fact, does not include all, and I reiterate the statement that public slaughter-houses, subject to official inspection, are a *sine qua non* to the health of the nation, and the compulsory inspection of every carcase of whatsoever animal that is killed for human consumption, conducted on fixed lines and rules, is positively necessary; and I further assert that until these are legalised by statute we have no protection whatever against the spread of disease through the medium of flesh used for the support of life. I am conscious that I have but inadequately expressed such ideas, on this important subject, as I desired to convey; my object has been to show that for the better protection of the public health sanitary legislation is imperative, and, whereas the medical faculty is the natural conserver of health, I hope I have not failed in showing you that legislation is not only necessary but well within the compass of possibility, provided active measures are taken to ensure it; and I know of no body of men better able to force on such measures than is the medical profession.

I must now pass on to that portion of my subject which refers to milk consumption. Many are the perils which beset the national health from the use of this most simple and natural article of diet, and whereas children and invalids who, in all probability, are constitutionally more susceptible of disease than are healthy and full-grown persons, rely in a very large measure upon milk for support and nutriment, it becomes a matter of the first importance that the public supply

from all sources should be subjected to such critical supervision as to render it, humanly speaking, practically impossible for milk to serve as a disseminator of disease in itself, or as a factor in the dissemination of disease from other sources. There is at the present time in force a Dairies, Cow-sheds and Milk Shops Order, which is supposed to be enforced by district local authorities; it is, however, practically, and to all intents and purposes, a dead letter. Were it enforced and carried out in its integrity there would not be much to desire beyond such improvements from time to time as experience is almost certain to suggest. The reason why it is not properly enforced is probably that suitable persons fully empowered have not yet been appointed. I therefore satisfy myself in the present instance by reminding you that, whereas suitable measures are in force they are nevertheless not carried out efficiently, and I pass on to show how important it is that systematic efficacy should be imparted to existing legislation. I have already shown you that the bovines are terribly responsible for the spread of disease, and the poor cow is deservedly made accountable for very much; but there are members of the medical profession who would put more upon her than she really deserves. I refer of course, for illustration of this, to the investigations made by Mr. Power and Dr. Klein, which were included in the Annual Report of the Local Government Board, 1885-86. As the result of his investigation, Mr. Power was led to believe that the milk from the Hendon cows did not become infected through introduction from human scarlatina, but that the infection was due to a diseased condition of the cows themselves; and Dr. Klein, who investigated the ailment among these Hendon cows, seems to have arrived at similar conclusions. Since that time Dr. Klein, presumably in support of his first theory, has stated that he has ascertained that a micro-coccus is present in the blood of persons suffering from scarlatina identical morphologically with the organism he obtained from the Hendon cows.

Professor J. Wortley Axe, of the Royal Veterinary College, who also acted at the time as Consulting Veterinary Surgeon to the British Dairy Farmers' Association, also made an independent investigation of this notable Hendon outbreak. He found that said outbreak

was nothing more than an easily recognised and well-known eruption confined to the teats of the cow only. The subjects of the eruption show no constitutional signs of disease, as the appetite remains unimpaired, the flow of milk continues undiminished, and the internal body temperature is normal. The eruption is essentially contagious and capable of transmission from one animal to another by the hands of the milkers, and the disease may be communicated to a person milking if he has an abrasion or cut on the hands. The disease is of common occurrence all over the country, and easily recognised by stock owners.

Professor Axe traced the origin of this outbreak to three cows purchased out of a herd of 30 or 40, and discovered that they had this eruption before they were introduced to the Hendon herd. Their milk was consumed in the place they came from, but no one developed scarlatina there. Other cows of this herd were sold to various dairymen in and around London, but no cases of scarlatina could be traced to the dairies into which these cows had been brought. It only appeared among customers of the one dairy at Hendon. After closely examining the whole of the circumstances from start to finish, Professor Axe winds up his report as follows :—

“Reviewing the facts stated above, I am of opinion that the disease which prevailed in the several herds referred to above, had a common origin, being in all directly or indirectly derived from the Derby cows. Five dairies were thus infected, but coincident scarlatina was unknown in the customers of four of them, and the inference becomes irresistible that the London epidemic, which has been imputed to the fifth, had its origin in some obscure source connected with the dairy by channels which enquiry has failed to reveal.” Professor McFadyean who, like Professor Axe, is a recognised authority upon veterinary pathology, makes this case, together with another similar one that took place in Dundee, the subject of withering sarcasm in an editorial article in the *Journal of Pathology* for September, 1889. He taunts the medical practitioner or officer of health for so readily falling back upon a teat eruption of the cow as the source of a scarlatina epidemic, because such a line of reasoning is simple, and makes no special

demand upon the investigating capabilities, while to trace the contagion to a human source would involve considerable time and trouble. It certainly does strike one that before gentlemen occupying the social and professional positions of Mr. Power and Dr. Klein promulgated such theories as they did concerning the origin of this scarlatina epidemic they would have not detracted from their own dignity had they first consulted with recognised veterinary pathologists, if for no other reason than the desirability of sparing the public an altogether unwarrantable scare, and the infliction upon the dairyman's trade of an unfair and damaging imputation. I believe I shall be quite within bounds if I state that not a member of the veterinary profession throughout the United Kingdom would support the theory of Mr. Power and Dr. Klein; but when, as in the case of Dr. Anderson, of Dundee, a member of the medical profession, who is also medical officer of health, ascribes an outbreak of typhoid fever to an eruption on cows' teats, we pass from the sublime to the ridiculous. There are those who think the medical profession has gone crazy on the subject of micro-organisms and their influence in the development of disease; and certainly the importance which Dr. Klein seems to attach to his discovery of the micrococcus before-mentioned will not be without its effects upon the minds of such persons.

Wherever micro-organisms peculiar to infectious disease are present, there is no doubt that milk is a peculiarly attractive vehicle for their transmission, and it thus becomes a factor in the dissemination of disease; it may be extremely difficult to trace the origin to its source; through this medium it is probable many epidemics are established; the specific disease is carried from one centre to another; the cholera germ, the typhoid fever germ, the germs of small pox, scarlet and typhus fevers and diphtheria may and very probably frequently are conveyed by milk from one place to another, but not one of these, as developed in the human subject, can be ascribed to the cow through her milk; the affections of the cow which are capable of transmission to the human subject through the medium of milk are aphthous fever, anthrax, tuberculosis and pyæmia. I am not aware that it has been satisfactorily cleared up how in aphthous fever the virus declares itself,

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but there seems to be good reason to believe that it is essentially in the quality of milk, and that the latter is not merely a vehicle for conveying the virus from its external manifestations in the cow; when, however, we come to consider how anthrax is conveyed from bovines to the human subject, we have only to remember that the vegetable organism known as the bacillus anthracis, microscopically examined, may always be observed in the milk of a stricken cow.

Time will not permit me to refer more fully to these diseases, as I wish to draw your attention still further to tuberculosis. There is no mistake about an animal suffering from apthous fever or anthrax, but tuberculosis is much more insidious in its onset and development, and less easily recognised. Fowls, sheep, goats, and pigs may and frequently do fall victims to it, but above all other descriptions of animals, bovines are most susceptible.

The question we have now to consider is whether the infective principle of tuberculosis can be conveyed in milk. In the case of animals various experiments have been made, which appear to leave no reason for doubt that it can, and the circumstantial evidence in favour of its infective properties to the human subject are, to my mind, so strong that they cannot with any show of reason be rejected or trifled with. I will deal with these latter first by quoting from Professor Walley. He says:—

“ In 1872 I lost a child in Edinburgh under circumstances which allowed but of one explanation, viz., that he had contracted mesenteric tuberculosis through the medium of milk. In a paper read at the meeting of the National Veterinary Association, held in London in 1883, Mr. Cox, of the Army Veterinary Department, related the particulars of a case which inevitably led to the same conclusion, as did also Mr. Hopkins, F.R.C.V.S., of Manchester. Dr. Fleming has also referred to a similar case as occurring in the child of a surgeon in the United States, and a short time ago a case of mesenteric tuberculosis by the inhibition of milk occurred in the child of a well-known veterinary officer of the Privy Council.”

Professor Axe, of the Royal Veterinary College,

London, in a pamphlet entitled *Milk in Relation to Public Health*, relates the following suggestive coincidence:—

“A few years ago Mr. Maw, veterinary surgeon, residing in a north country town, forwarded to me, at the Royal Veterinary College, the lungs of a calf largely invaded with tubercular disease. In the summer of the following year I was desired by him to visit a cow, which he stated to be suffering from chronic inflammation of the mammary gland. After a careful inspection of the animal, I arrived at the conclusion that she was the subject of tuberculosis, and that the affection of the gland was essentially of that nature. On expressing this opinion I was reminded of the calf whose lungs I had examined in London some time previously, and afterwards informed that it was the offspring of the cow in question. While we were conversing together, a little boy, about eight or nine years old, came into the yard having a handkerchief tied round his throat. On enquiring the reason of this investment, I was referred in explanation to swellings and ulcerations of the glands about the throat and neck which presented all the usual indications of tubercular disease. On asking the boy if he drank milk from the cows on the farm, he replied ‘yes,’ and supplemented the answer by the statement that he was very fond of it.”

From Dr. Fleming’s work entitled *The Influence of Heredity and Contagion in the Propagation of Tuberculosis*, I find the following case referred to as having previously been related by Dr. Stang of Amborach:—
“A boy, five years old, apparently strong in constitution, and descended from healthy parents, whose progenitors were exempt from hereditary disease, was attacked with scrofula, and died in four weeks from miliary tuberculosis of the lungs and enormous hypertrophy of the mesenteric glands. When making the autopsy it was accidentally ascertained that some time before the parents had to destroy a cow which, according to the testimony of the veterinary surgeon, was affected with pulmonary phthisis. The animal had been a good milch cow, and for a long time the boy had received a quantity of the milk immediately after it was drawn.” These facts are, to my mind, quite sufficient to make any thoughtful man pause. It is true all the cases lack, in a measure, that positive proof which some minds demand;

but many a man has been hanged on more slender evidence. I now pass on to the experimental investigations respecting tuberculous milk. I shall not trouble you with the inoculation experiments as I prefer relying on experience gained from ingestion, and in the first place I shall quote from the researches of Dr. Bang, Lecturer at the Royal Veterinary College, Copenhagen, a translation of which appears in Professor McFadyean's *Journal of Pathology*: Dr. Bang made a series of feeding experiments on eighteen rabbits and eight pigs; these animals received besides the milk only vegetable food, and after the milk was suspended water in the place of the milk.

Some of these animals received raw milk and some milk heated to various degrees, viz., 60°, 65°, 70°, and 75° C.

Of those fed with raw tuberculous milk both rabbits and pigs were all tuberculous in a marked degree; those which partook of the milk heated to 60° and 65° showed slight traces of tuberculosis, while those which had it heated to 70° and 75° C, when killed some time after the experiment was commenced, gave no evidence of infection, except two pigs which took milk heated to 70° and afterwards showed caseous and calcareous deposits in different lymphatic glands; but Dr. Bang was not perfectly satisfied that these pigs were not previously affected with the disease.

Professor Axe, in his before-mentioned pamphlet, remarks as follows:—

“ My own observations and experiments on the communicability of tuberculosis by the agency of milk have been very conclusive, as the following experiments will show:—(1) Two young pigs were fed almost exclusively on the milk of a tuberculous cow for ten days. On the twenty-first day after the last meal one of them showed slight indications of ill-health, which were marked by dulness, a harsh dry skin, a frequent short cough, discharge from the nose, and a watery condition of the eyes. On the fortieth day this animal was destroyed, and examination after death showed distinct evidence of tubercle in the lungs, lymph glands and intestines. (2) Gave a negative result. Of three kittens fed with milk from the same cow, two developed generalised tuberculosis; and the result in the third case was nega-

tive. Additional testimony to the sometimes infectious property of milk is afforded by Herr Albert Schwerte. This gentleman, in referring to an outbreak of tuberculosis in a herd of cattle, states that owing to the prevalence of the disease, the milk of the infected stock was given to a number of pigs, the result being that they were soon observed to waste and give evidence of disease. In a few weeks many of them died, and on being examined after death all the appearances and changes characteristic of the disease were noticed in the various organs of the body."

I think the foregoing facts are quite sufficiently serious to convince almost anyone that something of a practical and definite character should be done to protect the public against the probability of infection by the consumption of this most useful, natural, and nutritious article of diet. It has already been shown that, in addition to conveying the germs of certain diseases from the animal which produced it to man, it is also a very ready recipient and mechanical conveyer of the germs of numerous other contagious or infectious diseases. It may also become contaminated with all sorts of offensive and hurtful matter, through absence of proper cleanliness on the part of the milkers, so far as regards their own hands and the state of the cow's teats; in consequence of objectionable surroundings in filthy sheds, which are frequently located in districts of a most loathsome character; for want of properly cleaning the cans in which the milk is delivered; and also suitable methods of conveyance when the milk is brought from a distance, so as to preserve it from accumulation of dirt while *in transitu*.

Much greater care is required on the part of cow-keepers and dairymen than is at present taken, in consequence of the readiness with which milk is affected by the food cows eat, or with medicinal agents, or foreign substances accidentally passing in with the ingesta. I remember when, during my course of study at the R. V. C., I attended the lectures of the late Professor Tuson on Chemistry, how he related an instance of a number of cows which were pastured on fields also used for rifle practice, how the said cows became the subjects of lead poisoning, and that distinct traces of lead were found in the lacteal secretion as the

result of simple chemical tests. A similar experience he also related concerning some cows pastured on land adjoining some lead works. From this you will observe that not only is milk an attractive medium for poisonous substances outside the body, but that it will in course of secretion readily hold in solution from the blood material highly detrimental to those who thereafter partake of it. In further proof of the readiness with which it partakes of the character of food, to remind you that cows fed to excess on either swede turnips, carrots, or parsnips, imparts a flavour most decided of such food, and the same occurs when aromatic drugs have been used in large medicinal doses. In the face of such experience it is not difficult to understand what dangers attend its consumption if proper care is not taken to prevent the animals taking anything, either accidentally or wilfully, into the system that might be injurious to life.

To point out all the sanitary and hygienic requirements peculiar to dairy management in detail would furnish material sufficient for a paper in itself. Already my very disjointed remarks have been far too much drawn out. I must, therefore, content myself with the hope that in my imperfect attempt to interest you on a subject of such vital importance to the public health, I shall at least have succeeded in arousing attention to a matter that calls aloud for prompt and effective legal measures.

Apart from these, no doubt the medical profession could, if it would only take it up, set an example of how hygiene and sanitation ought to be brought to bear on the conduct of businesses for milk production and distribution by taking pecuniary interest in a model dairy farm, which should be conducted on very strict lines, to serve as an example of how the thing ought to be done; and if it did, the profession would never have cause to regret it, for not only would a great philanthropic work be thus instituted, but a most satisfactory investment for money would be established.

DISCUSSION.

Dr. MOIR thanked Mr. Hurndall for the satisfaction the paper had given him. He had often talked over the matter with Mr. Hurndall, and thoroughly agreed with him as to the

necessity of careful inspection. He often recommended his patients to take the Jewish meat, as he believed it was thoroughly well inspected. Meat refused by Jewish butchers was sold to and bought by Gentiles. He wished to ask Mr. Hurndall about Jewish customs, and also as to the method of slaughtering. He was convinced that tubercle was spread by milk. The feeding of cows had much to do with generating disease. Many cows were brought up from the country and kept in sheds without fresh air or exercise for months, and their milk must be unwholesome. He asked what form the disease took in the men infected by the Hendon cows.

Mr. WRIGHT agreed with Dr. Moir as to the influence of milk on children. He had seen diarrhoea occur in children when the food of cows was changed.

Dr. TALBOT was greatly interested in the paper. He said Americans were much struck by the open and alluring way in which meat was exposed for sale in the streets in this country. It might pick up germs in that way. In America meat was not exposed. Some danger would perhaps be averted by the adoption of the new law of "protection" in the States. All meat exported had to be inspected.

Dr. WRIGHT (of America) had only been in the country twenty-four hours, and he had observed the great amount of meat exposed for sale. In America most of it is kept in ice chests, and only a little exposed. He explained the meat inspection in New York.

Dr. NEATBY asked if bacilli had been shown to be present in the milk of tuberculous cows.

Dr. COOPER was exceedingly well pleased to have the subject brought before the Society. Disease in cattle is due in a measure to the neglect of vegetation, which has its effect on animal life. Referring to the Hendon epidemic, he had heard that one of the cows had been taken to Wimbledon, and the houses which were more largely rented and where most milk was consumed were those where most disease occurred. The disease was probably due to the milk. It was traced to one dairy. He could not speak for the pathology of the question. He would have liked a little more description of tubercle in animals. He understood that the diagnosis was not always quite clear.

Dr. BURFORD expressed his thanks to Mr. Hurndall for his paper. Many lines of thought were opened. He was glad he had entered into the imperial aspect of the question. Gradually everything was coming under Government inspection, and meat and milk should be inspected as well as other things. Doubtfully diseased animals should be excluded for

the sake of the poor, as they would eat anything that was called meat—the cheapest they could buy. In some diseases it was easier to diagnose the disease from symptoms than *post mortem*. He was not sure that Government inspection was always likely to be efficient. Individual effort must not be neglected. Milk could be sterilized by boiling and meat by proper cooking. He alluded to the statement that there is a connection between cancer and pork-eating. He thought it would be safest to be vegetarians for the present.

Dr. CLARKE mentioned an incident which might explain how disease germs get into milk. He had seen, outside a dairy shop, empty milk-tins standing, and small street boys climbing up them, their dirty hands on the rims and their dirty heads inside. If they had any infectious disease about them the next delivery of milk would spread it all round the neighbourhood. Some incident of this kind might be the unexplained cause of the epidemic which Dr. Klein thought was traceable to the cows.

Dr. GALLEY BLACKLEY thought the giving of raw flesh to animals by way of experiment was not very conclusive. In the cooking a chop or steak it was surely much above 70° C. He quite agreed with Mr. Hurndall as to the insufficiency of present inspection. As regards milk, a safe and reliable disinfectant for milk was a desideratum. He had tried several things, and among others *fluo-silicate of sodium* proved effective; *boroglyceride* and *glacialine* are also used. He agreed with Dr. Burford that the hearty co-operation of scientific men all round might do much. We medical men stand in need of more pathological and sanitary training. He mentioned a case of tapeworm in a gentleman who drank waters at a foreign mineral spring in a field where cattle grazed.

Dr. DUDGEON (in the chair) thought Mr. Hurndall had made out a good case for veterinary inspection. Doctors (he spoke for himself) know nothing about animal diseases, and were quite unequal to the post. The terrific picture of diseases that may be caught from animals almost made him incline to vegetarianism. He was consoling himself with the statement of foreign doctors that goats were immune from phthisis, but he was sorry to hear from Mr. Hurndall that even goats might take the disease. However, those who have tasted goat's flesh would pronounce it a poor substitute for beef or mutton. Other diseases may be taken from other animals. Trichinosis is taken from pigs in Germany, where (*pace* Dr. Galley Blackley) raw food is eaten. Jews in Germany are very subject to a tapeworm which is said to be taken from fish. Jews in travelling, when they cannot get

meat from their own butchers, eat fish. It is especially from pike and carp that it is caught. We may take advantage of Koch's discovery in one way. As he has found by inoculating guinea-pigs he makes them immune from tuberculosis, so if we inoculate our children with his fluid, when they grow up to years of discretion (or indiscretion) they will be able to eat tuberculous meat without fear! Then there is another disease that may be taken from animals. A lady whom he attended had serpiginous ulcers in her mouth at a time when the foot-and-mouth disease was rife. She had nothing wrong with her feet. When she boiled all the milk she took (and she drank a good deal) she soon got well of the ulcers.

Mr. HURNDALL (in reply) said, in reference to Jews' slaughtering, that bleeding does not get rid of pathological diseases. Jews are very particular. They refuse the carcass of any animal which shows any sign of disease. The feeding of animals does make much difference in the milk. He had no doubt Dr. Moir was correct in attributing the diarrhoea in his case to the feeding of the cows. The men inoculated from the Hendon cows showed elongated ulcers, exactly like those on the cows' teats. Referring to the use of ice chests, he said housewives did not like meat that had been in ice, as it made it uncertain in the cooking. Tubercle bacilli are found in milk in large numbers. Dr. Cooper was right in his statements about vegetation. He blamed landlords for not seeing to this. He was glad Dr. Cooper had spoken strongly on the Hendon investigation. All the milk infected did come from one dairy; but the point was that no scarlatina occurred from the forty other cows sent to other dairies. Dr. Cooper asked about the detection of tubercle. There are many cows found tuberculous *post mortem*, when there is nothing to show it during life. Tuberculous cows could be fattened. Bacilli are found more in the organs than in the flesh. It is only when far gone that the flesh is affected. Dr. Burford had said that milk might be boiled, but he did not think boiled milk was very palatable. He thought rich people required protecting as much as the poor. Regarding veal, he thought on the Continent calves were not slaughtered at so early an age as with us. The tape-worm in Dr. Blackley's case probably came from the excreta of a dog. Tuberculosis is found among cows of the short-horn breed more than any other breed, while the Ayrshire breed are almost, if not entirely, free from the disease. The reason generally assigned for its prevalence among short-horns is that the most noted and fashionable sires were tainted with tuberculosis, and so handed down the seeds of the disease from generation to generation.

THE IRRITABLE MUCOUS MEMBRANE OF THE GOUTY SUBJECT.

By J. GALLEY BLACKLEY, M.B., Lond.,

Senior Physician to the London Homœopathic Hospital.

GENTLEMEN,—In looking over the voluminous literature of gout, it has always appeared to me that too much space is given up to speculations upon the precise nature of the disease, and too little to its more subtle manifestations. So far as its commoner and more tangible phases are concerned, there is no lack of knowledge, but it is surprising how little has really been done to reduce to something like order the material we possess in the accounts of its effects upon internal organs, more especially those where the mucous membranes are chiefly involved. It is for this reason that I have ventured to choose as the subject of my paper for this evening the irritable mucous membrane as it occurs in the gouty subject. There is a common saying in Germany that two things are inevitable to mortals here below, "death and the third class of the order of the red eagle;" if for "mortals" you substitute "medical men," then I think we may say that sooner or later the gouty patient with a sensitive mucous membrane is sure to present himself.

With acute gout and with chronic gout so far as it affects the joints, or leads to the well known local deposits of urate of soda, I do not propose to deal. It is with the latent, or suppressed form, that we are concerned this evening; in fact, with the entity which goes for want of a better term under the name of the "gouty diathesis," and the evidences of which are frequently seen only in disturbances of the respiratory, digestive, urinary, or cutaneous systems or of the brain.

I.—*Respiratory Sphere.*

In order to give you a connected idea of what the effects of gout are upon the respiratory mucous membrane, I will endeavour to draw a picture, from the life, of a patient whom I have in my mind's eye at the moment; reminding you that the respiratory tract is a

continuous mucous membrane, commencing with the conjunctiva and continued through lachrymal ducts, nasal cavities, pharynx, larynx, trachea, bronchi, and bronchial tubes to the finest bronchioles and their terminal air-cells.

CASE I.

Mrs. T., aged 55, is a well-preserved lady of sanguine temperament, German by birth, rather inclined to *embonpoint*, with gouty antecedents and a history of undoubted attacks of gout, in the shape of articular gout (of which traces are still evident in distorted finger joints), eczema, asthma, deafness, urate of soda deposits, and passing of red gravel. The conjunctivæ are usually slightly injected, and the lids somewhat red at the edges, and she frequently complains of a gritty feeling under the eyelids (no tophi are to be seen in the conjunctivæ). The nasal mucous membrane is pale, somewhat swollen, and rather inclined to a dusky hue; coryza occurs on the slightest provocation, and is generally accompanied by much stinging and smarting about the posterior opening of the nares; the tongue is large, pale, covered with a thin whitish coat; uvula relaxed, pale or dusky, not pink, and showing dilated veins. The epiglottis and neighbouring parts somewhat turgid and injected. The voice is usually rough and apt to assume the ægophonic character, especially after exposure to damp, and this is usually followed by a loud barking or ringing cough. Breath sounds over cricoid, trachea and bronchi usually harsh or stridulous. At the margins of the lungs in front and behind, are limited patches of over-resonant lung, indicating slight emphysema. Breath-sounds are everywhere somewhat harsh and expiration prolonged, and a slight mucous r le is usually heard over various parts of the chest. As regards the alimentary sphere, primary digestion is good, and the patient takes an ordinary diet with whisky as a beverage (freely diluted of course). She is frequently troubled with attacks of bilious diarrh ea, and has some piles. The urine is free from albumen, but has from time to time contained sugar. Uric acid is usually present in quantity and is voided as red gravel. This I may remark is a fairly typical case, and affords a good idea of the quiescent stage. So far as the urinary symptoms are concerned, it may be taken as even more

characteristic. The writer of the article on gout in Quain's *Dictionary of Medicine*, in speaking of the connection existing between gout and uric acid, is of opinion that in chronic gout, uric acid is deficient in the secretions and urea is steady. This is quite opposed to my own experience, which has been almost invariably that the uric acid is in excess whilst the daily excretion of urea is diminished; this is, in fact, what one would expect if we look upon urea as the ultimate product of the oxidation of nitrogenous waste material. In some at least of my cases I have found the percentage of urea in the urine and the total daily excretion to be below the average, whilst free uric acid has been as constantly present.

You will doubtless have gathered from my description that such a patient is constantly in a condition of unstable equilibrium, and liable to acute catarrhal attacks. These may arise from a variety of causes, cold, fatigue, emanations from decaying vegetable matter, (particularly mouldy straw) &c. Independently of the fact that these acute attacks differ but little from those seen in non-gouty patients, to attempt anything like an exhaustive description of them would require a whole evening, so I will not attempt it. I may, perhaps, be permitted, however, to give you, firstly, another sketch, from the life, of an acute respiratory catarrh occurring in a patient who at the best is in what I have called a condition of unstable equilibrium; and secondly a few points of interest relating to such attacks generally, more especially in the matter of treatment.

CASE II.

Mrs. X., æt. 68, has suffered with occasional attacks of articular gout for more than 25 years, and has visited nearly every foreign spa of any repute in the treatment of gout. In her ordinary or quiescent condition she affords an excellent example of the class of case I attempted to describe; the condition which may in a few words be summed up as "irritable mucous membranc." Caught a cold on October 5th whilst returning from Bath, and sent for me on the 10th. This resulted in a prolonged sojourn indoors, during which time, to relieve the distressing night cough, I snipped off about $\frac{3}{16}$ in. of elongated uvula. Bronchial symptoms remained troublesome, and the patient, although rising at 11 every day,

remained in one room. Expectoration was almost nil, but coryza persisted for ten days; ten or a dozen handkerchiefs were used daily. Menthol and boric acid snuff so long as used relieved this, but did not cut it short. The patient complained of much pain behind the sternum, striking through to left shoulder-blade, and in the left hypochondrium. For this *bryonia* and *kali bichromicum* were used with good effect. Inhalations of the oil of *pumilio pine*, prepared according to the Throat Hospital pharmacopœia, gave considerable relief, as did also the use of the *chloride of ammonium* inhaler. *Arsenicum* and *kali hydriod.* were given internally most of the time. The muscular pains in the shoulder spread to the trapezius muscle on both sides, and in the hypochondrium became aggravated to such an extent that I prescribed a course of massage at the hands of an experienced masseuse. This had been commenced less than a week, when one day (Jan. 1st, 1891), after a morning temperature of 99°, the patient was seized at 4 p.m. with a rigor, and on my seeing her the same evening I found the temperature 101°, skin hot and dry. *Aconite* was given. Next day the afternoon temperature had risen to 101·8; slight perspiration had occurred in the night, but the skin was again dry. The attack rapidly developed into one of lobular pneumonia, and its further progress will best be understood by reference to the chart which I here hand round. The patient made a slow recovery, the attack of pneumonia being followed by one of pustular eczema, and this in its turn by one of general pruritus.

Coryza occurring in the gouty patient is usually of the variety called fluent, and may often be cut short by the use of a snuff composed of menthol, boric acid, and ground coffee.

If in spite of treatment the catarrh should descend still further, it usually attacks fauces, pharynx and larynx simultaneously. When examined in a good light (which by the way in gouty patients is frequently not the easiest possible operation on account of the extreme irritability of the fauces) we find the mucous membrane everywhere has lost its pale and smooth surface, is florid and uneven with the surface capillaries very much distended, a small vein along the front of the uvula being especially prominent. The epiglottis, false

and even true vocal cords are red and injected, and as would be expected the voice becomes raspy in consequence and the frequent cough is of a noisy barking character. Acute laryngitis is fortunately rare, but the sub-acute form is exceedingly common in gouty patients. The cough is frequently very distressing, especially in the night, being kept up by the mechanical irritation due to the lengthened uvula. This troublesome state of matters may be at once relieved by snipping off a portion of the pendulous uvula by means of a curved pair of scissors after first well spraying the uvula with a three or four per cent. solution of cocaine.

Chronic bronchial catarrh, commonly called chronic bronchitis, is of such exceeding frequency, both in the out-patient rooms and in the wards of all hospitals, that I will not waste the time of those present by attempting to describe the symptoms of a disease well known to all. It will naturally be asked in what respects cases of chronic bronchitis occurring in gouty subjects differ from the rank and file of the cases met with in hospital practice. I will therefore enumerate what I consider to be the chief points of difference between an average case of chronic bronchitis as met with in hospitals and the same thing occurring in an undoubtedly gouty subject.

Firstly, then, we have the history of the patient, which on careful scrutiny will usually furnish a record of gouty troubles of a more or less pronounced kind, either in the shape of articular gout, of attacks of eczema, of asthma, of red gravel, or of renal colic, with voiding of uric acid calculi. In patients over 60, deafness, if associated with the corresponding opacity of the membrana tympani, will frequently furnish a clue as to the nature of other obscure bronchial ailments. In the actual condition of the patient we usually find more or less distortion of joints, especially of fingers and toes. If actual eczema be not present, it is exceedingly common to find an irritable patch of skin on one or both shins, generally slightly pigmented, and frequently presenting marks of cicatrization of an old ulcer. The urine as a rule is dense and hyperacid, depositing uric acid crystals when an acid is added to it. As regards the bronchial catarrh itself, it is usually of the variety known as catarrh *sec*, the amount of expectoration being sometimes exceedingly small, differing completely in this respect from the

humid variety as we know it in hospital practice, where the quantity is generally enormous, and where bronchiectasis, due to dilated bronchi, with night sweats and clubbing of finger-ends is so common. Genuine attacks of spasmodic asthma I look upon as almost pathognomonic, for these will be found on careful examination to alternate with other undoubted outbursts of a gouty character, as eczema, indigestion, or articular gout. Attacks of dyspnoea closely simulating asthma (so-called bronchial asthma) are also very commonly met with. These, as was pointed out eighteen years ago by my father, are due not to spasm, but to a temporary oedematous condition of the mucous lining of the smaller bronchial tubes, and culminate usually in copious expectoration of clear serum-like fluid. Emphysema, although commonly met with, usually occurs only to a limited extent, and does not actually endanger life as in so many of our hospital cases.

II.—*Alimentary sphere.*

Here the gouty diathesis, or poison if you will, makes its presence known by disturbances affecting parts of the alimentary mucous membrane. It has been urged by some authors that these are merely internal disorders occurring in gouty persons and differing in their nature and treatment in no respect from those usually observed, or, in other words, that they possess no specific gouty character, but there can be little doubt that the gouty diathesis if generated in a constitution too weak to develop the local affection in the extremities is productive of various disorders affecting internal organs, most frequently those of digestion and excretion. When, moreover, in connection with the generation of the gouty diathesis the constitutional powers have been greatly impaired and the functions of excretion weakened, numerous internal disorders result whether the patient may have experienced a fully formed fit of gout or not. It is a common experience, at least under homœopathic treatment, that patients who in middle life have suffered from attacks of articular gout, at a later stage are sufferers only from affections of the excretory, respiratory, or alimentary organs.

Commencing with the buccal cavity and its contents, we find the lining membrane pale, smooth and some-

what pearly in appearance; it presents distinctly less unevenness of surface than is met with in a young healthy subject. The gums are apt to be spongy, and are often retrocedent, leading first to exposure of the neck of the tooth and finally to loss of the same without caries, an affection perfectly well known to the dentist under the name of Rigg's disease. For this reason our patients are not infrequently edentulous, or at best have but the substitute provided by the dentist.

The tongue is large, smooth, pale, not indented at the edges, and usually covered with a thin whitish coat; not seldom, too, it is very sensitive to the contact of acids or spices from the presence of cracks down the centre.

The patient constantly complains of dryness of the mouth, and occasionally there is an abundant growth of *Leptothrix buccalis* to be found on examination near the hinder molars. (This ought to direct one's scrutiny to the urine, for it is by no means uncommon to find this condition of mouth associated with temporary glycosuria.)

Little need be said as to the condition of the soft palate, uvula, and pharynx, except that they too are usually pervaded with the same feeling of dryness, a condition of things which naturally enough leads, even after very complete mastication, to real or fancied inability to swallow.

A condition of subacute œsophagitis, with severe pain referred to the cardiac end of the stomach, is by no means rare during the progress of gouty indigestion. The pain is aggravated by swallowing, and is produced equally by liquids or solids.

In the stomach itself we have gastralgia, usually alternating with other symptoms. The appetite is usually fastidious or impaired, but not seldom unnaturally keen, a symptom probably caused by the condition of vascular erethism of mucous membranes, which is a special feature of the disease, and a symptom moreover which requires to be studiously disregarded by the watchful physician. Distension and pain at the epigastrium, acid or acrid eructations, nausea or vomiting, painful oppression, flatulence, palpitation, with mental depression, anxiety, or hypochondriasis. Tenderness and fulness in the region of the liver are common symptoms, with constipated clay-coloured or olive-green

stools, indicating lack of healthy bile. That the functions of the liver are often seriously interfered with is also sufficiently indicated by the frequent occurrence in gouty patients of a certain type of temporary or even permanent glycosuria.

Although constipation is the rule, attacks of bilious or abilious diarrhoea are frequent in individual cases. These may be preceded by severe pain in the region of the gall-bladder, sometimes amounting to true hepatic colic with its usual concomitants of icterus, bile in urine and general pruritus. In patients habitually constipated hæmorrhoids and pruritus ani are almost invariably present, and the contractile power of the large intestine has usually been largely interfered with by steady use of aperient medicines or enemata. The patient's anxiety on this score is usually almost amusing, a period of 48 hours passed without a stool being a sure prelude in the patient's mind to an attack of stercoraceous vomiting, and this in spite of all the cheering assurances of the physician to the contrary.

Our patient occasionally has attacks of true colic, especially after exposure or after eating indigestible articles of food, colic which reminds me always of the true lead colic I saw in the wards of the Gumpendorff Hospital in Vienna in 1870-71.

It will be noted that all these symptoms may be truly styled functional or nervous, very rarely inflammatory.

In order to impress upon your minds the most ordinary of these gastric and intestinal symptoms in their quiescent state, I will again give you a sketch from the life of a patient who even at his best suffers either constantly or at frequent intervals from disturbances of the alimentary tract; usually from catarrh, frequently but by no means always associated with bronchial catarrh.

CASE III.

Mr. S., aged 72, of sanguineo-nervous temperament, tall and erect; retired merchant; a Yorkshireman by birth, but has lived 40 years in London. Has lost nearly all his teeth, all but a very few of the lower incisors being replaced by artificial ones. He has been a sufferer for many years from gastric and bronchial catarrh at frequent intervals, occasionally from eczema, asthma, jaundice, or glycosuria, and more rarely from slight

articular gout. He is at all times extremely anxious about his health, and when ill becomes positively hypochondriacal. Has been treated homœopathically for the last 40 years. In his ordinary quiescent condition his complexion is ruddy and he is moderately stout (12 stone). His tongue is large, not indented, smooth on the surface, pale and covered with a silvery ur. The fauces and pharynx are smooth, bluish, and show numerous enlarged veins. He suffers from flatulence as a rule, and frequently from distension at epigastrium and palpitation (sometimes very severe). The appetite is usually keen and he has an inordinate love for sweet things. Takes very little wine, no beer or spirits. Liver usually normal in dimension and no fulness to be made out over the gall-bladder. Bowels usually regular; has piles which do not bleed. Urine generally deposits crystals of uric acid when allowed to stand, and after the slightest cold a copious deposit of amorphous urates. Sp. gr. averages 1022, and rarely rises above 1028, even when sugar is present, as happens occasionally. Bilious diarrhœa usually due to some error in diet occurs somewhat frequently, and the patient has had one attack of hepatic colic since I knew him, although no gall-stones were passed, only inspissated bile. Also several attacks of bronchitis.

I have referred to the occurrence at times of a saccharine condition of the urine in gouty subjects. This occurs with considerable frequency, and should be looked for in all patients who are the subjects of gouty dyspepsia. Probably the reason why it is so frequently overlooked is that the amount of inconvenience to the patient is so slight; the urine is rarely increased in quantity and but little in specific gravity, and the percentage quantity of sugar is as a rule small. Without venturing upon speculations as to the causation of glycosuria, I would merely mention as a somewhat significant coincidence that such cases as I have seen have invariably been in dyspeptic subjects, and usually such as were liable to definite liver attacks in addition to other gouty troubles. This form of glycosuria is usually, though not invariably, transient, a few weeks or months at most being its usual duration. I have, however, one patient, an old man of 75, who has been a sufferer for five years to my knowledge. It is important

to be on the *qui vive* for the probable occurrence of such a symptom, and quite as important to let the patient or his friends know of it and of its probable cessation within a few weeks, for failing this it is by no means uncommon for the patient to consult another medical man, who pronounces the case to be one of diabetes, and suggests either a visit to a well-known specialist or a six weeks' sojourn at Carlsbad, either course being, as I think, totally unnecessary. It is, in my opinion, precisely this class of cases of temporary glycosuria that have earned for Carlsbad a reputation for the cure of genuine diabetes, a reputation which I should be only too glad to see justified in practice; but so far I am bound to say that all the cases of undoubted diabetes which I have seen after a sojourn at Carlsbad have returned uncured. To commence with, I find that the symptom may be disregarded altogether; I have never seen any ill-effect from this course, and spontaneous cessation of the saccharine condition of the urine has always occurred within three or four months, except in the single case I have mentioned above. Even in this last the only troublesome condition associated with the glycosuria is cataract in one eye, and it is hard to say that this would not have occurred in any case.

DISCUSSION.

Dr. HUGHES said Dr. Galley Blackley's paper was interesting, and showed great research, but it did not contain much food for discussion, as he did not go largely into therapeutics. He would like his opinion on a case of an old gentleman who had much flatulence with tenesmus of bladder and rectum two hours after luncheon, though he had no trouble after his other meals. He had had gout, and during the present illness he had had gouty grumblings in the toes. Hot mustard foot-baths had removed the pains, but not helped the intestinal trouble. He asked if our diagnosis of gout made any difference in the selection of remedies as distinguished from simple affections.

Dr. DYCE BROWN thought the subject of great interest. He thought nineteen-twentieths of chronic catarrhal cases were dependent on gouty diathesis. We don't now see so much acute gout, but we see the results. The symptoms vary immensely in individual cases. He did not think the diagnosis helped much in the treatment. He thought one main feature was getting the skin to act by lamp or Turkish

bath; also regulating the diet, which should be light, not comprising much meat, with fruit and vegetables. Of medicines *sulphur*, *merc. biniod.*, or *corrosivus*, *lycopodium* and *natrum muriaticum* were the chief. His experience was that constipation with flatulence was the rule, and not diarrhoea, as in Dr. Blackley's cases. Cases where there is uric acid sand were the exception; amorphous urates were the rule.

Dr. E. B. ROCHE mentioned a case of alternating irritable lung and eczema; all these symptoms were removed after marriage. He believed the cause was worry, which had affected the liver, and in his opinion the liver had much to do with gouty manifestations.

Dr. DAY mentioned a case of frequent micturition in an old gentleman who was gouty. The case proved intractable to remedies.

Mr. DUDLEY WRIGHT had seen a case in an elderly woman who had constant calls to micturate, which *nux* and *sulphur* alternately relieved. She had weak irritable heart and some oedema. He asked Dr. Blackley if he had met with gouty seborrhea of the external auditory meatus? There was itching of the canal, which led to scratching, which resulted in a slight moist exudation. This lasts some days, and then tends to disappear. He would like to know what remedies Dr. Blackley had found useful for it. He had seen a patient who had cough from lung irritation, which condition was cured by keeping the feet warm.

Mr. KNOX SHAW thought Dr. Blackley's paper afforded much food for thought. He had noticed gouty diathesis affecting certain organs of the body. Mr. Hutchinson described the "gouty," or "hot, irritable eye," and Mr. Shaw had confirmed his observation. Generally in the night, the eye becomes painful and hot, and yet when looked at there is very little to see. Here the diagnosis of gout was helpful. He thought Dr. Dyce Brown's opinion that the diagnosis was not very helpful was contradicted by the treatment Dr. Dyce Brown described. He was often able to pronounce a patient gouty by finding concretions of urate of soda inside the conjunctiva as well as tophi in the ear. The former cause much irritation, and need removing. In his experience, when there is frequent micturition not due to enlarged prostate, it is due to a highly acid condition of the urine. This is relieved by medicines. There is another point. He was anxious to know the relation between gout and sugar in the urine. Patients came to oculists for failure of vision. He had had several cases with hæmorrhagic condition of retina. There had nearly always been sugar. The patients had not the faintest

idea that anything was wrong with them. The sugar is not permanent, and may disappear without relieving the condition of the retina. He asked Dr. Hughes to keep his patient without his lunch.

Dr. DUDGEON (in the chair) regretted with Dr. Hughes that the paper was not of a more therapeutic character. He believed that much was laid to the door of gout which was more properly attributable to alcohol. He had met with cases which had been called gout by a number of doctors, which were evidently due to over indulgence in alcohol. On inquiring into the habits of a gouty gentleman, the latter said: "I take nothing gouty; I only take whisky." This Dr. Dudgeon prohibited, and he lost all his "gout." He had, on the other hand, seen exquisite cases of gout in teetotalers, without even a suspicion of hereditary tendency. A great desideratum is a real specific for the gouty diathesis.

Dr. GALLEY BLACKLEY (in reply) regretted that he had not ventured into the region of therapeutics. He thought the paper itself would afford ground for discussion. Dr. Hughes' case he should certainly put down as gouty. He agreed with Dr. Dyce Brown that the taint is transmitted. He believed that the diagnosis of gout made a distinct difference in the treatment. He also thought we had at least two powerful specifics in gout—*sulphur* and *arsenicum*. These are contained in the springs recommended for gout. Among others *lycopodium* is the most useful. He questioned Dr. Dyce Brown's statement that urates were always found; that was not his experience. When there was no catarrh, there was uric acid; when catarrh appeared, there were urates. He believed the liver was much involved in gout. An east wind tried gouty patients much. He had frequently met with gouty seborrhea of the external auditory meatus. *Sulphur* given internally and applied as ointment cured this. He was much interested in the "irritable eye" mentioned by Mr. Shaw. He had met with one marked case. He had alluded to the gouty conjunctiva in his paper. He endorsed Mr. Shaw's advice to Dr. Hughes about his case. He agreed with Dr. Dudgeon that most gouty patients would be better without alcohol in any shape.

A STUDY OF DELPHINIUM STAPHISAGRIA.

BY EDWARD BLAKE, M.D.

Nor the most insignificant of those bays which must for ever deck the brow of the Immortal Master is that he laid bare a thousand unsuspected virtues lurking in those old simples of which we talk so much, and, I fear, use too little.

You all know that the transcendent genius of Hahnemann, like that of the great Darwin, who resembles him in so many ways—in modesty of manner, in simplicity of mind, in patience of investigation and in an extraordinary power of minute, nay even microscopic, observation—is shown not so much by the brilliant generalisations with which each startled the quidnuncs of his day, as by the amazing number of hard and stubborn facts, well observed and well authenticated, which these giants managed to heap together into time-defying scientific tumuli.

The splendid hypotheses of both have already been shaped and pared by the effects of new observations and of added knowledge. But the strict logic of their facts remains, and must remain, as an undying monument, more persistent than the pyramids of Egypt.

That the Seer of Cöthen's having contributed more actual specifics to medicine than any known physician before or since his day, may possibly form the popular basis of esteem in a day when few persons have any leisure to think, is more than probable. To us this is not so; to us has been accorded the rare privilege of knowing this unrivalled mind in its deepest recesses.

There was a time when the intellect of man was so large that small matters could not be contemplated without a fine sense of scorn; now it is but a trite truism to say that the infinitely great is necessarily based on the infinitely little. If men were weighed by the actual practical benefits which they have conferred on their kind, none would hold his own with this plain physician,

who first taught us the way to cure cheaply and quickly, not indeed so much those rare and recondite diseases, which distress the rich, as those common, vulgar ailments which afflict ordinary work-day humanity. Nor did Hahnemann, who was ever actuated by the pure spirit of research, think it beneath him to test the powers of a common plant, the Larkspur, chiefly connected in the minds of men to this very day with a loathsome parasite. He stooped to this species of organic small-tooth-comb, and rescuing it from its ignoble alliance, placed it in the honourable post of the forefront in that great army which he recruited to fight the old battle against disease and decay and suffering and death. The fact is, we are not half vain enough of Hahnemann, and of his work and his powers; familiarity has robbed them of some of their *prestige*; we are used to them, and we take them too much for granted. *Delphinium* is itself a drug of which all good homœopaths ought to be very proud. As a curative agent Hahnemann literally created it.

It was the custom of Hahnemann to introduce a fresh drug to the notice of his disciples, and of the profession at large, by a kind of little speech of introduction. Just as we present to each other two distinguished guests with a small verbal flourish of trumpets.

But in the exordium which precedes the *delphinium* proving, we miss the imposing list of Old School authorities with which we are familiar in Dr. Dudgeon's well-known translation—a list amounting to no less than 93 names in the case of *opium*.

Neither references nor quotations from traditional medicine are cited for *staphisagria*; and for the best of all reasons, there were none for Hahnemann to cite. So we do well to call it a Creation of the Master's Mind.

We may remember that *staphisagria* was proved by Hahnemann himself, and by some of his most careful and conscientious coadjutors—Cubitz, Franz, Gross, Gutmann, Hartmann, Haynel, Herrmann, Hornburg, Kummer, Langhammer, Stapf and Teuthorn, who recorded between them no less than 721 symptoms, of which 200 were observed by Hahnemann himself.

We are constrained to say that of the 64 drugs (omitting the three magnetes) whose provings Hahnemann left as a priceless legacy to the world, not

one has been more thoroughly worked out; and yet *staphisagria* has scarcely received fair treatment from us, it has been a little "left out in the cold."

Let us turn to the memorable words with which Hahnemann ushers into the world this new Therapeutic Child of his.

"What enormous power must not this drug possess! Now, as our new and only healing art shows by experience that every drug is medicinal in proportion to the energy of its action on the healthy, and that it only overcomes the natural disease by virtue of its pathogenetic power provided it is analogous to the latter, it follows that a medicine can subdue the most serious diseases, the more injuriously it acts on healthy human beings, and that we have only to ascertain exactly its peculiar injurious effects in order to know to what curative purposes it may be applied in the art of restoring human health. Its power, be it never so energetic, does not by any means call for its rejection; nay, it makes it all the more valuable; for, on the one hand, its power of altering the human health only reveals to us all the more distinctly and clearly the peculiar morbid states which it can produce on healthy human beings, so that we may all the more surely and indubitably discover the cases of disease in which it is to be employed in similarity (homœopathically) and therefore curatively; whilst, on the other hand, its energy, be that never so great, may be easily moderated by appropriate dilution and reduction of dose, so that it shall become only useful and not hurtful, if it be found to correspond in the greatest similarity with the symptoms of the disease which we wish to cure. It is just to the most powerful medicines in the smallest doses that we look for the greatest curative virtue in the most serious diseases of peculiar character for which this and no other medicine is suitable."

"For these unexceptionable reasons," says Hahnemann, "I anticipated a great treasure of curative action in the most peculiar diseases from *staphisagria*; ; and these reasons led me to make careful trials of it on healthy subjects, the results of which are recorded in the following symptoms. Thus, curative virtues have been elicited from this medicinal substance which are of infinitely greater value than its power to kill lice (the

only medicinal property the ordinary quackish medical art knew it to possess), curative virtues which the homœopathic practitioner may make use of with marvellous effect in rare morbid states, for which there is no other remedy but this.”

This is a remarkable utterance; it is interesting as being one of the clearest and simplest of the enunciations of the so-called law of similars.

A careful study of the genius of *staphisagria*, and of its alkaloid *delphinine*,* reveals the interesting fact that these drugs are especially called for in the diseases peculiar to the extremes of life. The fierce metabolism of infancy, and the perverted tissue-changes of a second childhood, call alike for such remedies as *staphisagria*, *baryta* and their congeners. In their action in the domain of the special senses, on the region of the nape, on the alimentary tract, the glandular system, the urinary apparatus, and the lower extremities, they present many points of resemblance.

Dr. James Dore Blake, of Taunton, a most able practical physician, one of the pioneers of homœopathy, who sustained a bitter persecution for his creed in the earlier part of this century, well known as the first prover and introducer of *calendula*, relied on *staphisagria* as his stock remedy for senile sciatica. He was of course led to select this particular drug from observing that not only does *staphisagria* cover the constipation so often lying at the root of this form of neuralgia in the aged, but at the same time it aids so many of the side issues, *par exemple*, the vesical troubles and the nuchal sorrows so frequently associated with it.

It was the outcome of my study of these sides of *staphisagria* that induced me to give it a trial in that common but distressing result of motherhood, a pouched and protruding bladder. We, British doctors, owe a great debt to the penetration of our transatlantic brethren for first forcing the gravity of neglected cystocele on our notice. To them, too, will go up the incense of gratitude from myriads of mothers as yet unborn, who will reap the benefits of American gynecic teaching. For though the wisest accoucheur may, in spite of a thorough maceration and wearying out by means of preliminary dilatation,

* See Article *Staphisagria*, vol. iv. of *Cyc. Drug. Pathog.* p. 131.

meet in his practice with an acutely ruptured perineum, only the foolish man will leave it torn. He alone will ruthlessly condemn the poor, fond, trusting creature reposing on his want of wisdom to the present sorrows of reflex hæmorrhage, scalding dysuria, delayed convalescence, possible septicemia, arrested sub-involution and the future worry of cystocele, with uterine procidentia and rectal protrusion.

All gynecologists are perfectly familiar with the sad group of symptoms, having as its more pronounced features inability to retain the water and to discharge the fæces; a detestable forcing feeling; a loin languor; wearisome aching in the sacral region and from the vertebra prominens upwards; the peevish and fretful or despondent mood.

In cases of prolapsed bladder, where the unfortunate subject either could not or would not submit to the radical operation for the repair of the perineum, I have been for many years in the habit of employing *staphisagria* locally to the vesical tumour, and at the same time I like to administer a high dilution of this remedy internally. This latter I prefer doing when the stomach is void. Topically, the drug is best applied in the form of a saturated glycerole. Carefully carded animal wool is a better vehicle for application than cotton; it retains its elasticity when wetted.

The adjacent viscera being emptied and all tight waistbands removed, the patient assumes the salaam or knee-elbow posture. Half-a-dozen tampons in the form of a kite-tail are introduced into the vagina, and packed well up around the cervix during forced expiration. Unless the patient be very silly or very corpulent she soon learns to do this for herself. The vagina should be quite filled with this wool, which is worn during the whole day. In bad cases it is needful to support the perineum in addition by means of a broad thick T-bandage, the horizontal portion of which should be at least three inches wide and should be adjusted to the trunk just below the hip. Similarly the menstrual belt, for obvious anatomic reasons, should never encircle the body above the iliac line, or it becomes a potent factor, combined with a tight corset and with heavy skirts, in adding prolapsus of the pelvic contents at the time when the viscera are heaviest.

I can speak feelingly of the sad success of this treatment as more than a temporary alleviant, because, on more than one occasion women who had decided to let me do perineorrhaphy for them have so sensibly improved under it that, to my chagrin, the operation has been postponed *sine die*!

We will, before taking leave of this valuable drug, glance a little at the rest of its many actions. Most of them are symptoms quite at home in the gynecic notebook. The sad, grey outlook of life; the enfeebled memory; the bursting headache, itching scalp and facial papules; the dilatation of the pupils preceded by temporary contraction; the inflamed lids; irritated canthi point, like the similar symptoms in *spigelia*, to rheumatic sclero-conjunctivitis. Symptoms 120-30 suggest choroiditis; whilst the scintillating scotoma pertains more to certain deep-seated changes in the intra-cranial circulation.

Tinnitus is recorded by two provers.

Pustulation has been noted in the upper lips and inside the nose. Also the lips are ulcerated on their borders.

The submaxillary symptoms are strangely suggestive of a drug—not much allied to *staphisagria*—namely, *mercury*. The same observations hold good of the dental and gingival symptoms. The typical toothache of *delphinium* is “tearing.” The pathologic condition corresponds with periodontitis atrophica, so-called “receding gums.”

Herrmann's symptom, “when chewing he feels as if the teeth were pressed deeper into the gums” reminds one of the “sense of elongation of the teeth” in *phosphorus*.

[Allen's Index gives for “feeling of long teeth,” *chelid.*, *cocculus*, *castor* and *petroleum*.]

The tongue is white, the palate sore, due apparently to herpes; compare *acetic acid*.

Three provers had ptyalism (*conf. mercury*) heart-burn, eructation, hiccough, four times nausea; and actual vomiting occurred twice. *Adipsia* distinguishes *staphisagria* and *rheum* from the “thirst” of *rhus* and the “great thirst” of *spigelia*.

The flatulent colic of *staphisagria* is intensified by urinating, distinguished from that of *rheum*, aggravated by movement.

Staphisagria has constipation followed by diarrhœa; *rheum*, diarrhœa followed by costiveness.

Anal itching is noted in two provers.

The urinary symptoms are numerous and strongly marked; they point as distinctly to prostatic troubles in males as to cystocele in women. The *staphisagria* tamponade might be used per rectum in the case of males for intractable prostatic hypertrophy.

The itching of the genitals, in both genders, recalls the symptoms induced by *galipœa cusparia*, usually known as *angostura vera*.

Old people, we know, are very prone to acute and distressing but quite temporary strangury. Very young practitioners administer dysuric remedies with no result. Older doctors hasten to give a remedy for flatus incarcerated in the sigmoid flexure or in the rectum; they also direct that the nurse apply succussion to the descending colon. I am indebted to my friend, Dr. Richard Hughes, for the valuable hint to administer *pulsatilla* under these circumstances. It has not failed me yet; should it do so, I shall certainly fall back on *staphisagria*.

There are nine coryza symptoms, carrying us back again in mind to *mercury*.

The twelve cough symptoms, always aggravated in the case of Dr. Franz by eating [compare *nux vomica*], point to pharyngitis rather than to laryngitis. Possibly some are, like the "oppression" and "stitches" in the chest, spinal in origin.

The nape and sacrum symptoms we have already noticed; they are very typical of *staphisagria*.

The upper extremity symptoms ought to yield good results in treating the osteo-arthritis so common in real senility and in the imitation old age of pelvic patients.

Restless nights, disturbed by dreams of remarkable vividness, are naturally followed by drowsy days. As in *stramonium*, the prover either dreams of murder or encounters some ferocious beast.

The cerebral congestion we may therefore conclude is more arterial than venous.

The rigors are usually adipsic, one prover alone having "great thirst."

The cardiac symptoms, like the perverted sensations in the tongue, resemble the action of *aconite*.

CASE.—STAPHISAGRIA IN LEFT DELTOID MYALGIA.

Mrs. ———, aged 50, came on July 2nd, 1888, for recurrent headache since early childhood, *i.e.*, for more than forty years.

The pain is frontal; it corresponds with the distribution of the two supraorbital branches of the fifth pair.

Twelve years ago, whilst nursing, she had a mental shock, which greatly augmented the severity of the headaches. This shock was followed by temporary loss of the senses of smell and of taste, and by impairment of that of hearing.

The double supraorbital pain has usually recurred at intervals of seven days.

The change of life occurred five months ago.

She also suffers from attacks of acute spinal anæmia, apparently depending on the condition of her heart, and associated with the following symptoms:—First there comes acute temporal pain; this is accompanied by a distressing sense of choking followed by passive pharyngitis. Later in the day there are rigors and a feeling of sickness; then diarrhœa begins, and afterwards she becomes intensely drowsy. Usually there is complete arrest of urine. Sometimes she has palpitation, with panting breath. She has been prone to these attacks from her girlhood.

For the cold stage *veratrum album* in the third decimal dilution was recommended, and it gave marked relief. The extreme drowsiness was successfully combated with *papaver somniferum*, thirty centesimal.

Inhalations of *moschus*, matrix tincture appeared to relieve the dyspnœa, and also the palpitation, for which I afterwards gave *asafetida* in the twelfth centesimal with some advantage.

But to *lachesis* is due the credit of curing this remarkable case. In dilutions, varying from 6 to 30, it swept away the headache, aggravated by movement and by noise, but even more by *light*. Whilst taking the *trigonocephalus* she also lost the giddiness, the noises in the head, the flushing, dry mouth and throat, loss

of appetite, epigastric sinking and abdominal flatus, dyspnoea, tickling cough, and the palpitation, occurring both on exertion and after excitement.

Under the influence of *lachesis* this patient enjoyed five months of immunity from headaches which had, before taking the remedy, recurred once a week for 40 years. The other attacks, viz., those of acute cerebro-spinal anæmia, had lasted during five-and-twenty years, recurring at intervals of about two months. Latterly they had become much more frequent, leaving only three weeks of freedom from the distressing disturbance.

These also ceased to afflict her, and she had singularly good health with one exception, which we shall presently notice, during the remainder of the year.

The only adjuvants employed were gentle continuous current to *vagus*; upward electro-massage to lower extremities and to the respiratory muscles. Of course the patient, who respired very imperfectly, was taught to breathe. Allowance have been made for the beneficial effects of these auxiliary measures, the rest of the credit remains with the venom of the Indian snake.

This patient, on 25th October, 1890, again made her appearance at my rooms, looking much improved in appearance. She had lost her look of distress and had put on flesh.

She now complained of a severe aching pain from the left elbow to the left shoulder. This pain quite prevented the use of the left arm at its upper part; it grew worse in bed.

The biceps, the brachialis anticus and the deltoid were the chief muscles involved, all supplied, as you know, by the musculo-cutaneous nerve, the external branch of the outer cord of the brachial plexus. There was no impairment of reaction to the various muscular stimuli.

The biceps and the brachialis anticus made a slow recovery under *baptisia* 1x, *apis* 6, *rhus* 12 and *sulphur* 30, selected from subjective indications.

The patient lived at a considerable distance. Owing to this fact and to the extreme inclemency of the weather, I saw very little of her, but she sent an occasional report. Thus I heard that whilst the other muscles had recovered their normal state, the deltoid hung fire and inflicted a good deal of pain and loss of rest till the end of March.

I was then preparing this drug as a contribution to the American Congress, when I was struck with the similarity between the whole group of this worthy woman's symptoms and the complete pathogenesis of *staphisagria*.

So I wrote a prescription for *staphisagria* twelfth centesimal, to be taken before each meal. The same remedy was given in the first decimal dilution at bed time.

The deltoid was well rubbed with oil of *stavesacre* twice a-day.

The last part of the prescription had to be suspended on account of the free appearance, after its use, of a red, itching eruption resembling *lichen urticatus*.

The *staphisagria* was prescribed on 24th March of this year, the deltoid pain having persisted for nearly six months.

It disappeared, whilst taking *staphisagria*, in seven days, and up to the present time it shows no sign of returning.

DISCUSSION.

Dr. BURFORD praised the practical nature of Dr. Blake's paper. Referring to Dr. Blake's mention of *pulsatilla*, he recalled Hahnemann's note that many of the symptoms of *pulsatilla* are traceable to flatulence, and disappear when the flatulence is got rid of. Many symptoms which are useful indications for a drug are not found in the provings. And too much attention may be paid to provings. The characteristic tongue of *pulsatilla* is a white one, but this does not appear in all. *Apis* is said to be of great value in nephritis; there were no nephritic symptoms in the provings. Clinical totalities and careful records of cases were quite as essential as the provings.

Dr. COOPER said when he first came to the Homœopathic Hospital *staphisagria* was much more extensively used than it is now. He would look upon it as a remedy of great value in ear diseases. It acts on teeth and alveolar periosteum, but he had never "come in upon" the action of the remedy. Until one has been familiarised with a drug one does not get out of it so much as would be expected. Dr. Wilson had cured many cases of eye disease when a symptom "heat in the eyeball so great that it dims the spectacles" was present. He thought the history of the drug might be better known—its botanic and popular medical history. *Staphisagria*, with old herbalists, is spoken of as "louse-wort." He placed very little reliance on local applications. It was impossible to differentiate

between the action of several drugs—*hydrastis*, *staphisagria*, and others—when locally applied.

Dr. FERNIE referred to the history of the drug. He said the ancients, Pliny and Dioscorides, used the seeds as a purgative. Pliny used the powdered seeds to the scalp to destroy vermin. He had not read that it caused any eruption. Dr. Philips says there are two principles—*delphinine* and *staphisagrine*—which have different, and even opposite, action. Did not the administration of the entire drug entail the counteracting of the one principle by the other? He thought the history of the drug was pretty well known, and the explanation of its names interesting. *Staphisagria* implies a wild vine or raisin, with reference to the leaf or seed; and *delphinium* likens the spurred rectury to a dolphin. The oil is described in Martindale's *Extra Pharmacopœia*.

Dr. CLARKE had had experience in many of the uses of the drug mentioned by Dr. Blake. In a case of prolapsed bladder where there was sensitiveness of the pudenda as shown by aggravation on sitting down, *staphisagria* had given great relief. He had frequent occasion to use it in toothache. He had put on record a case of enlarged tonsils in which the symptoms, stitching from throat into ear on swallowing, had led to its use, which resulted in speedy cure. Tumours of the eyelid had inflamed and disappeared under its use, and excrescence on the gums.

Dr. HUGHES was very glad that there should be a "*Materia Medica* night" occasionally; and to have a drug brought before us so well proved and so little used as *staphisagria*. Its possession of such alkaloids as *delphinine* and *staphisagrine* shows its energy; and Dr. Hughes thought that the powers of these substances gave us the clue to the action of the present drug. *Delphinine* acts like *aconitine*, inducing a numbness and tingling in the extremities, which, as with its analogue, would probably go on, if pushed, to neuralgia. Hence, the value of *staphisagria* in neuralgia of arms and legs. On the other hand, *staphisagrine* is an irritant, and the mother-plant is of undoubted value in such a condition when occurring in the genito-urinary organs, especially when old gonorrhœas have crept through the seminal ducts and into the prostate. His (Dr. Hughes') own experience with it had been mainly in those quarters; but also as a preventive of recurrent styes.

Mr. KNOX SHAW had been anxious to find something to relieve tumours of the lids without operation, and had given *staphisagria* 1x to 3 among other drugs, but he got no results. The natural cure is by inflammation, and he thought the case referred to by Dr. Clarke was cured by nature and not by *staphisagria*.

Dr. CLARKE said the tumours existed a long time, and had no tendency to inflame before *staphisagria* was given. Moreover, *staphisagria* corresponded to the patient, and was, in fact, the simillimum.

Dr. DUDGEON (in the chair) had had very little experience of the drug. He had used it in toothache from recession of the gum. The relief to the pain was almost instantaneous. The old school had not made much use of the drug—principally as a destroyer of lice. The use of the oil as a stimulating application to indolent ulcers had been given up as too violent. Referring to the symptom, "heat in the eyeball dimming the spectacles," he said the dimming was produced by sweat from the skin of the face and not by heat in the eyeball.

In reply, Dr. EDWARD BLAKE agreed with Dr. Burford that the so-called tongue indications are often illusory. The same drug in the same dose causes a variety of coatings on the tongue in different persons. A given drug appears to bring out the special tendency of the patient to a certain form of gastric disturbance.

With regard to the adenitis of the eyelid, Dr. Blake treated such cases according to their cause. If irritating material from the eyeball, as in the case of strumous conjunctivitis by entering the meibomian follicles, set up resulting disturbance there, then, of course, the conjunctival disorder must be treated.

If an infectious disease of scalp induced itching, and the hand was then applied to the lid, the scalp should be attended to. Naturalists say that a very minute beetle, obtained from dogs, will enter the lid follicles and set up serious irritation there.

Mercury administered internally, and at the same time applied locally, had cured the greatest number of chronic cases, and *pulsatilla* the greatest number of acute cases in Dr. Blake's hands.

Two speakers had doubted the specific effect of a drug applied locally to the vagina. Why should they do so? The vaginal tube is a very absorbent canal in health, witness the prompt effect of *arsenic* introduced with criminal intent. But the real reply to this difficulty is, that *staphisagria* relieves whether it be given in high attenuations or in low, whether it be applied topically or administered internally.

ON THE MEDICINAL USES OF THE BEE STING
POISON.

BY W. T. FERNIE, M.D.

MR. PRESIDENT AND GENTLEMEN,—On the occasion of our last meeting here, Dr. Galley Blackley made a playful reference to me as having awoke, after a three years' slumber, to some sense of my responsibility towards this Society. I ask your permission to explain that it is a privilege of the old to sleep, and that feeling myself considerably superannuated among so many younger men in the plentitude of their modern learning, I have sat as a disciple rather than as one of the *Patres Conscripti* at our monthly assemblies since I had the honour of becoming enrolled amongst you three years ago.

Now in venturing to offer a paper, I beg you, *solvere senescentem*, to make allowances for such lack of knowledge as I may display concerning the advanced tenets of recent physiology, whilst holding me excused for employing the language of a past pathology rather than the compound classical nomenclature of to-day's *fin de siècle* attainment.

Pleading thus, I will take as my text a case which I attended as long ago as in 1858, and which first brought to my knowledge the potential uses of the bee-sting poison as a curative agent in disease. At that time I was an orthodox country practitioner in Hampshire, and the patient to whom I allude came under my care as an old pensioner, who eked out his daily pittance by working as an agricultural labourer on the Squire's estate. He was about sixty years old, and of rheumatic tendencies, living in a damp locality on the edge of the New Forest.

His symptoms in brief—as far as I remember them—were those of endocarditis, becoming subacute, with a systolic murmur, and with embarrassed action of the heart through dilatation, but without any marked hypertrophy. The kidneys were not implicated as shown by any albuminuria, and the old soldier was a temperate man, except for getting now and then bemused in beer at

the village tavern on a Saturday night, like many of his class. Nevertheless, I well remember his urine at the time was scanty and high coloured, with copious lithic deposits.

All the symptoms I have recited gradually increased, together with growing dyspnœa, and with general anasarca, which became more and more urgent, until at length the man took altogether to his bed, and seemed doomed to sleep quickly in God's acre with his rustic forefathers.

He was treated with alkalies, hydragogue cathartics, and diuretics, *secundum artem*, being also seen and prescribed for by one and another of my friendly *confrères* from the adjoining county hospital, where I had been lately the house surgeon.

However, the poor fellow went from bad to worse, and became at last so completely waterlogged as to lie an enormous mass of shapeless humanity, semi-comatose, and "babbling of green fields," in a small attic at the top of the narrow, steep, cottage stairs, down which how he might be presently brought on the way to his long home seemed a problem difficult of solution.

It happened finally that, on my visiting him in this dire extremity, I found his womenfolk in the garden, making a brew from refuse honeycomb just after taking their bees, and I was asked if some of the reeking beverage might be given to the sick man in case he could drink it.

Readily assenting to the use of this, or any other proposed *solatium*, under such desperate conditions, I left with the full assurance I had seen the last of my patient in the land of the living.

About a week afterwards, having to ride past the cottage, which was in a remote part of my district, and wondering that I had not been applied to as Registrar of deaths to record his decease (for, like George Colman's "two single gentlemen rolled into one," I was then unitedly the Poor Law Medical Officer and the Government Charon), I dismounted, not doubting that I should find the defunct pensioner still awaiting interment, which had been delayed through some casual hindrance in providing the necessary *obolus*, or in convening the distant relatives; but to my intense surprise, on entering the downstairs dwelling room, I beheld the

man comfortably discussing some broth, sitting there, restored to his ordinary proportions, "clothed, and in his right mind."

It had happened that shortly after beginning to drink the bee beer, which he took with avidity, profuse watery discharges commenced from the intestinal and renal outlets, which continued until all the dropsical swelling had disappeared, the dyspnoea had become relieved, and the heart ceased to give him distress, or to remain sensibly disturbed. In short, I had no alternative but to believe that either the strange brew, or some wonderful natural crisis occurring just at the time by a singular coincidence, had brought back my patient from the open portals of the grave.

Finding the unlooked-for improvement to continue, and casting about in my mind for an explanation of its cause, I chanced to describe the case and its present issue to my friend Dr. John Wilde, now of Weston-super-Mare, but who then, having the courage of his opinions, avowedly practised homœopathy as a Poor Law Doctor in a district immediately adjoining mine. He at once recognised the fact that some bee sting virus contained in the beer, as got from dead bees and brood comb boiled up in the brew, had acted specifically on the cardiac serous membranes, as well as on the mucous excretory linings of the sufferer, and had operated homœopathically for his prompt and happy rescue. Dr. Wilde further sent me a pamphlet which had then been recently published, on *Apis Mellifica; or the Poison of the Honey Bee considered as a Therapeutic Agent*, by C. W. Wolff, M.D., of Berlin, which little book I read with deep interest, gaining new light from its pages, and explicit instruction about the provings and well ascertained effects of the remedy in question.

Incidentally I may add that the patient whose case I have been describing went on uninterruptedly to complete convalescence, and was able after a while to resume his work in the fields. He retained his health for the five or six more years of my sojourn near him; and eventually he died, I believe of old age, uncomplicated by any renewed trouble of the heart or any return of dropsy.

From the small treatise of Dr. Wolff I learnt that his practical experience, based on the provings of Dr. Hering,

and attesting the faith of his own grateful heart with respect to the bee sting poison, showed the medicine to be eminently curative for œdematous swellings in general, for the higher grades of ophthalmia, for inflamed states of the tongue, mouth and throat; also by its specific power over the whole internal mucous membrane and its appendages.

Dr. Wolff had likewise employed the *apis* very successfully for curing furuncles, urticaria, and erysipelas, as well as for the typhoid fever, which he was emphatically persuaded becomes engendered by the process of vaccination. Moreover, he had convinced himself that *apis* is the most sovereign remedy for intermittent fever, annihilating the disease so radically that no relapses ever take place and no secondary symptoms are ever developed.

For measles, scarlet fever, panaritias, spontaneous limping, white swelling of the knee, and dysentery, Dr. Wolff had further found *apis* to be an invaluable and most trustworthy weapon of defence; whilst he abundantly verified the necessity which others had recorded for caution in giving this medicine to pregnant women, though conversely he knew of no drug endowed with such reliable virtues for preventing miscarriage, particularly during the first half of gestation.

His doses ranged from a pellet of *apis* 30 to a drop of tincture of the third strength, repeated at intervals or sub-divided. Taken altogether, he had come to regard *apis* as the greatest polychrest medicine, next to *aconite*, which homœopathic pharmacy can furnish.

From the first, while perusing all these startling statements about *apis*, and endeavouring to receive them with an unprejudiced mind, one great difficulty beset me—that of supposing any such animal poisons as the virus of the bee and cognate creatures capable of exercising, when swallowed, any influence for good or for harm on the human subject as ordinarily constituted, unless through some solution of continuity of a mucous surface, so as to allow of direct absorption—or, unless by acquiring special powers of stimulating afresh, when fractionally attenuated, tissues impaired by disease. Here I will cite two instances which have happened recently within our immediate observation, and which are relevant to the point I have raised.

A few weeks ago, at an evening meeting of the Pharmaceutical Society, Surgeon Parke, of the Stanley Expedition, in giving a detailed description of the arrow poison employed by the Pigmies in Central Africa, with such fatal results, against our men, narrated the fact that of those who were struck with poisoned arrows at the battle of Uva Sheba, all died except Lieutenant Stairs, whose wound was sucked by Surgeon Parke himself. The ingredients of the poison, as far as they could be ascertained, were procured exclusively from vegetable sources. I quote this instance as exhibiting the immunity from toxication manifested by Surgeon Parke.

Per contra.—On February 3rd of this year we were told in the daily journals that Mr. E. Bosanquet, the son of the well-known banker, was bitten by a rattlesnake, while shooting in Florida. Mr. E. Walker, who was with him, immediately applied his mouth to the wound and endeavoured to suck out the poison. Then, having tightly bandaged the wounded leg of his friend, Mr. Walker raised and carried him to Daytona, where Mr. Bosanquet died shortly after midnight in great agony. Mr. Walker also became seriously ill. He had a slight sore on the lip, and absorbed some of the poison into his system. An attack seized him which resembled partial paralysis, though eventually he became better and out of danger.

These would appear to be two typical cases. Nevertheless, I need not say that adequate inquirers have long since thrown a decisive light upon the *quæstio vexata*, and have redeemed it from dispute. Dr. Hughes, for example, has taught that a serpent poison will act as a toxicant when swallowed, or when applied to a sound serous, or mucous membrane, as shown by Drs. Brunton and Fayrer. "The idea," say they, "that it will only prove effective when absorbed through a lesion of surface or injected directly into the blood is erroneous."

Next I was led to consider what might be the chemical composition, or, perhaps, the organic character of the bee sting virus and of allied animal poisons; and then to wonder why any analogous toxicant, such as, for example, the vaccine lymph, should not act in the same potential way as was claimed for this *apis mellifica*, by being swallowed instead of being introduced into the

absorbent system through a puncture. If this desideratum could but be accomplished, many of the objections raised against vaccination would be silenced, and the Hahnemannian law of infinitesimalism would be triumphantly vindicated.

In subsequent years it has come about that the Pasteur theory and practice with regard to the rabid virus of dogs, and of other animals, have found a place in established medical therapeutics; and I take these as legitimate subjects for speculation from the point of view of my former and present reflections; saying so "with bated breath and whispered humbleness" rather than as laying the least claim to be an original thinker in the matter.

Dr. Gooch—who by common consent now speaks authoritatively on these points—says "a sheep fed upon potatoes which have been the medium for the cultivation of the anthrax bacillus, dies in a few days. Similarly animals fed upon the nodules of bovine tuberculosis become tubercular."

Bollinger also has demonstrated that milk can prove infectious if drunk when derived from cows suffering from any form of tuberculosis; and these facts appear to prove without doubt that certain animal poisons—which bacteriologists adopt as working septicly through living microbes or through the morbid matter which they manufacture—can exert their deleterious influence on the body by being swallowed, as well as by being injected into the blood.

Surely, therefore, we are justified in asking whether any clear line of distinction and demarcation lies between the bee sting poison, the serpent poisons, the vaccine virus, and the ultimate pathogenetic causes of rabies, tuberculosis, and the exanthematous infective fevers.

Dr. Bristowe, in an address given by him six weeks ago on tuberculosis, said: "Most of us believe that all specific infective diseases are due to specific living organisms." He added at the same time, "these septic organisms act commonly by means of a poison which they discharge, and which is absorbed by the circulating fluids; in which cases the poison is soluble, and can be obtained in solution, entirely free from bacterial or other organisms, and from putrefactive taint, or tendency." This being so, I would again press the question why such

a solution, when sufficiently diluted, may not be employed curatively as a medicine—with more precision, more singleness of action, and better facilities for regulation of its doses—not to speak of the paramount homœopathic advantages thus secured—than by subcutaneous injection or inoculation.

I am by no means unmindful of the effect produced within the stomach by its secretions operating on living microbes when swallowed.

According to Drs. Kurlow and Wagner, who have recently investigated the influence of gastric juice on pathogenic organisms, only the most prolific microbes, such as tubercle bacilli, the bacilli of anthrax, and perhaps the staphylococci can continue to exist in the normal gastric secretion; all others being destroyed by this powerful germicidal agent in less than half an hour.

But no collateral evidence is forthcoming, of which I am aware, tending to prove that the potential and toxicating solution eliminated by septic microbes is equally spoiled, and rendered abortive by contact with the gastric juices.

As to the chemical composition of the several animal poisons, I learn that formic acid is said to be the basis of *apis mellifica*, whilst bacteria are found on analysis to consist of mycoprotein (a combination of carbon, hydrogen and nitrogen, without sulphur or phosphorus), together with fat, ash, and undetermined substances.

But Dr. Gooch says “it is a positive fact that the intimate nature of the contagium in many diseases, such as hydrophobia, variola, vaccinia, scarlet fever, and measles, is at the present day undetermined, and invites further research.” I am therefore again warranted in supposing that as yet no ascertained line of separation exists between the poisons, when fundamentally considered, of the bee sting, serpents, rabies, and the infective febrile diseases.

One significant circumstance can be adduced with respect to the bee sting poison, as placing it—*cæteris paribus*—on a level with the attenuated forms of rabies virus employed by Pasteur for conferring immunity on his patients against harm by the concentrated virus. It is well known among bee keepers that after being repeatedly stung throughout some weeks, or months, a person who suffers acutely at first from the assaults of bees will become less and less liable to be affected thereby,

and eventually altogether impervious sensibly to the poison. As far as my personal experience in bee keeping for several years has led me to observe, this acquired immunity continues throughout a time of cessation from being stung—during the winter months until the next summer—being thus differentiated as I believe from the hardihood gained against tobacco, arsenic, and other noxious toxicants by those who have become inured to them, and which lasts so long only as they are habitually employed, and no longer. Notably as regards alcohol, a very small dose of this will serve to intoxicate the confirmed and degenerate drunkard, though when first beginning his career of inebriety the same person could probably swallow a skinful without becoming topheavy or incapable.

In speaking of the cultivating fluids employed by Pasteur and by other bacteriologists for attenuating septic organisms and obtaining their potential solutions, Dr. Gooch says great stress is to be laid upon the importance of successive cultivations of the microbes in these sterilised liquids, such as nutrient gelatine and the like, through many generations, as the objection that a chemical virus may be carried over from the original source is thus overcome." "And," he goes on to say, "any hypothetical chemical poison carried over from one tube to another would, after a great number of these cultivations, be diluted to such an immense extent as to be inappreciable, and absolutely inert." If this were so, the objection thus raised against my view that toxication by swallowing highly attenuated pathogenetic fluids may successfully supersede cultivated germ inoculation would be insuperable.

But our special and incontrovertible knowledge of the effects produced—whether by *apis* 30, as the bee sting poison—or by highly diluted *lachesis*, *naja*, *crotalus* and the like as serpent poisons, when swallowed medicinally, both refutes the allegation of Dr. Gooch, and tends to confirm the analogy between these chemical viruses and the toxic poisons obtained in solution from cultivated bacteria. Dr. Hughes says the curative action of *lachesis*, if worth anything at all, proves the validity of the infinitesimal dose. He further directs attention to the singular likeness between the symptoms of *crotalus*

poisoning and those of yellow fever, which would now in all probability be pronounced of bacterial causation.

In like manner, if the principle for which I contend is a valid one, the radically alterative effects promised by Dr. Koch and his followers from inoculation of his fluid against tubercular phthisis and lupus should be brought about as readily by internal administration of this fluid as by subcutaneously injecting it in high divisions, such as a milligramme, and without the attendant risk of a dangerous shock. But the safety and expediency of Dr. Koch's whole proceeding are as yet so much *sub judice* and even *sub lite*, that I refrain from dwelling on it.

As far as any analysis of his *tuberculine* has been made, it seems to be purely chemical, consisting of peptone, hemi-albumose, glycerine, and common salt. But it is further stated that after the primary bacilli from which this liquid is elaborated are destroyed by heat or by antiseptics in any cultivating fluid, spores are left which have a thick investing membrane of two layers. These spores are difficult of destruction, and can retain their vitality even when desiccated. No stain will penetrate them until the capsule has been ruptured or changed by strong acid; and this may certainly be accepted as an argument on our side for effective mechanical trituration of the tough, intractable spores, so as to make their contents soluble for absorption by mucous membranes, just as we pound up the diminutive nuts of *lycopodium*, each about $\frac{1}{800}$ th part of an inch in diameter, in an agate mortar, knowing that all preparations of this drug which do not involve a complete fracture of its particles are inert. For making even the first decimal strength a trituration of the spores for at least two hours is necessary.

More and more therefore am I led by these several arguments to advocate administration by the mouth of potent toxical organic agents highly attenuated and in a soluble form, whether these be classified as chemical or septic.

Reverting for a moment to the vaccine virus, and quoting the recent dictum of Dr. Bristowe that cow-pox is doubtless small-pox attenuated by passage through the cow, I would claim for the vaccine lymph, whether got from the heifer or by transmission through the human subject, an innocuous protective power of sure

action against small-pox by being taken internally, if the patient be at the time of its administration prone to contract variola. But the toxicant will presumably remain inert and abortive if no liability to take small-pox on exposure to its infection be then occupying the patient's system. For which self convincing reason the practice of thus protecting our patients, or leaving them unscathed if then needing no such protection, both as infants by this primary gastric vaccination, and as adults by the repeated process, should and would strongly commend itself to public favour, if the hypothesis can only be substantiated.

Perhaps you may at once detect fatal flaws in my mode of reasoning, and may suppose me, for lack of sufficient reading, or instruction upon a question already settled in a manner adverse to my views, to resemble the tailor in Shakespeare's play of King John, whom Hubert saw—

“Standing in slippers, which his nimble haste
Had falsely thrust upon contrary feet.”

Or, in less elegant phraseology, you may accuse me of having got hold of the wrong sow by the ear. If so, I shall penitently submit to correction at your lenient hands.

Or, it may be, you will say that whilst professing to talk about *apis mellifica* as a therapeutical agent, and discoursing of its various virtues, I have wandered aimlessly from the main road of my subject into barren by-paths of uninteresting and unsound pathology. Let me acknowledge, with confusion of face, that I have very little to tell from personal experience concerning the therapeutic action of the bee sting poison as a drug; and I have rather hoped to gain benefit by starting the subject and gleaning the experience of other more busy workers in the arena of modern medicine than to furnish original information on the point. It happened felicitously to myself, several years after my pensioner's fortunate episode, to prescribe tincture of *apis* from a distance for a sweet, fair-haired angel of a child, lying alarmingly ill with advancing hydrocephalus, and to rescue her straightway from the danger which threatened to quickly extinguish her life. Beyond this illustration, my acquaintance with *apis* medicinally has been restricted to the usual cases indicated by its provings.

and particularized in our text books. Under Dr. Blake's tuition I have learnt that the drug specially stimulates the vaso-motor apparatus, that it causes shooting pains in the occiput, and proves curative of septicæmic urticaria, such as follows on pyæmic absorption.

Also a medical friend of his, who took tincture of *apis* by mistake, experienced weakness and numbness in the upper limbs, particularly of the ulnar fingers.

And we were reminded at our last meeting that Dr. Gibbs Blake supplied a paper, some years ago, to the annals of our Society, on the cure of albuminuria by *apis*, with detailed cases.

Now, in conclusion, let me express a sincere hope I have not wearied you overmuch by my discursive aberrations, or seemed to treat a serious subject in too light and trivial a style. You will remember what Horace says in one of his epistles about the advantages of occasional levity, even in a grave treatise :

“ Discit enim citius, meminit que libentius illud
Quod quis deridet, quam quod probat et veneratur.”

“ Men see a joke, when to a sermon blind ;
What laughter points dwells longest in the mind.”

Whilst keenly alive to the deficiencies of my crude paper, as compared with the erudite and finished theses usually forthcoming at our monthly gatherings, I would pray you to be mindful that the rough stick of Brutus, cut by the hands of a clown from a Roman hedge, contained a rod of gold, and that, as Emerson pithily puts it, God sometimes hangs a heavy weight on one of the thinnest of wires.

DISCUSSION.

Dr. HUGHES, after expressing his enjoyment of Dr. Fernie's paper, said that he saw no reason why viruses should not act by the mouth, though not so potently as when introduced beneath the skin or into the veins. Vaccinine had been given by the mouth in small pox, and also to effect vaccination; in both cases with apparently good result. He doubted, however, whether patients generally would consent to be so vaccinated. Dr. Hughes thought Wolf's book a little too enthusiastic, and many of the supposed pathogenetic symptoms—taken from Hering—on which he bases his applications of *apis*, are “ clinical ” only.

Dr. BLAKE said that Dr. Burford was quite right in his observations at the last meeting; there was no evidence to

show that *apis* had primarily affected the kidney. Unfortunately, in the cases where there were renal symptoms no analysis of the urine appears to have been made. Dr. Blake had listened with peculiar interest to the contribution of Dr. Fernie. He was much struck with its cultivated and scholarly style. He said he felt quite a paternal pride in Dr. Fernie as having stood sponsor for him at the medical font. Dr. Blake used the animal poisons very largely in his practice, he relied on them in the most grave and urgent conditions. There is a strong family likeness between the animal poisons in their sphere of action; even the medusa acts on the skin, the heart, &c. The following proving, if substantiated, would go to show its power of profoundly modifying the condition of the intracranial perivascular spaces. In the *Lancet* for last March, Dr. Althaus says at p. 715: "I have seen a case of epilepsy in a farmer, aged 30, who had been in perfect health till he was one day stung by bees. This caused inflammation of the hand. He never recovered his health thoroughly after this, and nine months later had his first epileptic fit without any other assignable cause."

Unfortunately no information is given as to the condition of the urine. Yet even with this serious omission, the case is full of suggestiveness to physicians without prejudice. For another proving we are indebted to an allopathic doctor. It is of especial value for two reasons:—

1. The prover thought he had taken an entirely different drug, one that in his opinion was quite inert.

2. He was a sceptical, cool, and clear-headed person, with the critical temperament well marked. This fragmentary proving is so important and so brief, that I will venture to reproduce the whole:—

Feb. 15th, 1887. Dr.— says: "In the morning I had a pain as though an oat husk had stuck in the left side of the larynx, external to the aryepiglottic fold. Took about 13 minims of *apis mellifica*, thinking it was *lachesis* 6. I added a quantity of water and tossed off the mixture. I was then galvanising a patient. In about three minutes I began to feel very strange, and the sensation increased so that I had to stop what I was doing.

"I then sat down and wrote these notes *as the symptoms arose*.

"1. Feeling as of a sudden blow on the occiput. 2. Swimming sensation. 3. Sense of constriction in throat. 4. Sudden disappearance of pain in left hyoepiglottic fosse. 5. Twitching of muscles and slight trembling. 6. General sensation of fulness and weakness of coördinating power, especially in hands. 7. Oppression at bottom of sternum. 8. Pain down

left ulnar nerve. 9. Weight and tension at back of neck. 10. Dimness of sight. 11. Sense of weakness in upper limbs. 12. Slight numbness of left hand, particularly of ulnar fingers. This subsequently increased very much, and amounted to complete anæsthesia of left ulnar fingers. Also want of power, with incomplete anæsthesia of both hands. 13. Irritability of bladder, a usual symptom with me, diminished.

"You know what a thorough disbeliever I am in most of 'the so-called' provings."

Dr. Fernie had referred to him as using *apis* virus for auto-toxæmia, or self-poisoning with pus products. In these cases *apis* is indeed the "king of remedies." It covers well the anæmia, the skin affection and the profound apathy of the lymphatic system.

The following example was presented by the wife of the unconscious *apis* prover.

Mrs. —, age 37, suffered before marriage from endometritis and retroflexion. Married 10 years. Had borne two children. Becoming pregnant again, life was endangered by the extreme severity of the vomiting. It was thought right to induce artificial labour. Pelvic cellulitis followed this and the womb became bound down to the rectum by firm adhesions in Douglas' pouch. She now fell into a miserable condition. Low type of recurrent feverishness, extreme prostration with debilitating sweats and persistent pelvic pains. Early in 1881 a distinguished gynæcologist was consulted, who opened the abdomen, and removed the ovaries, which were found to be in a condition of cystic degeneration. After this the patient was much better for a year when she slowly reverted to her old condition. She now began to suffer from recurrent intractable vomiting, also from itching of the skin, sleeplessness, profound mental misery and loss of hair. The white face and greatly swollen, raw beef like tongue, irritable throat, poor appetite and torturing thirst, flatulence, abdominal fulness and severe constipation, pale urine, sp. gr. 1,005, the kidneys doing no depurating work, short breath, palpitation, loin pains, numbness along the ulnar nerves were present. There existed also much general dropsy and varicosis of legs. These symptoms yielded to *apis mellifica* 12 centesimal. Soon after witnessing the effect of the *apis* on his wife, the husband a specialist on the throat, was summoned one night by a neighbouring practitioner to operate on a case of œdema glottidis. Before proceeding to perform tracheotomy, the doctor bethought him of the *apis* 12. He resolved to give it a trial, and with the satisfactory result that the patient was out of peril by the morning, and the operation was permanently postponed. *Apis* is the only remedy which Dr. Blake had

seen remove chronic effusion between the layers of the broad ligament. Mrs. —, aged 28, had been married two years. Ten months ago was delivered of a still-born child at full term. She has never been well since. She feels a lump in her left groin, which has been diagnosed to be many different things by many differing doctors. The senior surgeon of the Samaritan kindly saw the case with me, and we agreed that it was the left broad ligament of the uterus greatly distended with fluid. As its formation had not been attended by rigors nor followed by hectic, and as its disappearance was associated with no hæmatin staining of the skin or urine, we considered that it was probably serous. It was possibly a ruptured cyst. Under the bee poison this condition disappeared in four weeks after 10 months' duration. The remedy was first given in the 6th centesimal for one week, then in the 3rd decimal dilution. Seven years have passed and no recurrence has taken place. This lady goes for long tricycle rides in the country—a fairly good test to apply to the parts once so seriously enfeebled.

Chronic pain in sacrum with œdema. In morning diarrhœa, myalgia of the deltoids, and for that peculiar rigidity of the throat, indicating submucous effusion, *apis* is invaluable. The typical headache appears to be of the bursting occipital type, resembling in site and action its congener *hellebore*, relieved by pressing with the hands. Of profound interest is the last case recorded in that invaluable work *The Cyclopædia of Drug Pathogenesis* under *apis*. This goes to show that bee poison is the remedy for reflex eustachian asthma. It also makes it appear probable that bee poison is volatile.

Mr. WRIGHT, in speaking of the action of *apis* in diphtheria, said that he was disappointed in the results he had obtained. In the case of a man admitted into the hospital under Dr. Moir for urgent dyspnoea, he examined the larynx and found that there was an extreme œdema of the whole of the structures of the upper aperture of the larynx. This was the condition in which *apis* was indicated, and it was accordingly given, but in spite of it, two days later, patches of typical diphtheritic membrane developed on the diseased parts. In many other cases in children he had found that *apis* had no influence in preventing the occurrence of the membrane.

Dr. MOIR, speaking of the same case as Mr. Wright, said he had come to the opposite conclusion, viz. : that the patient was much benefited by the *apis*, as it was a case which had been sent in for tracheotomy, and within 48 hours the greater part of the œdema was gone, but he agreed with Mr. Wright that it had no special influence on the diphtheritic membrane.

All bee-keepers seemed to get inoculated or indifferent to

the stings after a short time, and he would like to know from Dr. Fernie whether he suffered much from the stings when bee-keeping, and how soon he became inoculated. With regard to the administration of the animal poisons he thought the more exact methods by hypodermic injections or by absorption from a blistered surface, as recommended by Dr. Hayward for the serpent poisons, ought to be more extensively tried.

Mr. Cox, speaking of Mr. Wright's case of œdema of larynx, said that he had watched the case in the hospital from its commencement. The patient was admitted with intense dyspnoea, and tracheotomy appeared imminent; under *apis* the improvement was remarkable—the œdema passed off and respiration became easy. When able to examine the larynx two small patches of membrane were noted. The man got well, his improvement being rapid at first and gradual afterwards. He had no other medicine except *aconite* for some time.

Mr. WRIGHT said that Dr. Moir and Mr. Cox had misunderstood the remarks he had made about *apis* in Dr. Moir's patient. He contended that it had not prevented the membrane appearing, which was the case. The œdema certainly did subside, but the question remained was this due to the *apis* or the steam inhalations which the patient was receiving as an accessory treatment?

Dr. COOPER joined in the thanks so freely given to Dr. Fernie for his very interesting paper, and hoped that we shall be favoured by an increased proportion of papers dealing with drug-action, as this, pre-eminently, is the work of the Society. Dr. Fernie had mooted a question that bristled with difficulties, and one which could not possibly be dealt with in the compass of a short paper, namely, the variations in the behaviour of remedial agents when administered subcutaneously and by the mouth. Dr. Cooper had used subcutaneous injections at one time rather frequently, and he considered he had noted a marked difference in the behaviour of the high dilutions when given subcutaneously and by the mouth; he had never seen the slightest characteristic effect follow a hypodermic injection of a high dilution, but very marked effects had attended their buccal administration.

Again, *arnica* acted with intense violence when applied to the skin in persons sensitive to its action, but no such violent result had he seen from it when given by the mouth, and he argued from this, as well as from many other facts, that remedial agents differed very much in the intensity of their action in accordance with the part of the body to which they were applied. In the treatment of deaf cases, he had often used

our triturations as snuffs, and he had observed with some, a very marked effect upon remote organs, while with others the effect seemed limited, much more so than when given by the mouth, to adjoining organs. With *ammonium muriaticum*, for instance, its third decimal trituration is followed by a feeling of dryness not confined to the nasal mucous membrane, but extending very markedly to that of the rectum and other parts of the intestinal and vesical mucous tracts. The effects the *ammonium mur.* exerts is primarily a drying up of the fluids and consequent lessened liquidity of the fæces, and diminution in the quantity of urine, and this when given simply in the form of snuff. Coming to *apis*, Dr. Cooper insisted, as others had done, that *apis* cannot at all be considered as a polychrest; it acts most satisfactorily when indicated, but its indications do not justify us in considering it a polychrest. Dr. Cooper had seen *apis* act in the most magical manner in throats attended with localised patches of œdema; the puffy whitish submucous swelling that sometimes occurred in inflamed throats disappeared as by command after a dose or two of *apis*. Dr. Cooper was intensely interested by the narration of Dr. Fernie's initial case. He had heard of it many years ago from his old friend Dr. John Wilde, of Winchester, now of Weston-super-Mare, and if his memory served, the drink concocted by the peasants from the honeycomb on this occasion was termed in the country "hum" (to this Dr. Fernie assented), and he referred to it specially because when practising in Southampton he had been at pains to obtain information on the subject from his dispensary patients, and never succeeded in finding any who could enlighten him about it.

Dr. DUDGEON (in the chair) said he had seen *apis* of use in ascites, chemosis, and œdema of glottis. Cases of rheumatism had been of late years recorded as having been cured by the sting of bees inflicted voluntarily and involuntarily.

In reply to the remarks made by the several members, Dr. FERNIE said: He scarcely could agree with Dr. Hughes that even if advised by medical men to swallow the vaccine lymph patients would object on the score of its being repulsive. In former times persons willingly took as medicines powdered skulls, serpents' dung, and other such abominations; whilst to-day, mysterious matters such as anti-canceroso, anti-scrofuloso, &c., are unquestioningly swallowed. He would ask if the *apis* tincture, which seemed to fail with Mr. Wright, was reliably prepared from infuriated bees, according to the approved directions? though the recited case of the pensioner did not seem to bear out this necessity.

Dr. Cooper had kindly reminded him the brew which acted

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so successfully in the case adduced, and which Dr. Cooper remembered hearing about at the time, is called "hum" in Hampshire, and Dr. Fernie remarked that bee-hum had been certainly proved anything but hum-associated with another insect, the *cimex lectularius*.

He could not from personal experience answer the query of Dr. Moir, whether being repeatedly stung by bees provoked the use of bad language, with a craving for whiskey. In reply to the suggestion by Dr. Dudgeon, that the use of bees designedly for stinging a gouty or rheumatic limb may be beneficial, Dr. Fernie said his gardener, who helped him in attending to bees throughout several years, and was often stung by them, had no attack of rheumatism during all that time, though he had frequently suffered from the malady before, and has done so again since.

PRESIDENTIAL ADDRESS AT THE CLOSE OF
SESSION 1890-91.

By R. E. DUDGEON, M.D.

GENTLEMEN,—At the close of each session it is customary for the President to deliver an address by way of winding up the business of the year, and as Presidents should, of all men, be especially guided by precedents, I willingly conform to the time-honoured custom.

It is, I find, usual to give a *résumé* of the work we have done during the nine months occupied by the meetings of the Society. Criticism of that work by the President would be supererogatory and impertinent, as the papers that have been read and the cases that have been presented have already been adequately discussed in full meeting.

The initial meeting of the session was opened by a paper from Dr. Clarke, who, abandoning for a while his onerous labours as the homœopathic Atlas, sustaining on his unaided shoulders the whole *Homœopathic World*, kindly undertook to direct us in the true way and to warn us against straying into a false way in the practice of our special therapeutics. His paper was entitled "The Two Paths in Homœopathy." The title recalls to my memory that of a story which used to delight and instruct my childhood. It bore the name of "The Lofty and the Lowly Paths." I do not remember more about this interesting nursery tale than that the bad boy, who chose the high path, came to grief, whereas the good boy, who kept to the low road, got on all right. In Dr. Clarke's paper, on the contrary, the high path is apparently the one that meets his approbation, though it is beset with difficulties; whilst the other path—evidently a low one as he speaks disparagingly of it as "the road which takes the downward direction,"—though easy and flower-bestrewn, is, he seems to think, "the primrose way to the everlasting bonfire." Dr. Clarke's high and low paths have, of course, nothing to do with high and low potencies.

Dr. Clarke gave us a shock by evoking from its tomb the long buried doctrine of a vital principle or life force, which has at various periods haunted medicine under the names of Psyche, Archæus, Seele, Lebenskraft, &c. We hoped it had been finally laid to rest some 50 years ago. Ghosts of ordinary material bodies are gruesome things, but when the ghost of such an immaterial impalpable thing as a vital principle "revisits thus the glimpses of the moon" we cannot help feeling that it is something extra uncanny. Hahnemann resuscitated the doctrine in the last edition of the *Organon*, evidently because it fitted so nicely on to his hypothesis of the dematerialisation of medicines and the liberation of their medicinal powers from their connection with the drug substance by means of his pharmaceutical processes; but as it is only a theory incapable of proof or disproof, it may be held as a pious opinion or rejected without detriment to the stability of the homœopathic therapeutic rule, which got on very well before Hahnemann, in the last decade of his life, allied it with the even then moribund doctrine of an omnipotent and omnipresent vital principle. Had Burns been a doctor living in these times, we might fancy him addressing an ode to this troublesome immateriality in the style of his address to another evil spirit whose name I forbear to mention to ears polite:—

O you, whatever title like ye,
 Archæus, vital force or Psyche,
 What maks oor Clarke sae fidgin-fykie
 To ca' ye back?
 Has modern science failed to strike ye
 A mortal whack?

But I need not pursue the subject further. An annual address is hardly a fitting occasion for the consideration of such a lofty theme.

At the second meeting of the session, in November, Dr. Cook gave us a maiden paper, "On Therapeutics as an Applied Science." With much ingenuity and learning he showed the plausibility and probability of the homœopathic system by analogies from other departments of science. There can be no doubt that such a mode of treating the subject is well adapted to recommend homœopathy to all unprejudiced minds, and though it cannot supersede the direct proof afforded by the successful results of practice, it is eminently fitted to remove

the prejudices of scientific men and dispose them to take a favourable view of the claims of homœopathy to be the true science of therapeutics.

The third meeting in December was devoted to the exhibition of a large number of interesting cases, medical and surgical, by Dr. Carfrae, Mr. Knox Shaw, Dr. Moir, Dr. Neatby, Dr. Cox, Dr. Blackley, and Dr. Burford.

Dr. Dudley Wright occupied the attention of the Society at its fourth meeting in January with an admirable paper "On Some of the Common Diseases of the Pharynx and Larynx." These diseases were chronic pharyngitis and laryngitis, postnasal catarrh or Tornwald's disease, syphilitic pharyngitis and laryngitis, tubercular pharyngitis and laryngitis, and new growths of the air-passages. In truth, a goodly list of diseases, any one of which might almost have sufficed to occupy an evening. Of each of them we might say with Hamlet: "Ay, madam, it is common," but for all its commonness its cure is by no means so commonly understood as not to need a considerable amount of light being thrown on it. And it must be acknowledged that the author of the paper, and many of those who took part in the discussion it evoked, succeeded in throwing a great deal of light on the therapeutics of the diseases treated of.

The fifth meeting in February was devoted to the reading of a paper by Mr. Butcher, entitled "The Recent Discoveries of Koch and Pasteur as illustrating the Law of Similars." Mr. Butcher is eminently fitted for the treatment of such a subject from his great scientific acquirements and his highly original intellect. He was likewise specially qualified for giving a good account of Koch's method, as he had learned in Berlin itself much about it. But he did not touch upon the subject of the success or otherwise of Koch's treatment of human beings. He only referred to his laboratory experiments as illustrating the law of similars. Of course his paper was calculated to create a lively discussion, for we have amongst us not only some who are believers in Pasteur and Koch, but some who think that both these eminent *savants* have gone on quite a wrong method in their search for a cure for hydrophobia and phthisis. Some great man is reported to have said anything can be proved by figures, and this is conspicuously the case with regard especially to Pasteur's anti-rabic inoculations, for

while his partisans, such as Sir J. Paget and Sir J. Lister, show by figures that his injections have saved the lives of many persons who otherwise would have died of hydrophobia (the former puts the number at 900, the latter at 12,000 in four years!) his opponents, like Drs. Lutaud and Peter, prove equally convincingly by figures that his injections so far from having prevented hydrophobia have spread it, and thus have been instrumental in causing the deaths of many who otherwise would never have had the disease. Another great man has said nothing is so fallacious as figures—except facts; so what are we to believe? “Who shall decide when doctors disagree?”

The results of the anti-tubercular injections of Koch are not so uncertain. It is now generally admitted that the whole business is a lamentable fiasco—that none have been cured but many killed by it. The Koch episode does not redound greatly to the credit of the medical profession. The first announcement of the so-called discovery caused an invasion of the capital of Prussia by doctors from all parts of the world. It was a most undignified scamper—a kind of “devil take the hindmost”—all eager to be the first to obtain a drop of the precious lymph, whose composition was then utterly unknown. The report that enough lymph for a thousand inoculations could be had for 25 shillings, and that the doctors of Berlin were charging from £5 to £10 for each inoculation, was enough to make the mouths water of the thousands of practitioners who were half-starving on half-crown fees. When the grand smash came, the disappointment of the credulous lymph-seekers must have been aggravated by the discredit they had brought on an honourable profession by their indecent haste to employ a secret nostrum—an altogether unprofessional proceeding which the chief exponents of medical ethics had frequently condemned in the most explicit terms.

Incidentally I may remark that Koch's idea of curing tuberculosis by its own virus was anticipated long ago by homœopathy, the very name Koch gives to the prepared virus, “tuberculinum,” being that given many years since by Swan to his similar preparation. The homœopathic idea passing through the allopathic brain was ruined in the transit, and *tuberculinum*, which, employed after the method of Hahnemann has only benefited

patients, when used according to the directions of Koch has hurried many victims into a premature grave. One of our members, Dr. Burnett, has published a book, in which he shows how helpful *tuberculinum* is when rationally employed.

The sixth meeting in March was pleasantly and profitably spent in listening to an interesting paper by our esteemed veterinary colleague, Mr. Hurndall, on "Our Public Flesh and Milk Supply in Relation to Hygiene." The author, though not a member of the Society, is a welcome visitor, and last year favoured us with his experience on the homœopathic treatment of influenza in the special subjects of his *clientèle*, viz. :—horses. It is very satisfactory to us to find that horses are very amenable to homœopathic treatment, and we are glad to know that our system is practised with excellent results by such a skilful and scientific veterinary surgeon as Mr. Hurndall. Speaking for myself, I have a special fondness for veterinary practice, for I was once very near being a military veterinary surgeon. It happened in this way: Some thirty years ago, being seized with the desire to become acquainted with the art of war, I entered the military service of her most gracious Majesty in the reserve forces. I may mention that I served for nearly twenty years in the ranks, but that my wish to witness real warfare was not gratified, as during all that long period this country was never once invaded by a hostile army, and you are doubtless aware that the reserve forces are not sent on foreign service. I cannot say that my military career was altogether bloodless, for on one of our field-days a spectator was shot through the body by a ramrod which had been carelessly left in a rifle. But as the victim was only a clergyman and therefore a pacific non-combatant, the catastrophe could not be fairly regarded as an incident of real warfare. The colonel of my regiment one day told me that he thought what he was pleased to term my talents were wasted in the rank and file of the regiment, and he asked me if I would not like to be one of the regimental doctors. I at once replied no, my object in joining the army was the slaughter, not the cure, of my fellow creatures; of the latter I had quite enough in my civil capacity. He then asked me if I would not accept a commission as an officer of some

sort. I replied that if I quitted the ranks I would only exchange my present status for that of veterinary surgeon. He asked me what I knew about horses' diseases. I replied, nothing at all, but that did not signify, for if I were appointed to the post of veterinary surgeon I would adopt the stamping-out plan which had been so successfully enforced by the Government in the case of the cattle plague; and when a horse seemed ill and unfit for work I would order it to be slaughtered and a sound one procured. The colonel seemed struck by the simplicity and efficacy of my plan, but regretted that, as ours was an infantry regiment, and there were only three horses in the regiment—his own, the major's and the adjutant's—it seemed hardly worth while creating a special surgeon for such a small *clientèle*. I could not agree with him there, as the number did not matter when the whole efficiency of the regiment in the face of the enemy might be endangered by the disablement of the charger of any one of those important officers. Such an accident could not happen in a dragoon regiment, as any officer whose horse was disabled could be supplied with another from the ranks, therefore the fewer the horses in a regiment the greater the need of an official to see to their efficiency. My arguments did not move the colonel to adopt my suggestion. I have often noticed that colonels are indisposed to introduce any novelty or reform, however excellent, into their regiment unless it has originated in their own brain.

This little bit of military autobiography will enable you to understand the interest I feel in veterinary subjects, and how thoroughly pleased I was to listen to the experience of our able veterinarian, Mr. Hurndall.

The chief object of his paper was to show that there could be no safety for the consumers of butcher's meat unless the body of every ox was, as it were, sat upon by a veterinary coroner, and a verdict of "died from non-natural causes" returned. This is similar to the Jewish plan with regard to their "Kosher" meat, and as we are apparently about to be deluged with an immense importation of wandering Jews from Russia, we may in course of time become so Hebrewised as to adopt their peculiar custom in regard to meat-inspection.

At our meeting in April we were favoured with an excellent paper by our worthy honorary secretary, Dr.

Blackley, on "The Irritable Mucous Membrane of the Gouty Subject," which was fully up to date in erudition and practical value. I have often observed that patients seem to derive considerable comfort from the doctor's assurance that their complaints are due to gout in their system. Probably their satisfaction is owing to their belief, originally started by Lord Chesterfield, I believe, that gout is a highly respectable disease. When hereditary it shows a sort of aristocratic strain in the blood, of which every well-regulated mind ought to feel proud. The consciousness of the gentility of the disease may tend to mitigate its anguish, even though the victim may find that Ovid was right when he says :

Tollere nodosam nescit medicina podagram.

At our May meeting Dr. Blake gave us a luminous and interesting paper, entitled "A Study of Delphinium Staphisagria." Though the drug has been known to the faculty from the very earliest times, little use has been made of it by the old school, except as an application to the head, in order to destroy that loathsome vermin which Burns apostrophizes as an

*Ugly, creepin', blastit wonner,
Detested, shunned by saint and sinner.*

On the other hand, Hahnemann discovered in it great therapeutic virtues, which were all set forth by Dr. Blake, whose observations will materially help to precisionise its sphere of therapeutic utility.

At our last meeting in June, Dr. Fernie improved the shining hour by discoursing on the therapeutic virtues of the busy bee. His paper, besides being replete with practical wisdom, was witty and humorous, and while it instructed it amused his audience, and elicited a general wish that the author would soon gratify us with another paper. Had Dr. Watts been still alive to hear Dr. Fernie's paper he might have added a verse in his celebrated poem about that exemplary insect, the bee, something in this style :

*How artfully she stores her tail
With venom, strong and sure,
Adapted to a two-fold use—
To poison and to cure.*

Casting a retrospective glance on the session just terminated, I think I may say that it has been a very satisfactory one. We have had excellent papers read

and instructive discussions. We have had many interesting cases of rare disease exhibited, and we have had fair average attendances of members. We have increased the number of our members by the election of six new ones.

We have to regret the loss of two of our oldest members by death: Mr. Ayerst, of London, who though he remained a member of the Society to the last, did not attend our meetings of late years, and Dr. Moore, of Liverpool, who during his rare visits to London occasionally delighted us with his genial presence.

Indirectly connected with the Society we have had a series of post-graduate lectures delivered by some of our members belonging to the staff of the hospital. These lectures have been most interesting and instructive, and have been much appreciated by the audiences. It is to be hoped this excellent plan will be continued in future years.

As the British Homœopathic Society is intimately connected with the London Homœopathic Hospital, all that concerns this institution interests us in the highest degree. Accordingly we have viewed with feelings of the warmest sympathy the amazingly successful efforts made by the board of management of the hospital, headed by their indefatigable, energetic and liberal chairman, Major Vaughan Morgan, to collect funds for rebuilding, with all the scientific improvements required by modern sanitation and hygiene, the hospital which we feel has hitherto but inadequately supplied the wants of the patients who have flocked to it. Now that the large sum of £30,000 has been collected there need be no delay in commencing the work of rebuilding, and perhaps before our next annual meeting we may have the pleasure of assembling in the hall of a handsome and commodious new hospital, which will increase the reputation and extend the knowledge of homœopathy.

I cannot leave the subject of the hospital without alluding to the great progress that has been made in the surgical department. There can be no doubt that during the last decade immense advances have been made in operative surgery, more especially in that of the abdomen, and that many cases which formerly would have perished from lack of operative help are now saved by the surgeon's skill. As we have a surgical department

in the hospital, it would be shameful if the surgery were not quite up to date. We are proud to know that, thanks to the perfect skill of our surgeons, that reproach cannot be applied to our hospital. I do not hesitate to say that operations as skilfully performed and as wonderfully successful as those in any of the existing hospitals may be witnessed in the London Homœopathic Hospital.

Since we parted in June last year there has been but little mention of homœopathy in the old school periodicals. Our old adversary, "R. B. C.," *alias* Mr. Robert Brudenell Carter, distinguished himself by reporting to the Ophthalmological Society the outrageous conduct of one of the members who actually "submitted to consult with a homœopath," and proposing that the Society should pass a resolution to the effect that "it is inexpedient and improper for its members to engage in professional consultations with avowed homœopaths, or with persons holding office in homœopathic institutions." The Ophthalmological Society would have nothing to do with Mr. Carter's resolution, whereupon Mr. Carter indited an acrimonious letter to the *Lancet* in which he loaded with equal abuse homœopaths and the majority of the members of the Society, and loftily announced his resignation of the membership of the Society. Of course Mr. Carter's letter was duly answered, and a very pretty quarrel was kept up for a few weeks in the columns of the *Lancet*. Except this little fight there has been nothing stirring in the homœopathic controversial sphere. It is to be hoped that it may not be long before some new assailant of homœopathy enters the list and gives our school the opportunity of having a fair stand up fight for the cause of scientific therapeutics. A young truth always flourishes amid the din of controversy. The palm of victory is not to be had without the dust of strife—*palma non sine pulvere*.

A characteristic attempt at boycotting was enacted at Bath on the occasion of Hospital Saturday. It appears that hitherto the collection on that day was in some way monopolised by the Royal United Hospital and was managed by the committee of that hospital. The committee of the Homœopathic Hospital considered this unfair, and thought that the collection should, as in other places, be made for all the hospitals of the place, including their own. They accordingly proposed to the

committee of the allopathic hospital that the collection should be a general one; the proceeds to be afterwards divided among the hospitals proportionally. The allopathic committee scornfully refused to "enter into correspondence with" the homœopathic committee, so the latter instituted a separate collection for their own hospital, which was so far successful that they got upwards of £130. For my own part, I think the homœopaths acted perfectly right, and I should always approve of an energetic resistance being offered to all such attempts to treat us otherwise than on a footing of perfect equality. If we allow ourselves to be sat on we shall certainly be squashed.

In the old school nothing of permanent importance to medicine has occurred. Of course, a good many new antipyretics and hypnotics have been introduced, but as the same thing has occurred frequently during the last decade, and the novelties after a short trial are discarded for some still newer remedies of the same class, we need not trouble ourselves much about them.

Each remedy as it is introduced is said to be, like Keating's insect powder, "perfectly harmless to animal life," but it invariably happens after a longer or shorter trial that some of those who have employed it, write to the medical periodicals to complain of its poisonous action on their patients. The most amusing incident in the old school is the tragi-comic drama enacted in Berlin in connection with the Koch cure of tuberculosis, to which I have already alluded.

The hopes raised in the breasts of the aged by Dr. Brown-Sequard's announcement that he had discovered the true elixir vitæ have alas! not been realised. This is to me personally a great disappointment, as I had looked forward to renewing my youth at this new fountain of jouvence, when I might have roused your enthusiasm by a lively, vigorous and youthful address, in place of wearying you with the vapid babblings of senility.

I was just about to write that nothing more of a new and original character had appeared in connection with old physic, when I received by post a work entitled, "Rhyming and Mnemonic Key to Materia Medica." In this the author, who modestly conceals his name, endeavours to fix on the memory by means of rhymes

and puns the rather dry facts of drug compounding. Sometimes he contents himself with the mere enumeration of the constituents of the compounds of the official pharmacopœia, as thus:—

“*Linimentum Aconiti*—

Take *aconite*-root and rectified spirit, parts twenty,
And *camphor* one part, you see it is plenty.”

But he usually includes a bit of therapeutical information in his rhyme:—

“*Plumbi acetæ, opium*, confection of roses
Makes a pill, which if taken, stops bleeding from noses.”

“*Sulph. magnesia* one ounce and *mucil. amyli*,
With one ounce olive oil to act on the rectum.”

“Gum arabic in powder, syrup, cinnamon and chalk
This *mistura cretæ*, diarrhœas will balk.”

These are perhaps the most favourable specimens of the author's work. In many of the couplets the metre and rhyme are both conspicuous by their absence, as for instance:—

“*Calomel*, 80 grains, one ounce *æzungia*
Prescribed much it is for scrotal eczema.”

The idea appeared to me to be good, though the execution certainly leaves something to be desired. Why not utilise it for the purpose of impressing the homœopathic therapeutics on the mind? I remember when I was a student a certain teacher of anatomy in Edinburgh was credited with having invented a whole system of mnemonic rhymes for the purpose of teaching his class students anatomy. I can only recall one specimen of this curious industry. In order to enable the student to remember the relative position of larynx and pharynx (called in Scotland laarynx and phaarynx) this elegant couplet was to be learned by heart:—

“The laarynx lies beneath the skin,
The phaarynx lies far in.”

Some of us remember how our distinguished colleague, Dr. Tod Helmuth, at the dinner of the International Homœopathic Congress in 1881, delighted us by reciting a poem of his own composition, in which he gave a sort of history of surgery and its chief operations. He showed that operative surgery was a very ancient art, the earliest recorded example of it being the enucleation of Adam's rib. An Italian of the name of Guanciali in 1840 published a poem in Latin hexameters all about Hahnemann

and his medicines; but he rather limited himself to giving a poetical account of the pathogenetic effects of the chief homœopathic medicines, and as he chose to write in Latin the circle of his readers was limited.

I thought that something might be done in the style of the *Rhyming Mnemonic Key* to impress on the unlearned reader's mind the salient facts of homœopathic therapeutics. I remembered how the succession of kings, from William the Conqueror downwards, and some of the striking facts of English history, had been engraved on my memory by the rhymes learnt in the nursery, setting forth how—

“Norman Willy, the Conqueror, long did reign,
Red Billy, his son, by an arrow was slain.
Henry the First was a scholar bright,
And Stephen was forced for his crown to fight.”

And so on. If a serious subject like history could be legitimately taught in rhyming couplets, why not that equally serious subject, medicine?

I forthwith set to work to try and get the idea put into execution. Among my friends I have one who is what I may call a spiritualistic poet. Under the inspiration of spirits he will reel you off any quantity of rhymes on any given subject. So I interviewed him, told him what I wanted, put a copy of Dr. Clarke's *Prescriber* into his hand and a glass of Glenlivet into his slot, and so set him going. In a short time he produced a sheet full of couplets, wherein a number of our medicines and their therapeutic uses are set forth in alphabetical order as follows:—

If inflammation holds you tight
You'll loose its grip with *Aconite*,

For erysipelas, on my honour,
There's nought can equal *Belladonna*.

When flatulence unstable is
Take *Carbo vegetabilis*.

When our heart's action seems to fail us,
We take a dose of *Digitalis*.

Euphrasia, anglicè Eyebright
Is good for clearing up dim sight.

A tapeworm in a lad or lass
Is quickly killed by *Filix mas*.

Psoriasis an ugly sight is,
It's been cured often by *Graphites*.

To keep your boils from going deeper
Take every night and morning *Hepar*.

To one by sorrow who's emacia-
Ted, the safe cure is *Ignatia*.

For sweats excessive *Jaborandi*
Is of all med'cines the most handy.

Lest toothache tease you you should note
The remedy is *Kreasote*.

To give a gout-racked person *Ledum*
Is vastly better than to bleed him.

A cure for bilious trouble is
Mercurius solubilis.

Take for disordered stomach a
Pilule of *Nux vomica*.

If drowsiness you overcome
Then take a dose of *Opium*.

From Pentland Firth to Bosphorus
Pneumonia's cure is *Phosphorus*.

If grave disease has made you pine
A grand restorative's *Quinine*.

If suffering from furunculus
Your remedy's *Ranunculus*.

If thread worms make your baby whine
Give him a dose of *Santonine*.

When wheezy mucus clogs the chest
Tartar emetic is the best.

If you're attacked by diabetes
Uranium helps—see E. Blake's treatise.

Its full and copious proving stamps
Veratrum as the cure for cramps.

Water applied, both cold and hot,
Cures of diseases a great lot.

When maidens' menses painful come
Then dose them with *Xanthoxylum*.

Whene'er you feel down on your luck, a
Remedy you'll find in *Yucca*.

The sufferings from excess of drink—
Experto crede—yield to *Zinc*.

When I objected that the poetry was hardly up to the high standard I anticipated, the author replied: What could you expect from a single glass of whisky? If it had been a bottle the lines would have had more spirit in them. You can't get more out of a vessel than you put in it—and so forth. I only give this specimen by way of a hint to others who may be disposed to adopt this method of popularising homœopathy. Now that the allopaths have taken to the poetical plan, we may follow their example and show them that homœopathic therapeutics is quite as susceptible of poetic treatment

as their pharmacopœia. *The Rhyming Repertory of Rational Remedies* would be as good a title as that of the allopathic work I have introduced to your notice. The historical nursery rhymes, of which I gave you a specimen, were, if I remember aright, set to a lively tune, and though lively music might seem hardly suited to such a grave subject as medicine, there might not be the same objection to intoning the *Rhyming Repertory* if it were considered advisable to give a public reading of it. But, perhaps, I had better avoid any allusion to ecclesiastical forms, lest it might suggest to some of you to propose reading the Communion Service for my benefit—or the reverse.

Gentlemen, we have well earned our holiday, and I trust we may all enjoy it. But I must remind you that to-morrow the Annual Congress, which is something quite apart from our Society, is to meet in this room, and I hope it may be largely patronised by our members, one of whom, our excellent friend, Mr. Harris, is to occupy the presidential chair. I am sure all you, and many others, will give him their cordial support.

Thanking you for the patience with which you have listened to my address, which I wish for your sakes had been better worth listening to, I bid you farewell until October next, when I trust we shall again assemble like giants refreshed by our holiday, prepared to develop our scientific therapeutics and extend the knowledge of the beneficent system of Hahnemann—*urbi et orbi*.

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