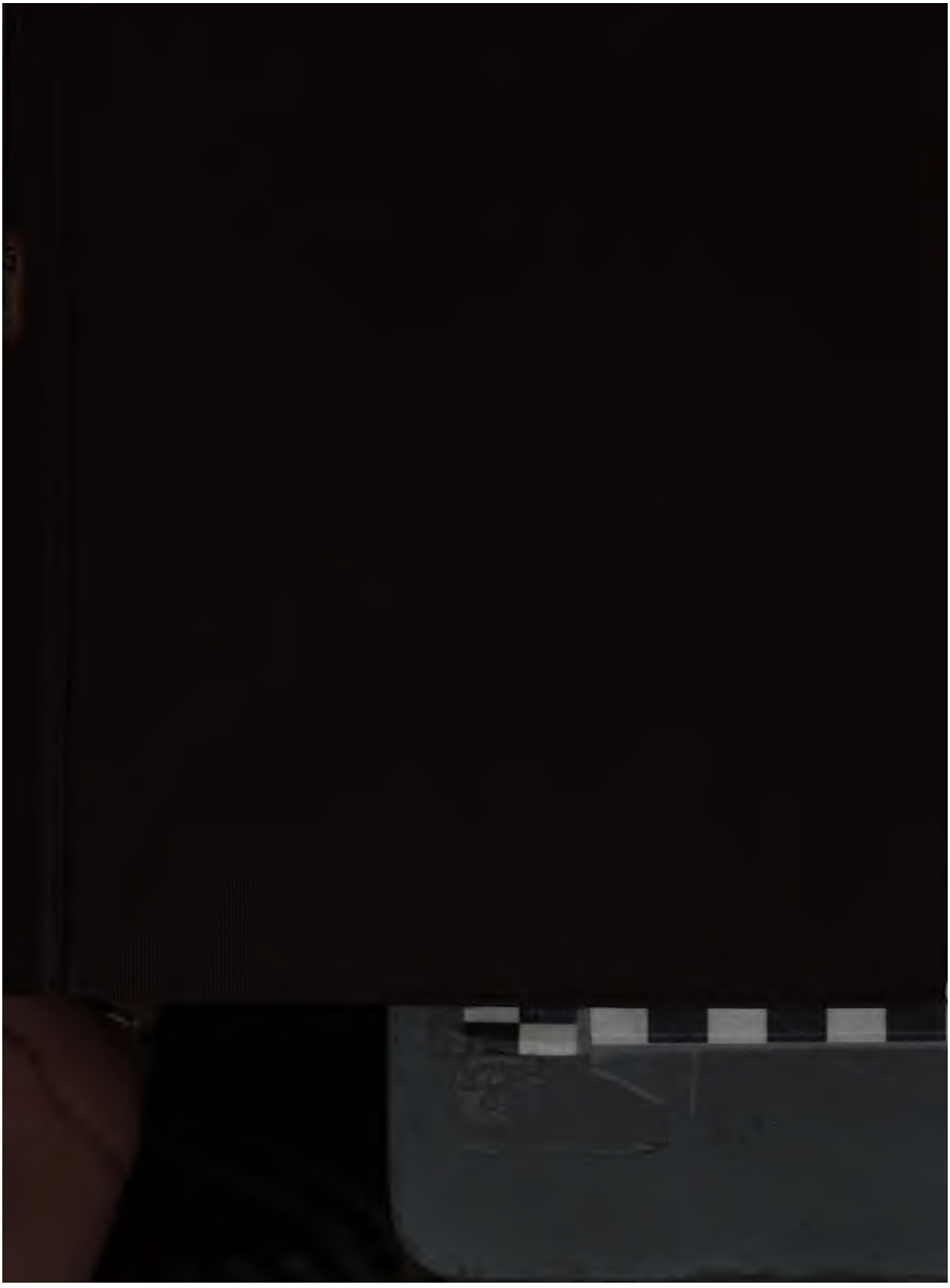

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OF THE

British Homœopathic Society

NEW SERIES

VOL. XV.

SESSION 1906-1907

EDITED BY

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NOTICE.

THIS volume comprises the Proceedings of the BRITISH HOMŒOPATHIC SOCIETY during its Sixty-second Session, 1906-1907.

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Dr. Goldsbrough, 82, *Wimpole Street, London, W.*

THE ENTHUSIASM OF HOMŒOPATHY.

THE PRESIDENTIAL ADDRESS, DELIVERED AT THE OPENING OF THE SESSION 1906-1907 OF THE BRITISH HOMŒOPATHIC SOCIETY.

BY JOHN HENRY CLARKE, M.D.EDIN.,
President of the Society.

Fellows and Members of the British Homœopathic Society,—First let me express the deep sense of gratitude I feel for the great honour you have conferred upon me in electing me to the highest office in your gift—a gratitude which is all the deeper because the honour was entirely unsolicited on my part, and unexpected. I accept the honour with all the greater pleasure because I recognise in it something more than a purely personal favour. There is only one possible reason why you have elected me, and that is that you all know me for a "whole-hogger," and, doubtless, will expect me to live up to my reputation. I assure you that the best of all that is in me is at the service of this Society so long as, by your favour, I occupy this chair;

for in serving this Society I know I am serving the cause of Homœopathy.

Homœopathy is a jealous mistress; she will brook no serious rivalry. My friend, Dr. Moir, who has lately taken to golf, was telling me the other day that no person can attain the first rank in any game with a ball, and be first-rate in any other line of life as well. Whether or not Homœopathy is to be reckoned as a game of ball—by virtue of its globules, its pilules, and its globular drops—certain it is that it provides scope for all the best energies of every one of us, and of as many more as like to come into the fold; and a life-devotion to Homœopathy will not leave much energy to spare for anything else.

And from whatever point of view we regard it, Homœopathy is a mistress of whom we have every reason to be proud. Whether we regard it as a philosophy, as a science, or as a life-saving, health-giving art, we may well be content to devote our lives to its exposition, elucidation and advancement. There is no branch of human endeavour more fruitful than ours in the practical advancement of our race and civilisation, and there is no department of our art, no section or degree of Homœopathy, which does not command the sympathy and fostering care of our Society. Like the Roman poet, our Society may say—*Homœopata sum: nihil homœopathici a me alienum puto.*

If any one wishes to know what is my religion, I reply, I am Homœopath. My politics? I am Homœopath. My fatherland? Homœopathy. With me, Homœopathy is first, and second, and third, and everything else that is desirable comes after that. This, I feel, is the proper attitude for the Society to assume, and that this is the attitude the Society has assumed, I read as the meaning of your election of myself to occupy this chair.

Among the pleasures which your choice has given me, not the smallest is the fact that I succeed in this office my godfather in Homœopathy, Dr. Alfred Edward Hawkes. It is now thirty years since he took on himself the responsibility of inducting me into the art and mystery of our craft, as he had already inducted James Compton Burnett before me.

I can only say I hope I may not disgrace my parentage in the way I discharge the office of this chair; for I am certain of this, the British Homœopathic Society has never possessed a more devoted, whole-hearted, and efficient President than it possessed in him.

When I took my first timid peeps into Homœopathy, I had a notion at the back of my mind that I should soon be able to find out and appropriate all the good there was in it, and that I need not necessarily separate myself from the body of the profession, if I decided to make use of it. But that notion was pretty soon knocked out of me. I found in it very much more than I anticipated, and I found this in addition, that if I was to make anything at all out of it, I must devote my life to it, and associate myself with others who did the same. In short, there was no help for it, I must go the whole hog or none.

It is a very useful habit to acquire, especially early in life, to answer every question presented for solution with a simple "yes" or "no." This may seem trite and common-place, but it is not quite so easy to practise as it looks; and I cordially commend it to the younger portion of my hearers for their most careful consideration. If you think of it for a moment, you will perceive that ninety-nine persons out of every hundred, when they are confronted with a vital question in their path, answer it with that seductive little particle, "perhaps," or, they are like the divine who stumbled over some knotty point of theology in his sermon, and dealt with it in the way you remember: "Brethren," said he, "do not let us shirk this question, let us boldly face it, and—pass it by," and this is what he did; and that is what most of us are doing, all day long, without knowing it. But there is no progress possible along that line.

The only possible line of progress is to think a thing out to the bottom, to reduce it to the point where a "yes" or a "no" is all that is required. Is it a fact that likes cure likes, or is it not? That was a former question to be answered. The answer, on the evidence, was overwhelmingly "yes." Therefore, that question was done with for ever. There was

no need to waste a halfpenny-worth of thought on that point ever again. But there were plenty of other questions arising out of it. These, again, had each in its turn to be answered "yes" or "no," and once answered these, in their turn, were out of the way for good and all. But until they have been answered they are so many *impedimenta* which will stop our advance altogether, or send us off into some easy by-path which leads us nowhere, or into a bog.

Every member of this Society has answered the first great question in the same way that I did. For us the question of Homœopathy is no longer a matter of "perhaps;" it is a fact settled once for all. It is not a matter of creed; it is a matter of knowledge; it belongs to the "everlasting yea."

But the questions that come next? What of them? There are many and of many kinds; and to no two of us are they presented in exactly the same way, or in exactly the same order. And this is quite right; for we are all differently constituted, and all have finally to shape our work to our own pattern. Happily, Homœopathy is like Nature—infinite in its varieties and possibilities, so that every one of us is able to strike out the line most suited to his gifts. The knowledge of this should breed in us all a wholesome charity to one another. It is not in the nature of things that we should all practise on the same exact model. But whilst broadening and deepening our sympathies it should also make strong and deep the current of our enthusiasm for the one common object we have at heart.

It seems to be my fate to take the longest possible route in order to reach my goal. Born but one hundred and thirty miles from London, I was not allowed to reach this Promised Land until I had travelled some six and twenty thousand. I came by way of Edinburgh, Glasgow, and New Zealand. In the same way fate compelled me to circumnavigate Homœopathy, to sail over its oceans, explore its continents, and visit its distant isles, before it permitted me to reach this present goal, which is the highest to which a British homœopath can aspire. However, I am not complaining of fate. Fate generally knows what she is about,

and I make it a fixed rule in life never, on any account, to quarrel with her. The result of my peregrinations is that I have had a good deal of my native provincialism and parochialism knocked out of me, and am all the better able to take the wider and juster view which you expect in one who occupies this chair, and which I feel that this Society itself desires to take.

It seems to me that this Society ought to command the sympathies of every section of homœopaths; and it ought, in its turn, to foster Homœopathy in all its grades and all its branches. This Society should have no preferences; however much and however acutely certain sections of homœopaths may debate certain points among themselves—and it is in every way desirable that they should do so—this Society, as a Society, can take no sides in the disputes, and I, as your President, shall endeavour to preserve this judicial position as your representative.

I have observed that in the homœopathic fold there are puritans of two sorts. I am no puritan myself, but I have a good deal of sympathy with puritans of all kinds. The homœopathic puritans appear at both ends, as it were, of Homœopathy. On the one hand there are those who refuse to prescribe in a case of disease any drug which has not actually caused that disease, or something very like it. At the same time the puritans of this type generally object to prescribing on any symptom which has not been produced on a healthy person; or, if they do prescribe on a symptom otherwise obtained, they feel constrained to apologise to the allopaths for this lapse from virtue, as they feel it to be.

At the other end of the scale are puritans of another sort. These take Hahnemann's *Organon* for their scripture, and in accordance with its directions take the symptoms of each case for their guide, irrespective of the name of the disease the patient may be suffering from. These consider that the only path of virtue lies in giving one remedy at a time, and the smallest possible dose of that.

Having travelled over all this ground, as I have already said, from one end of the scale to the other, both these types of puritans have my warm sympathies, though for

my now part I must profess myself a perfect libertine in these matters—and I think, as I have already said, that this Society, in its corporate capacity, ought to be a libertine also.

Each of these sections of homœopaths, and every shade between, must be allowed to work out its salvation in peace, and each individual homœopath must be allowed to do the same. It is not so much a question of which is right and which is wrong as it is a question of individual capacity. There is not one of us who cannot teach the rest something, though he can never communicate all he knows. But all can help in the evolution of our body. If any one cares to know what my own personal proclivities are, I should put it in this aphoristic form: "The further from Allopathy the nearer to Grace," or "The nearer to Allopathy the further from Grace," if you prefer it that way. But I am not here to-night to trouble you with personalities. We are all members of one Society, and this Society has only one interest—Homœopathy. It is inspired by one enthusiasm —the enthusiasm of Homœopathy. Every sincere worker whose chief aim in life is to exemplify the homœopathic law has the right to the Society's countenance and support. The law is one and the glory of it, but we cannot all practise it exactly alike however much we may desire to do so. We can all aim at one ideal, and the higher we can pitch our aim the more likely we are to reach high attainment; but we have each to find out the particular method which gives the best results to our individual limited powers.

Only, it will be well if we do not take too humble a view of our powers and their limitations; and, whatever we do, let us ever be eager to extend our borders. I hold that the greatest service any man can render to his fellows is to make them discontented with their lot, and the more discontented I can leave you all to-night, at the close of this address, the better gratified I shall be. The days have gone by for ever when the recessional hymn used to be sung at the church door as the great ones emerged after service:—

> "God bless the squire and all his rich relations,
> And teach us poor folks to keep our proper stations"

This is the hymn which the allopathic squirearchy would dearly love to have homœopaths sing. But our hymning days are over, and, for my part, I never had a voice. As for stations, I maintain that we have no stations—we must always be moving on; and if I can, in some measure, discharge the humble policeman's duty, of moving you all on to-night, I shall feel that my election has not been in vain.

There is a world of importance in that "moving on." Motion is life. Stagnation is decay. And no less important than motion is the direction in which the movement takes place. It matters not what our grade or shade of homœopathic practice may be, so long as we are ever moving onward, forward, and upward, further and further away from the region of allopathic name-fetters and negations, we are contributing to the evolution of our art and the welfare of our race. And the force which alone can move us is enthusiasm—the enthusiasm of Homœopathy.

In the clash of conflicting creeds, the "Enthusiasm of Humanity" has been put forward as an all-sufficient motive power to inspire the efforts of every good man in striving for the welfare of the race. In this Society, and in all cognate societies, the spring of all our efforts against human ills, the force which carries us onward towards the perfecting of our art, is the enthusiasm of Homœopathy. It is this which inspired Hahnemann, when once he had grasped the idea, to undertake those mighty labours, the magnitude of which even his followers but imperfectly recognise. It was this which upheld him through all the persecutions with which his professional brethren greeted his great reform. The enthusiasm of Homœopathy has had its martyrs as well as its heroes; and who shall say that its martyrs have not suffered in a cause worthy of their pains? Enthusiasm knows no laws of human making—only the laws of Nature herself.

Of all the enthusiasts whom Homœopathy has evoked, there is none more remarkable than the fiery Mure, now best known by his "Materia Medica of Brazil." The story of his career is so very remarkable, and so very appro-

priate to a time of revival such as we now see the beginning of in our own land, that I will give it you in the words of Dr. Dudgeon from the second volume of the *British Journal of Homœopathy* (1849), *apropos* of a notice of Mure's work "Doctrine de l'École de Rio de Janeiro et Pathogenesie Bresilienne," published in Paris in 1849. Dr. Dudgeon truly says, "Mure's whole career bears such an air of knight-errantry and romance about it, that it seems something like a fiction," but he has every reason to believe that the facts as stated are true. At the time Dr. Dudgeon wrote, Dr. Mure was still living, and the whole of his professional career up to this date comprised only thirteen years. Dr. Dudgeon shall tell how much he put into them.

M. Mure was a French merchant, well known at Palermo; and having fallen into extreme ill-health (phthisis pulmonalis is said to have been his malady), he was given over by his allopathic physicians. Apparently in the last stage of consumption, the *Organon* of Hahnemann fell into his hands, which he eagerly perused; and struck by the new light revealed in this extraordinary work, a ray of hope beamed upon him, and he hastened away from Palermo to seek that relief from the hands of the homœopathists which he was unable to obtain from the adherents of the old school. On his arrival at Lyons he placed himself under the care of the venerable Dr. Count Des Guidi. Such was his miserable condition on leaving Sicily, his friends scarcely expected he would survive the fatigues of the sea voyage. Their astonishment was great when they saw him return in a few months in perfect health. All Palermo flocked around him, and begged he would give them information respecting the system which had produced on him these marvellous results.

He made some cautious experiments with homœopathic remedies, and with complete success. Several physicians of Palermo were convinced by the proofs they saw of the efficacy of Homœopathy, and set about studying it with diligence.

Mure was now resolved to consecrate the life that had been saved by Homœopathy to its propagation; and, abandoning his commercial pursuits, he went to Montpellier to study medicine and obtain the legal qualifications for practising as a physician.

Having completed his studies and obtained his degree, he began to devote himself to propagate Homœopathy. Malta was the first spot he chose for his operations. He arrived there in

1836. In the Grand Hall of the Knights of Provence, at Valetta, he got up an exhibition of his cures; something, we suppose, in the style of those formerly witnessed in this country, though on a more extensive scale, but not on that account of less questionable propriety; but Dr. Mure, in his proselytising ardour, was no stickler for professional etiquette. He succeeded in making converts of some medical men there, particularly of Drs. Fennich, Buonavia, and De Claude. The cholera having broken out in the kingdom of Naples, he crossed over to Palermo in 1837, and on the voyage wrote some papers on the progress of Homœopathy and the homœopathic treatment of cholera, with Hahnemann's instructions for the cure of that disease. These he published on his arrival. The cholera not appearing in Sicily, he went elsewhere to propagate the faith, but was speedily recalled to Palermo by the invasion of the pest in 1837; he did not arrive there, however, until the disease was already in its decline, after having carried off near a quarter of the population in forty days. Whilst most of the allopathic physicians had fled from the town during these fatal days, two of Mure's disciples, Drs. De Blasi and Bartoli, remained faithful to their post, and were instrumental in rescuing a number of persons from the grave. However, the Academy of Palermo, which had erased De Blasi's name from among its members on account of his heretical opinions, refused to register the cases treated by the homœopathists; but the Government, appreciating the excellence of their treatment, took care to spread a knowledge of the method pursued by them among the parts of the country still ravaged by the plague.

Our hero now set about translating a repertorium from the German for the use of the Sicilian physicians, and established a pharmacy, where he made all the homœopathic preparations with his own hands. He here invented a machine for triturating the medicines, and another for succussing the dilutions, of which he has given us drawings in the *Bibl. Hom. de Géneve*, and also in the work before us. His plan was to triturate every substance, mineral, vegetable, and animal, up to the third attenuation, and with his succussion machine to give 300 shakes to each dilution. He undertook to supply every medical man gratuitously with all the homœopathic preparations. Not being able to obtain bottles in sufficient quantity, he established a glass-blowing manufactory, himself instructing the workmen, whereby he was enabled to supply with pocket pharmacies all the medical men who applied to him, and who were by no means few in number. During this time he translated into Italian Jahr's Manual.

In the beginning of 1838 he opened a dispensary at Palermo, and soon afterwards a second in the centre of the town on a magnificent scale. In less than a year the number of patients daily seen here amounted to upwards of 200, and above six physicians were occupied in attending to them. Physicians, students, lawyers, priests, literary men, flocked to this temple of charity to hear from the patients themselves an account of their astonishing cures, we are told; and thus this dispensary became the centre of the propaganda for Sicily. The allopathic physicians, our informant assures us, found themselves almost deserted by their patients; the apothecaries begged to be allowed to sell the homœopathic medicines, and the wards of the great hospital were almost forsaken. In some public hospitals Homœopathy was adopted, viz., in the hospitals of Morreale, Mistretta, Pietraperzia, and that of the brothers of San Giovanni de Dio, their physicians having become converts to the new system. In a very short time about thirty physicians declared themselves favourable to the new doctrines, the principal of whom were Tranchina, De Blasi, De Bartoli, Morello, Tripi, Calandra, Bandiera, the Marquis Inguagiato, Vassallo, Lipomi, Cinirella, Acito, Maglienti, Strina, Selvaggio, Perez, Evola, Bonelli, Bataglia, Magri.

Under the editorship of De Blasi the *Annali di la med. Omeopatica*, a periodical journal for the propagation of Homœopathy, was established.

A homœopathic society was formed, which in 1844 was formally recognised by Government and converted into "The Royal Homœopathic Academy." Courses of lectures on Homœopathy were delivered.

Having thus given the impulse to Homœopathy in Sicily, our indefatigable colleague, desiring a new field for his beneficent conquests, turned his eyes towards Paris; and, thinking things were not going on quickly enough there to his liking, he resolved to stir up the energies of his dormant *confrères*.

Arrived in Paris, in 1839, he immediately set about the foundation of a homœopathic institute, for the purpose of spreading the system by practice, instruction, and publications.

A dispensary was opened every day for the poor; courses of lectures were announced: on Clinical Homœopathy by Dr. Croserio; on the Theory and History of Homœopathy, and on Materia Medica, by Dr. Jahr. Two newspapers for the indoctrination of the public were set a-going—a daily one, the *Capitole;* and a weekly one, the *Nouveau Monde*. A homœopathic pharmacy was established, provided with all Dr. Mure's ingenious apparatus.

A library, containing all the homœopathic works necessary for the student, was formed.

The opening of this institute on November 20, 1839, was rendered peculiarly imposing by the presence of Hahnemann himself, and a long oration was pronounced by Dr. Jahr, which is reported in the *Bibl. Hom. de Géneve* for 1840, where also may be found numerous particulars relative to the impulse given to Homœopathy in France by Dr. Mure, the opposition he encountered, and the spirit with which he attacked his adversaries.

But this restless spirit yearned like Alexander for new world's to conquer; he desired to find some land where he might be the first to break the ground, and to convey blessings hitherto unknown to a race of men ignorant of the glorious doctrines of Hahnemann. He determined to cross the ocean and rear the standard of Homœopathy in the virgin soil of South America. Accordingly he sailed for Rio de Janeiro, and arrived there in 1840. The traces of Homœopathy in the Brazilian empire were but few before this time. In 1834, a Dr. Maya had published an article against Homœopathy. In 1837 a M. Jahn had presented a thesis on Homœopathy to the Faculty of Medicine of Rio, in which he related some cases of homœopathic treatment, but these were performed with massive doses of medicines in the crude state, and were not crowned with much success. Dr. Mure himself had before this time sent books and medicines to Brazil, but no one seems to have taken any notice of them. Shortly after his arrival in Rio he converted a young surgeon of considerable celebrity as a skilful operator, A. J. Souto de Amaral, who died two years afterwards without ever abandoning entirely allopathic procedures. He was shortly after his arrival despatched by the Brazilian Government to Ste. Catherine to found a phalansterian colony, for our hero is an ardent Fourierist, and a disciple of Swedenborg to boot. On his journey he treated many patients, and spread abroad a knowledge of the system. At Ste. Catherine he made a convert of Dr. T. de Silveira. At the end of March, 1841, we find him again at Rio, where he was joined by Dr. Lisboa, and he soon succeeded in converting a number of allopathic physicians, and vigorously assailed the old school by his publications and successful practice. He travelled about from place to place, creating wherever he went a homœopathic public, whom he left in charge of some medical man of whom he had made a convert. His custom, we believe, was, when he arrived in any new town, to address appeals to the priests, in the name of charity and Christianity, to assist him in the propagation of the system, and

by this means he made numerous converts among the clergy, whose influence with the laity served to spread a knowledge of Homœopathy in a very short time, and crowds speedily flocked to his gratuitous consultations.

His resources being speedily exhausted in these disinterested efforts to spread the cause, he found himself forced to settle down to remunerative practice, which he did in Rio in 1842. Towards the end of that year, with the assistance of Dr. Martins and Dr. Lisboa, he founded the Brazilian Institute, and opened the first dispensary in Rio. In July, 1844, the foundation of the homœopathic school was laid, and the course of study was opened in January, 1845.

On this wonderful story of the sacred fire I have only a few remarks to make. Mure's descent on Paris may seem to us a somewhat gratuitous piece of missioning; but those who have read the letters of Hahnemann, published in the *Homœopathic World*, in April last year, will realise that there was plenty of justification; if, indeed, anything more in this line was needed than the co-operation of Jahr and Hahnemann himself in the enterprise.

Another point worthy of notice is the fact that the Homœopathic Society, formed by Mure in Palermo, became a few years later "The Royal Homœopathic Academy," and that reminds me of our own Society. Now that the air is positively thick with Royal Charters, is there, I ask, any reason why our Society should not have what is surely its due, and become the "Royal" or the "Imperial" Homœopathic Society?

Yet another lesson may be drawn from this history. When a patient was cured by a homœopath in those days he did not fall down and worship the man who cured him; but he was at once on fire with enthusiasm for the *System* which had cured him. Gratitude to the doctor or doctors, no doubt, there was, but the greater glory was the glory of Homœopathy. It seems to me that nowadays things are somewhat reversed.

Finally—before leaving this inspiring topic—I should like to point out that the Homœopathy which cured Mure, and with which he worked most of his wonders, was the

Homœopathy of the *Organon*, the *Materia Medica Pura*, and the *Chronic Diseases*. We cannot go back to those times, or give up the hundreds of remedies which have been added to the materia medica since those days; but it is open to question whether we do not lose almost as much as we gain by these additions. When the symptom lists of the materia medica were in the compass of Hahnemann's own works, with a few additions, it was possible to know every remedy almost by heart. Now it is not possible, and a scrappy knowledge of many things has to do duty for a perfect knowledge of a few. The remedy for this state of things is to perfect the form of our materia medica and our repertories. Especially in the latter direction is the need great and pressing.

What, then, is Homœopathy that it should deserve and command such consuming enthusiasm as it has evoked?

Homœopathy is the exemplification in the sphere of drug-action of a grand natural law which lies at the root of all the philosophies. The law itself is wider, deeper and vaster than the part of it we know and use; but Hahnemann has seized it, and fixed it for ever in the realm of drug-action, and brought it into the region of practical affairs. Philosophies are very fine things indeed, and of the greatest value in clearing the minds of thinkers; but the philosopher who can make his philosophy *work*, and, above all, who can enable all who will to work it equally with himself—he is indeed among the heroes and demi-gods of the race. Such is Hahnemann. The law of "Likes to Likes" may be developed infinitely in many directions, affording work for philosophers for ages to come; but that is not our concern. Our business is to *do*, and in the sphere of our action there is scope for all the enthusiasm and all the effort that any one lifetime can manifest. For us "Likes to Likes" means, as it meant to Hahnemann—healing the sick. By the clearness of his vision of the law of Likes in the realm of drug-action, by the amazing industry and masterly skill with which he spelled out for us the language of drugs and the language of morbid action, enabling us to

interpret either into the terms of the other, he has secured for ever the liberty of all those medical men who have the will to be free. We are no longer the slaves of authority—we can go direct to Nature and interrogate her direct for ourselves. There is no high priest of medical science, there is no church, there is no academy, which we are bound to ask to do the interpreting for us. Hahnemann has abolished all that ceremony, and has given liberty to the medical world.

True, the medical world does not like liberty over much. The "helots" of medical science prefer their chains to the alternative of having to do their thinking for themselves. Thinking is still the *summum malum* of the average medical man; and herein lies the strength of the academies in their efforts to strangle Homœopathy. They may spare themselves this trouble. Evolution is on their track, and if they do not move onward and cast off their chains in time, it will crush them and their chains together.

Homœopaths are sometimes aghast when they contemplate the numbers of the opposition. They forget that in some things numbers do not count; and when the numbers are opposing a natural law, and the few have the law on their side, the few are the strong, and the many are the weak, no matter how large their majority may be. When there was but one homœopath in existence, Hahnemann himself, even then Homœopathy was stronger than the entire world of medical obscurantism arrayed against it. Why, then, should homœopaths of the present day, with thousands of duly qualified adherents, and millions of lay supporters, harbour any doubt as to our ultimate victory? I can understand homœopaths being modest about their own powers, though I have no particular admiration for the Uriah Heep tone either in homœopaths or in any one else. But I cannot understand any homœopath adopting humble and apologetic views of Homœopathy. As well might it be possible for the astronomer to apologise for the meanness of the universe and its myriad globes of light; or the botanist to be humble about the wonders of the world of vegetation, as for the homœopath to be apologetic in regard

to Homœopathy. We may not all be Mures, but we must all be touched with the fire of the enthusiasm of Homœopathy if we are to worthily fill the position of trust we have accepted in joining its ranks.

It may be well to distinguish a little between Hahnemann and Homœopathy. It will be noticed that it is the enthusiasm of *Homœopathy* that is the gospel I am preaching, and not the worship of its discoverer. In my admiration of Hahnemann, and in my gratitude to him, I yield to no man; but Homœopathy is greater than Hahnemann: Hahnemann discovered and revealed its laws, but he did not make its laws, and it existed in the nature of things before he or our world was born.

Hahnemann asked for the world's criticism, and for ours; and there is only one criticism we can make: "Do it after me," he said, "only, do it right." It is by *doing*, only, that we can effectively criticise Hahnemann. The criticism that is to try his work is the criterion of our practice. Neither Hahnemann nor any other man is above that; and it is not in accepting his words as inspired utterances that we do him most honour, it is by putting them to the test of practice and confirming, enlarging, or disproving them.

The worship of Hahnemann is not the religion of this Society, but the enthusiasm of Homœopathy is; and the more complete our devotion, the more fiery our zeal, the greater is the glory we render to our leader and benefactor. Individual members of this Society may have many religions. For aught I know, there is no bar to our membership in Judaism, Catholicism, Protestantism, Agnosticism, Buddhism, Confucianism, or any other religious profession. But the Society has a religion of its own—the Enthusiasm of Homœopathy. It is this which has moved the Society to deeds in the past, and it is this which must carry us on to conquest in the future. The same fire which urged Mure to his great work moved this Society to produce Dudgeon's translations of Hahnemann's *Organon*, and his *Materia Medica Pura*. The same fire moved Hughes to design and complete his grand work, the "Cyclopædia of Drug Patho-

genesy." The same motive has fashioned and put into shape a clinical reportory to the great treasures of our library, for which Drs. Dudgeon, Epps, and Burford are, I believe, chiefly responsible. The sacred fire is not exhausted by these efforts; it is only beginning to blaze; and with due direction will produce yet greater results in the future.

The isolation of our body has thrown upon this Society work which is not absolutely proper to it, and on this account its monthly meetings have been distributed among sectional subjects which have left to Homœopathy proper—for materia medica *is* Homœopathy—only three evenings in the session. I am not sure that it would not have been better to have provided one or more subsidiary societies for the work of the other sections, for it is plain that if it takes the Society four years to compass a dozen materia medica evenings the enthusiasm of Homœopathy can hardly have adequate vent in its public gatherings. At our next annual meeting, I believe, proposals are to be brought forward which it is hoped may meet this defect in a measure; but, in the meantime, I would point out that Homœopathy enters into every field of our operations, and I would suggest that the readers of papers—whether in surgery, gynæcology, or pathology—should endeavour to keep the subject of materia medica well in view, so that every night of the session should be a Homœopathy night, no matter to what section the subject of the paper may belong.

I have noticed with pleasure of late years a very markedly increased interest in materia medica in our Society, and this has been signalised by the large attendances and keen discussions which materia medica evenings have always commanded. I have been told that it has been more difficult to secure papers for the materia medica evenings of the Society than for the others. This I can hardly understand; for a little Society of about a dozen members, established for materia medica subjects alone, has found no difficulty in providing two papers a month during the session, and its members last session provided papers for at least four evenings for this

Society into the bargain. I trust, then, that however active this Society may be during the coming session in other branches of its work, the Enthusiasm of Homœopathy may compel adequate attention to the subject of drug-action.

There are two other matters to which I should like to allude before I conclude, and one is the position which this Society ought to occupy in relation to the homœopathic public; and the other is the attitude our Society ought to assume towards the Allopathic Sect.

I will take these subjects in the order in which I have named them.

What, I should like to ask, does the British homœopathic public know about the British Homœopathic Society? Very little I fear. Why is that? The reason, I shall be probably told, is that our Society is by its very nature an exclusively professional society. This is so; but it is so because professional intercourse is in its way just as important for the advance of homœopathic interests as is popular combination and support. Now, homœopathic interests are the interests of the public when we come to analyse them; and it is in every way desirable that our Society should command the interest of the public in its proceedings, in the same way that the Royal Society commands the interests of the British public in its doings, as being composed of its expert representatives in the world of science. On the other hand, our Society should extend a sympathetic interest to all lay societies working for the common cause. I am not forgetting that the British Homœopathic Association is a child of this Society, but I think that the Society itself might in some way recognise its relation and duty to the homœopathic public by some public annual function analogous to the annual soirée of the Royal Society.

And now about the allopaths. What is the duty of this Society towards them? My reply to that query is that we ought to leave them severely alone. Individually, allopaths are, no doubt, jolly good fellows, like the rest of us; but the allopathic body as such claims no allegiance and no respect from us. The profession is one thing, the allopathic sect is another. We are as much "the profession" as they, and

are just as much entitled to make our own rules as they, and just as little entitled to impose rules of our making on them as they are to impose their rules on us.

Our business is to go on our own way absolutely regardless of anything they may think, or do, or say—to treat them, in short, in exactly the same way as they treat us. If they presume to talk to us about manners, or ethics, or etiquette, we can reply that when their representative journals and societies freely welcome our communications we will listen to anything they have to say about manners—but not before. We will not promise, even then, to accept their suggestions; but until they alter their own behaviour towards us, they are simply out of court.

As to what they may say about our practice—there, again, they are quite out of court. There have been members of our Society who have thought it necessary to apologise to allopaths for using some of the remedies we use, such, for instance, as lachesis and psorinum. Others have apologised for using high potencies, and have sought to justify themselves by the discoveries of chemists and physicists of the powers of infinitesimal quantities. Now, this is all wrong. Homœopaths owe no allegience to allopaths. Homœopathy is established science. Allopathy is established nescience. The sight of Homœopathy paying court to allopathy; of homœopaths paying court to allopaths, is to me sickening in the extreme. It is light paying court to darkness; truth paying court to error; virtue paying court to vice. One blast of the enthusiasm of Homœopathy should be enough to cremate such infamy from our midst.

Fellow Homœopathists of this Society, I have done. Open your hearts to the sacred fire. Do nothing to quench it, but everything to feed it, and let the session which now opens become an epoch in our history and in the history of Homœopathy in our land. That it may be such is my wish and hope, and whatever there is in me to help you to make it such is entirely and cordially at your service.

ADDENDUM.

Here, gentlemen, originally closed my address, written, as it was, before my recent visit to America. But I cannot

allow the epoch-making events of the late International Homœopathic Congress to pass without reference in an address on the Enthusiasm of Homœopathy, although, by so doing, I may run the risk of appearing to forestall the reports of your own chosen delegates to that Congress. In those historic six days at Atlantic City, including the 10th to the 15th of September, the gathering under President James H. McClelland achieved a very triumph of the Enthusiasm of Homœopathy. We who witnessed it, who shared in it, who wondered at the victory it has gained, at the unassailable position it has won in the new world, bring back the story for your emulation. A profound confidence in the immutable Law of Similars, a burning zeal to make the right prevail, to advance the welfare of mankind, a single eye to the interests of our science, and a lofty scorn for all base truckling to the allopathic faction—these are the forces with which our Transatlantic cousins have won their victories; these are the forces which will carry them and us on to complete triumph. Gentlemen of the British Homœopathic Society, I bring you the New World's greetings. As true as two and two make four we can win if we will. America has shown us how it can be done—shall we—*can* we—hesitate to follow?

ON THE THEORY OF THE PRACTICE OF MEDICINE.[1]

A PRESIDENTIAL ADDRESS DELIVERED BEFORE THE LIVERPOOL BRANCH, BRITISH HOMŒOPATHIC SOCIETY.

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

BEFORE entering upon my subject proper, allow me in a few words to express my sense of the honour which you have conferred on me in electing me to fill the responsible post of President of this Society. It has been, as you will all readily appreciate, a matter of very considerable thought and anxiety to me that I should have to meet you here

[1] Read October 11, 1906.

to-night charged with the onerous duty of delivering the Presidential Address. But difficult though this undertaking has proved to be, I am fain to confess that my anxieties have not been therein exhausted, and that the task of suitably discharging the duties of the chair from month to month bulks equally formidably upon my present mental horizon. I would, therefore, claim your indulgence not alone in respect to the duty which falls to my lot to-night, but also in regard to the conduct of our subsequent meetings; in this latter connection I would confidently appeal to you for assistance in upholding the welfare of the Society and in maintaining the standard of merit which has, in past years, characterised its work.

The care of the sick, and the restoration to health of suffering mankind, are essentially practical matters, constituting the art of medicine. But the practice of this art cannot be dissociated from the more theoretical problems which diseases afford both in themselves and through their reactions to the treatment adopted. We find, therefore, that a theory of the practice of physic becomes a necessary factor, not only in the training of the aspirant to medicine, but also in the life work of the practising physician. In old school circles this theoretical department of medicine has been more fruitful in demonstrating the nature and the life-histories of diseases than in evolving a principle or principles with which to regulate our treatment of them. It cannot, of course, be doubted that the increased knowledge of diseases thus gained has, in some instances, afforded signal help in regard to their preventive treatment. The following passage, taken from a recent work entitled "Principia Therapeutica" (Harrington Sainsbury), puts the case from the allopathic point of view so forcibly and so well, that I cannot refrain from quoting *in extenso:* "The study of pathology should have a very distinct bearing upon treatment. Investigation into the progress of disease taken back to its very beginnings, brings us to health and therewith to a recognition of the first departure from health, and, presumably, to the cause of this departure. Knowledge of the cause should teach the argument by which we may hope to prevail against and anticipate the first false

step. . . . Consider that, in the long chain of cause and effect, which stretches from the present back into the past, each link in the chain is at one and the same moment the consequence (symptom) of the links which have preceded, and the antecedent (cause) of the links which follow. Thus the ague fit follows upon the microbic invasion; the microbe stands in some causal relation to the mosquito; the mosquito to the marsh; now the marsh depends upon certain telluric conditions; these in their persistence have been permitted through agricultural ignorance or indifference; behind these have lain an unsound system of economics, the folly of the schools, a moral decadence, certain racial characteristics . . . thus and thus backwards, in never-ending sequence to the birth of matter and the origin of sin. But if disease owns such a parentage, by what name shall we call the physician who waits for the sign of the malarial paroxysm when he might have dealt with the microbic invasion. It will be less harsh only than that which we shall bestow upon the man of science who refuses to treat the pyrexia because he cannot get at the miasm. As usual, pride rides for a fall, for whilst the physician who with humility treats a symptom finds that therein he has treated a cause, the man of science who contemptuously passes the symptom by in search of the cause discovers that he is ever confronted by a symptom. One rule, and one rule only, must govern our treatment of every form of disease—it is that we should reach back as far as possible in the morbid sequence and there interrupt it." One other quotation, this time from the prologue of the same book, deserves mention: "If it be true, as Plato, the master thinker, says, that an unexamined life is not worth living, then it must follow, since the greater includes the less, that an unexamined practice is not worth practising. It is for this reason, and because we are in danger of being engulfed in the ever-rising flood of new remedies, that I have ventured to set down certain considerations, in the hope that they may prove of service to those who have undertaken to navigate the ship of health. There are those who make light of general principles, knowledge of detail being their sole demand, but this

point of view sees one side only of the shield, be it silver or gold, as it shall please them; and whilst general principles without details make but a foolish business, it is no less true that details without guiding principles yield but a busy foolishness."

I have given these two extracts, as I believe they represent the case from the point of view of an enlightened allopath, in such a way as would command the assent of the allopathic profession generally. I have already admitted that the advances made in the knowledge of diseases have led to some considerable—I cannot say correspondingly great—improvements in regard to their preventive treatment, but I do not consider that the same can be said in regard to the medicinal treatment of diseases. It is one thing to trace, as Sainsbury suggests, the disease processes back to their very origin, but it is another, and a much more difficult thing, to learn "the argument by which we may hope to prevail against and anticipate the first false step." *Tolle causam* has ever been the cry, but it becomes, if anything, more difficult of fulfilment the farther back you trace the disease, and the more intimately you find it associated with the mysterious processes which go on in the interior of the cells and fluids of the body.

Turning to our own school, we find that homœopaths have also a theory of the practice of physic, but in this instance the special department in which progress has been made is not that which has to do with the nature and life-histories of diseases, but that of treatment and the principle underlying treatment. We go so far as to maintain that in Homœopathy resides the secret of scientific therapeutics, that, as Dunham long ago pointed out, Homœopathy is indeed the science of therapeutics. *Scio* and not *credo* is, as was pointed out at the recent quinquennial congress, the homœopaths' birthright and possession. It must, however, always be remembered that Homœopathy began as a practical proposition, and that it still remains a practical proposition, though there has grown up around the practice of it a mass of theoretical considerations and beliefs, many of which are of the greatest possible service in the conduct

of it. It is this admixture, if I may so term it, of theoretical considerations with the practice of the art that incidentally gives rise to the very varying expositions of Homœopathy which are current amongst us. The high dilutionist and the low dilutionist both profess the same law of cure, yet their actual methods of practice are very different, largely, if not entirely, owing to the radically different theoretical conceptions which each entertains—in other words, the closest possible relation subsists between each exponent's practice of the art, and his grasp of the science or underlying principles of it. During the course of the past few sessions, I have from time to time had the pleasure of bringing before your notice papers dealing with the principles of Homœopathy as viewed through my spectacles. As already remarked, the personal equation plays a very important part in the consideration of the science as well as in the conduct of the art. I was fortunate, as I think, in being first initiated into Homœopathy through what I may term the portals of the science rather than by the more devious route, which novitiates who enter experimentally have to traverse. It is said that a good beginning is half the battle, and I am firmly convinced of this, that the truth of this adage is nowhere more forcibly exampled than it is in regard to Homœopathy. It is to my mind a great misfortune that so many of the adherents to Homœopathy enter on the study of the art without a due appreciation of the science of it. When we consider the difficulties which we, after many years' experience in Homœopathy, still have to contend with, can we wonder that beginners in it, who are but feebly furnished with a knowledge of the root principles of it, should feel themselves handicapped in their endeavours to initiate themselves experimentally. This disability, under which Homœopathy in this country languishes, will only be dispelled at such time when we shall have attained to the status which shall entitle us to petition for, and to obtain —though this latter step is likely to be most difficult of realisation—a Royal Charter conveying to us the right to found a college and university wherein the theory of the practice of physic may be taught *more Hahnemanne*. In

passing, it may be pertinent to remark that Dr. Dyce Brown's compilation of Homœopathy amongst the allopaths shows very vividly the necessity there is for a clear and explicit statement of the general principles of Homœopathy, because we must remember that allopaths can generally explain away the homœopathicity of the drug actions therein referred to, and though on the principle of the summation of stimuli such an aggregation as Dr. Dyce Brown has gathered together may cause some searching of heart, there is little doubt that a companion brochure, emphasising and elaborating the root principles of the science, would assist in convincing many men of the superior merits of Homœopathy. Such a treatise has already seen the light of day in the masterly sketch which Dr. Burford, in his presidential address to the British Homœopathic Society, gave of the origin and the scope of our therapeutic law, *similia similibus curantur*. I believe that if this work were issued broadcast amongst the medical profession of this country, it would be the means of bringing many to investigate and acknowledge the claims of Homœopathy. Seeing, therefore, that I base so high a value upon the correct appreciation of the theoretic side of Homœopathy, you will perhaps bear with me if I devote some part of my time to-night to an exposition of it.

When Hahnemann was engaged in the task of translating Cullen's "Materia Medica," he noticed that the symptoms therein given as produced by Peruvian bark bore a remarkable resemblance to the symptoms of ague, for which he knew that drug was almost a specific. So struck was he by this apparent incongruity of a drug curing a condition to which it could itself give rise, that he determined to verify upon himself the symptoms given as produced by the drug, and as a result of his experiment he found that this similarity between the drug effects of Peruvian bark and the symptoms of ague actually did subsist. This fact in its turn suggested in Hahnemann's mind the idea that in this very similarity might be found the reason for the drug's successful applications, and prompted by this thought, he entered upon a

course of experiment and research which ended in the promulgation of his law of cure, *similia similibus curantur*. In the beginning this generalisation was pretty much a leap in the dark; it was what in the language of the logician would be termed the inductive hazard, by which the gap subsisting between the particular and the general can only be bridged over. But first and last, it was conceived and strengthened by methods of reasoning and of observation which conform to all the demands which logic, not only of Hahnemann's but of later days, makes. In Hibben's work upon inductive logic, I find that the only three legitimate modes of inductive inference which are nowadays recognised, are (1) the method of enumeration; (2) the method of comparison or analogy, and (3) the method of scientific analysis or search after causal connection.

The method of enumeration, which Hibben says consists in noting to what extent the individual instances of like nature accumulate, the mere number of instances producing a certain psychological impression and creating, through the laws of association, the expectation of a continuous repetition of the experience in question, was laid under contribution by Hahnemann. Having satisfied himself upon the cinchona instance, he immediately set himself to search the records of past medical lore to find out if this similarity there obtained, and this he was successful in establishing in very many instances. In the appendix to the *Organon* you will find a tabulated list of instances which Hahnemann unearthed from allopathic sources in applying this enumeration method. This list, though it does not constitute a conclusive proof of the veracity of Hahnemann's inductive inference, certainly does form a very strong corroborative testimony in its favour.

This enumerative method was not relied upon solely by Hahnemann; he also employed the second method, that of analogy. In sections 34-47, *Organon*, Hahnemann discusses the operations which we find occurring in Nature, when on the one hand two dissimilar, and on the other hand two similar diseases meet in one body; and he shows through instances culled from allopathic sources that in the case

of dissimilar diseases the result is that the stronger suspends the weaker, or that the two join forces and so make up a complex disease, whereas in the case of the similar diseases, they neither repel one another nor suspend one another, so that the old one shall return after the new one has run its course, and that just as little can they exist beside each other in the same organism, or together form a double complex disease. I do not want to labour this point or to affirm that the entire list of instances with which Hahnemann supports his contention will bear critical inspection, but I do think it worthy of notice as illustrating Hahnemann's sagacity and logical acumen in thus availing himself of what is logically speaking a very sound method of inductive inference, viz., the method of analogy. The final stand of the truth of an inductive inference must, in the end, depend upon its satisfying the third method, that of scientific analysis, or the search after causal connection. This matter of causation is much too abstruse and complicated a one to allow of its consideration in an abstract way, but regarded practically and in connection with the inductive inference which Hahnemann made, I need only say this, that the methods which Hahnemann adopted are the very ones of which causal analysis, according to logicians, must be mediated. Hibben, referring to causal analysis, says: "This is effected by observation and experiment—observation is something more than mere looking at phenomena; it means concentration of attention for the purpose of research; it means discriminating insight, an appreciation of likeness and difference; it means a penetration beneath surface appearances and an apprehension of the essential features of the objects of perception. Experiment consists in modifying the elements which form the complex antecedents in order to observe the resultant effect upon the corresponding consequent. Herschel speaks of observation and experiment as passive and active observation."

This passage might, I think, very well be said to be descriptive of Hahnemann's genius, which laboured through very many years of painful observation and experiment to establish the truth of the causal connection contained in *similia similibus curantur*. Given that it were true that

cinchona cured ague by virtue of the similarity of their symptoms, then a knowledge of the pure effects of other drugs would indicate the diseases in which they too would be serviceable and by means of this knowledge the induction could be tested as to its invariability. This argument led, as you are aware, to Hahnemann's self-sacrificing labours as a prover, and the results of these labours when applied to subsequent clinical experiences afforded ample confirmatory evidence in favour of the inductive inference, *similia similibus curantur*. In this way Hahnemann's method conformed to that other requisite of inductive science in that it afforded the opportunity of deductive verification as well as of scientific prediction, which, in the case of the medical art, is equally, if not more, important. I need scarcely remind you of the classical instance of this latter faculty which occurred in Hahnemann's time, and through his instrumentality. The scourge of cholera, until then an unknown disease, made its appearance in Eastern Europe, having gradually spread thither from Asiatic sources. The mortality attending this new disease was such as to render it a matter of concern and notoriety far ahead of its actual incidence, and in this way Hahnemann, in common with other Germans, became acquainted with the classical symptomatology of the complaint long before he had the opportunity of actually seeing a case. Yet for this hitherto unknown ailment Hahnemann was able by virtue of his inductive inference to indicate not merely the general line of treatment, but the actual and specific remedies calculated to do service according to the predominating phase which attended individual cases. Of the success attending this prediction, the experience, not alone in that epidemic, but in numerous later epidemics, has furnished ample confirmatory evidence.

We have seen thus far that Hahnemann's methods were in strict accordance with the requirements of present-day logic and science. We have now to consider another element with which the fortunes of Homœopathy are intimately associated. I refer to the explanatory theories which the evolution of this therapeutic law gradually but

true that with us the final step of our procedure lies in the choice of a remedy which shall contain the greatest number of symptoms similar to those found in the observed condition, but this is a much more difficult matter—and one less deserving of scornful epithet—than the corresponding allopathic procedure which ultimates in a prescription containing, perhaps, three or four remedies, each one of which is supposed to direct its energies towards one particular organ or symptom. As a matter of fact, the practice of medicine *more Hahnemanne* is a more difficult undertaking than it is under any other auspices, and that, too, in spite of the fact that the homœopathic system affords us certain advantages of which others are ignorant. The method of provings which is peculiar to Homœopathy has so enlarged the bounds of our knowledge of medicinal properties that we are enabled, thanks to the law, to utilise as indications for treatment, signs and symptoms, which to allopaths are utterly useless. Chief amongst those I would place the mental and the moral symptoms of the patients. The homœopath accustomed, as he is, by his study of the materia medica to note the far-reaching effects which drugs can produce on man's innermost nature, is prompt to notice and to utilise similar perturbations which may be met with in natural diseases. Again, in the pathogenesis of various drugs there is contained a picture in which the temperament and the diathesis of the drug stand prominently out, and these pictures we find reproduced in our various patients, so that we come to realise, often before our patients have started to tell us their complaints, what drug it is which will suit them. In spite, however, of these adjuvants to practice, the work of a homœopathic practitioner is no easy one; his vocation is, as Hahnemann puts it, in the preface to the *Organon*, one in which indolence, love of ease and obstinacy, preclude effective service, which can only be rendered by untiring zeal and entire freedom from prejudice. Furnished with these requisites the practice of Homœopathy becomes gradually more and more satisfying and successful.

THE CURABILITY OF PHTHISIS IN THE LIGHT OF MODERN RESEARCH.[1]

BY W. THEOPHILUS ORD, M.R.C.S.ENG., L.R.C.P.LOND.
Physician to the Hahnemann Convalescent Home and Dispensaries, Bournemouth.

MR. PRESIDENT AND GENTLEMEN,—Some two years ago I had the privilege of reading a paper before this Society on the treatment of phthisis pulmonalis, especially in its later stages. I then recommended to your notice a little known and used drug, namely, the iodide of tin. Since then our hopes in the future cure of consumption have been raised by the rise and development of the opsonic treatment of bacterial diseases by Professor Wright. Success has already attended this discovery, and since it advances on undoubtedly homœopathic lines, we may shortly expect to see the new method of treating these diseases established on a permanent basis.

Especially interested, as I am in the study and treatment of phthisis, this has seemed a good opportunity to consider our position as homœopaths in the light of modern research, as affecting that disease. I propose to-night to (1) briefly examine our present homœopathic treatment of consumption, in view of the introduction of opsonic injections for tuberculosis; (2) to enquire what place in our methods the new vaccine treatment may be expected to take; (3) to consider what—if any—deficiencies in homœopathic medication it may supply; and, lastly (4) to suggest special points in phthisis pulmonalis which call for attention from those who are experimenting in opsonic investigations.

THE IMPORTANCE OF TREATING THE DIATHESIS IN TUBERCULOUS FAMILIES.

It has always been agreed that to be successful, treatment in phthisis pulmonalis depends upon early diagnosis.

[1] Presented to the Section of Gene Medicine and Pathology, November 1, 1906.

We admit this in Homœopathy of course, and we can, I think, go a step farther than our old school colleagues, and say—by a pardonable Irishism—that phthisis is most easily cured before it has begun. By which I mean, that in the pretubercular stage, before definite lesions can be discovered in the lung, homœopathic treatment is of the very greatest value, and that no other medicinal method can approach it in importance in diathetic treatment. Every general practitioner who is guided by the law of similars in the selection of his remedies, especially those familiar with out-patient and dispensary practice, can recall families of tuberculous individuals who exhibit every tendency to phthisis. And yet by steady and persistent homœopathic treatment, members of such families have thrown off their weaknesses gradually, the diathesis seems to change, signs of tubercular tendencies have each year become fewer amongst them, until many have grown up healthy men and women, showing no evidence of chest delicacy. On the contrary, members of the same families who have not had such treatment, or have frequented only institutions where the methods we value are despised, have readily succumbed to some form of tubercular trouble, especially phthisis pulmonalis. The starting in life for themselves and leaving the parental roof seems to be an especially dangerous time for such persons. It is then important to frequently examine members of such families, and to urge a course of anti-tubercular treatment in all weakly cases.

The high value of homœopathic treatment in the tubercular diathesis as a preventive of phthisis being acknowledged, we may enquire whether modern developments in medicine offer any prospects of constitutional treatment superior to those we are accustomed to rely upon. Until recently we should have answered this query by a negative. But now those of us who have followed Professor Wright's experiments begin to enquire whether opsonic treatment may not have an important sphere of usefulness in raising the opsonic index of certain cases, and so increasing their powers of resistance to the tubercle bacillus. There is, as yet, some doubt as to the ratio of the opsonic index to the normal in

tubercular conditions. It has been even stated that the index in developed phthisis is higher than the normal.[1] In local tubercular infection Professor Wright gives the opsonic power as being permanently low, and that it does not vary. I shall be glad to hear if any facts have been ascertained regarding the opsonic index in individuals of marked tubercular diathesis, before any deposits have been detected. Presumably their powers of resistance must be low, otherwise they would not so readily become infected. If this view proves correct, a time may come when the children of phthisical parents may be required to undergo a course of inoculations to bring their opsonic power to the normal. What an incalculable boon it would be to the human race could phthisis be guarded against as certainly and effectively as vaccination provides against small-pox, I need not point out. It has long been recognised that, although tubercular lesions are not transmitted from mother to offspring, the diathesis is hereditary. Preventive treatment which raised the equation of resistance to the tubercle bacillus, whether by Wright's opsonic method or other means, is, surely, what all investigators should aim at. For, were all tainted children successfully subjected to this, in a generation or two tubercle would almost vanish, and consumption become as rare as small-pox.

So far as our present knowledge goes, especially with regard to Wright's discoveries, we have yet to learn, not only its immediate value in diathetic treatment, but how long the effects of such treatment last. Are the powers of resistance permanently raised by a course of injections, or is the effect merely transient? As to the immediate benefits conferred by opsonic injections, thanks to the successful labours of our colleagues and others, we have ample evidence. Tubercular deposits in skin, bones, glands, and other localised infections, readily yield to the new treatment. From a continuance of the experiments now being conducted in this Hospital I look for an answer to our doubts as to the permanency of preventive opsonic treatment in the children of phthisical patients.

[1] *British Medical Journal*, 1905, ii., p 1617.

Should, however, our good hopes of the new method be doomed to disappointment, we, as homœopaths, need not be discouraged. The permanent effects of preventive homœopathic treatment can still be relied upon, and I trust that in future we shall be more successful in inducing the parents of such children to submit them to it in all suitable cases, without waiting until tubercular deposits become developed. It is difficult to get parents to do so; they seldom realise the important issue at stake. Perhaps, too, we may have been to blame in advocating too frequent repetition of the medicine. In these cases I find several daily doses quite unnecessary. One tablet or powder of the indicated drug at bedtime, or even twice a week, is ample. Some would say that once a week, or even once in two weeks, is more in accordance with Hahnemann's teaching and also with modern opsonic experience. By less frequent dosage the negative phase is avoided, and medicinal aggravation does not occur. Indeed, if the facts of negative and positive phases in opsonic reaction prove to be true generally of drug-action, the question will arise as to whether our usual methods of administering the homœopathic remedy may not sometimes prove the reverse of curative through too frequent or ill-timed dosing.

Those cases in which homœopathic medication has failed to do good, or at least to raise the opsonic index, will certainly prove suitable for Wright's treatment, whether actual tubercle has developed or not. And here an important point presents itself. What effect will opsonic injections (if successful) have upon subsequent homœopathic treatment? Is it not possible that after a course of injections, when the patient's index is raised, our remedies may act better, and even prove successful where they had previously failed? This hope has been raised in my mind by the following case. Two little boys, who have been under my care for tubercle of glands, subcutaneous tissue and bones, on and off for years, were recently submitted to opsonic injections through the kindness of our colleague, Dr. Watkins. The result was most successful; in a few weeks the ulcers had healed, and generally rapid improve-

ment set in. After several months the younger boy was brought to me with a new ulcer breaking out in his hand. I gave him calcarea carb., 6x, and in a fortnight it had healed again, and has remained so. Previously to opsonic treatment he had taken calc. carb. and many other remedies with little or no effect, but its action on this occasion was very decisive, and I think may have been due to a positive opsonic phase induced by the injections. There is, I think, nothing improbable in this idea. We know the teaching of our predecessors, that a few doses of sulphur in sluggish cases enhances the power of the organism to react to the indicated homœopathic remedy. If sulphur in high dilutions—when its ions are free to affect molecular movement in the body cells—can stimulate the drug-reacting power of the system, raising the opsonic index by Wright's method may, perhaps, have the same effect in stimulating reaction to our anti-tubercular remedies. In this connection we may recall the fact that in diphtheria the statistics presented to this Society by our colleague, Dr. Johnstone, some few years ago, showed that the best results were obtained by anti-diphtheritic serum combined with homœopathic medication. It would probably be correct to say that, after injection, reaction to specific drug treatment was stimulated in diphtheria, and it may be so in tuberculosis. These considerations, I think, lead us to expect that in early phthisis the best results will be obtained by opsonic injections at intervals, combined with continuous homœopathic treatment. I am hoping to test these ideas in my own practice, and shall be glad to hear if any others have done so. The labour and expense of ascertaining the opsonic index is at present the great difficulty in these methods. I hope that shortly a simpler test will be discovered.

Before leaving the subject of early phthisis, I should like to emphasise the importance of every aid to diagnosis which the advance of science offers us. The point as to whether tubercle has commenced in lung tissue is often impossible to decide by ordinary methods. Not only may the tubercular deposits be too small or ill-defined to detect,

or marked by an area of inflammatory consolidation, or by thickened pleura, so that little difference can be perceived in the percussion note. This also occurs when mischief begins deep in lung tissue. Where other symptoms of phthisis are present, I am inclined to lay little stress on the absence of dulness as a favourable sign. Cases have been known to turn out very badly when for some time no area of dulness could be detected, until indeed grave mischief had been done. It is now said that by X-ray examination of such cases, the affected areas can be discovered and mapped out. I have not yet been able to test this in practice, but so soon as suitable apparatus are available I hope to do so. If it is as successful as may be expected, in view of the importance of early diagnosis, examination by Röntgen Rays may prove a valuable aid in suspicious cases.

Another aid to diagnosis, thanks to Wright's methods of research, is the determination of the opsonic index in suspected tuberculosis. Where a series of measurements of the opsonic power of the blood reveal a persistently low tuberculo-opsonic equation, there is reason to believe that tubercle is somewhere present. But when a persistently normal opsonic power is found, the presence of tubercle is unlikely. When a constantly fluctuating opsonic index obtains, active tuberculosis is probably in progress.[1] Only a single examination may, in the light of other symptoms, be sufficient to determine a correct diagnosis in doubtful cases. These are the views now held by those who have accepted Professor Wright's teachings in their entirety. That in the opinion of some authorities they are not yet proven, I shall presently have occasion to point out. If, however, diagnosis from such evidence can be accepted as reliable, we shall soon, I think, have abundant proof of the fact.

Homœopathy in Early Phthisis.

In view of the facts we have been considering we are naturally confronted by this question: When a definite

[1] Wright and Reed, *Proc. Royal Society*, 1906, vol. lxxvii., p. 194.

lesion has been clearly diagnosed as tubercle in one or other lung, should we at once resort to opsonic testing and treatment, or shall we still be content with our well-tried homœopathic remedies? Let us for a moment consider our position. The methods we advocate have been employed by converts to Hahnemann's teaching for over a century. Our treatment of phthisis is the same as formerly, and very few remedies of importance have been added to the well-proved friends of Hahnemann's day. Surely this is the highest test that can be applied to any remedial measures—that the same drugs, and in the same forms and doses, and in accordance with the same principles, should cure the same disease with the same success as when first introduced a hundred years ago? With the possible exceptions of cinchona bark and mercury, neither of which are used in the same form, I am unaware of any old-school drugs that can stand this test in any disease. Whereas in phthisis there is no medicinal treatment in use now that was generally employed even fifty years ago. We can have no doubt as to the permanence of homœopathy; even under other names its principle is being more and more acknowledged in all schools of medicine. Whether opsonic treatment will stand such a test it is impossible to predict. At present we believe that it may prove a valuable aid to our homœopathic methods, and perhaps increase their effect, acting as it appears to in accordance with the same law of cure.

Bacillinum and Tuberculin in Phthisis.

It may be claimed by some of us that already homœopathy has anticipated the results of Wright's opsonic treatment in phthisis by the use of the nosode bacillinum, and of Koch's tuberculin in high dilutions. There seems to be some degree of truth in the suggestion. As you know, bacillinum, originated by Swan, in America, was first introduced here by the late Dr. Compton Burnett, and its use described in his book, "The Cure of Consumption by its own Virus." An admirable account of this drug is given in our president's valuable "Dictionary of Materia Medica." Many of us have had

experience of the remedy in our own practice, and probably our hopes of its proving curative in phthisis have not been justified. I would even say that in actual phthisis it has seldom much beneficial action, and its value falls below that of such drugs as iodide of arsenic or phosphorus. We must, however, in justice to its discoverer, remember that of all diseases pulmonary phthisis is one in which it is most difficult to correctly estimate the value of any medicine. Every new remedy for consumption—and in old-school practice their name is legion—is recommended by an impressive list of wonderfully cured cases. But however successful in its use the discoverer of a new remedy may have been, it is only when the drug has been tested by a large number of observers, who agree in their results, that after a time its true value is determined. Since the early days of homœopathy the only drugs which I can recall as having triumphantly withstood this test are the iodide of arsenic and iodine. In the later stages, judging from the encouraging reports received from colleagues, perhaps I may be forgiven for expressing the hope that the iodide of tin, stannum iodatum, will gradually obtain recognition as being of permanent value. But in applying these tests to bacillinum as a cure for phthisis, we find that it has not obtained general recognition amongst us. Experience has, however, proved it to have a distinct sphere of usefulness, not so much in phthisis as in the tubercular diathesis before phthisis has developed. More especially is it helpful in the early stages of tubercular disease of glands, joints, skin, and bones. In such cases it initiates healing processes, and appears to clear up obscure symptoms and conditions, acting in the manner which Hahnemann described as anti-psoric. By common consent its use has been limited to infrequent doses in high dilution, and so employed it is undoubtedly of value.

On almost identical lines has the homœopathic use of Koch's tuberculinum developed. After the melancholy collapse of this once vaunted "cure," the use of tuberculinum in old-school practice was quickly dropped, whilst it lingered out an attenuated existence as a means of diagnosis in veterinary work. As usual, it was left for the

despised homœopaths to map out the true medicinal use of this powerful poison, in accordance with the law of similars. The sphere of action and value of Koch's tuberculinum in practice has been found to be practically identical with that of the previously used and homœopathic bacillinum. Examination of the schema for both drugs in "Dr. Clarke's Dictionary of Materia Medica" will confirm this view. In describing tuberculinum the author states: "I do not find any appreciable difference between the action of tuberculinum and bacillinum. My own impression is that they are practically identical, and that one will answer to the indications of the other."[1] Most observers agree with this authority, and my own limited experience confirms it. No doubt these drugs owe their action to the same poison, namely, the virus contained in and excreted by the tubercle bacilli. It is this that causes the fever, night-sweats and hectic symptoms of early phthisis. We find, then, that this organic poison, when potentised according to Hahnemann's directions and used in accordance with the law of similars, whether as bacillinum or tuberculinum, is of value in precisely the same conditions and forms of tubercular infection that modern experiments show to limit the sphere of usefulness of the new tuberculin as used by Professor Wright. In fact, the new tuberculin is simply the old poison somewhat differently prepared, and owes its virtue to the same virus as the other two drugs. It is in the discovery of the tuberculo-opsonic index, by which the time for each dose of the potentised or attenuated virus can be scientifically ascertained that the great value of the new method appears to exist. Abundant evidence of the value of Wright's treatment has now accumulated, its chief successes being in tubercular disease of bones, ulceration of subcutaneous tissues, in enlarged glands before suppuration, and occasionally in lupus and early phthisis.

For years past many homœopaths have used bacillinum and tuberculinum with success in these same conditions, giving it in infrequent doses, occasionally intercurrently with other indicated remedies. It has been found that, as

[1] "Clarke's Dict. of Mat. Med.," vol. ii., part ii., p. 1461.

with the new vaccine treatment, where suppuration or symptoms of general systemic infection exist, these remedies fail. These points were clearly brought out at our late congress in June, by Dr. Watkins, in his paper on the "Vaccine Treatment of Infective Disease," together with the important fact that with a tuberculous lesion producing fever the patient is already receiving auto-inoculations of the virus, which render useless any further injections of the same poison as a remedial measure. Hence the futility of such attempts when hectic fever appears in phthisis; and the failure of bacillinum, tuberculin, and also Wright's opsonic treatment when systemic infection has so exhibited its presence.

It seems, then, that the value of opsonic treatment in phthisis, as at present advanced, will be limited to early cases without fever, somewhat as has been our use of bacillinum and tuberculinum. How far its power may exceed that of our older friends remains, I think, to be proved. In the careful testing of the tuberculo-opsonic index previous to each dose, and avoidance of dosing during the negative phase, the practical importance of treating a disease by its own virus is enormously increased. As to whether dosage by injection offers advantages over dosage *per ovum*, we hope presently to hear some evidence which will help us to decide the question. As homœopaths, it is important also for us to know whether the opsonic index is raised by the use of our ordinary drugs in phthisis when improvement is progressing. It has been stated that in ordinary open-air treatment for phthisis improvement continues without any raising of the opsonic index. This may be so, for we have yet to learn that phagocytosis in the presence of a high opsonic index is the only method of cure that Nature possesses in phthisis. It may be on quite another principle that homœopathic drugs, other than the nosodes, effect their cures, and this may be quite consistent with a continued low opsonic index. If that is so we should expect far better results after raising the index by Wright's or other methods. For the answers to these vital questions we must await the results of future experiments, which, I trust, will soon be available.

As to the tedious and difficult process of estimating the opsonic index, this, I hear, may possibly be simplified, or even omitted, according to a recent writer in the *Lancet*,[1] who states that by observation on different individuals the time required for the positive phase to develop may be discovered, and the need for estimating the index avoided. The whole subject of the opsonic index in phthisis, nevertheless, seems to be involved in some obscurity, for it was maintained less than a year ago in the *British Medical Journal*[2] that the blood in the majority of phthisical cases is of higher opsonic power than normal. This, I think, may be due to experiments tried on patients who have passed the early stages, and after hectic symptoms, and hence systemic infection, have occurred. Here, as we know, opsonic treatment is necessarily useless. It seems certain that in purely local tuberculosis, whether of the lungs or other parts, the opsonic index is permanently low, but that directly general infection occurs it becomes subject to violent and frequent fluctuations.

Besides the uses of Wright's opsonic treatment, which I have described, namely, in the pre-tubercular stage (as in the children of phthisical parents), and in the early stage of phthisis itself, we may, perhaps, hope for help from this method in another condition which often precedes consumption. There are cases in which pleurisy or pneumonia, and sometimes influenza, seem to leave patches of weakened lung tissue. In these the patients make a tardy and incomplete recovery, often with continued cough and chest pain, and tubercular infection is much to be dreaded. It seems to me that we might here get valued help by testing the tuberculo-opsonic index in such conditions and resorting to tubercular injections if indicated.

Vaccine Treatment in the Later Stages of Phthisis.

Nature proves herself capable of curing phthisis in every stage. We have all known apparently hopeless cases, in even the last stage, suddenly take a turn and recover, for

[1] *Lancet*, 1906, vol. i., p. 1099. [2] 1905, vol. ii., p. 1617.

no assignable reason that we can detect. Whether these cases are such as have a high opsonic index we do not yet know; I trust this important point may soon be cleared up. However, of this I am quite certain, and every year's experience increases my certainty, that under persistent homœopathic treatment many more advanced cases recover than of those left either without medicinal treatment, or with only such drugs as are commonly used by the other school. Also that in the most advanced cases, where cure is impossible, I have again and again seen undoubted reaction to the correctly chosen homœopathic remedy. The *vis medicatrix naturæ* is never completely exhausted whilst life continues, and will respond, perhaps feebly, to a homœopathic stimulus almost to the last. Do, then, the methods of modern research offer any hope of curing phthisis in the later stages? In approaching this question we must consider the cause of death in phthisis. Excluding accidental causes, such as hæmorrhage, pneumonia, &c., deaths from tuberculosis of the lungs, and indeed most other tubercular conditions, are due to streptococcus poisoning, combined with that of some other less known bacilli. It is said that one seventh of all deaths are due to this cause. Thus it is not the tubercle bacillus that causes death, but rather that by their destructive action on lung and other tissues, fields for breeding streptococci and other pyogenic germs are produced, and these alien germs poison the system with increasing virulence until death supervenes. I doubt very much if death from phthisis (excluding accidental causes) would ever occur did staphylococci not exist. If these germs, which are far more potent than the tubercle bacilli, could be eliminated, mere tubercular lesions are seldom sufficient to kill, for we all know how astonishingly little lung tissue a man can live with. If the body proves itself capable in certain advanced cases of ridding itself of the streptococcus infection, we may hope in time to discover by what means Nature accomplishes this. There is, I think, good reason for expecting that presently some serum or vaccine, very probably acting by opsonic power, may be found of value in such cases.

Modern investigation is advancing rapidly in this direction. As you know, an anti-streptococcus serum has been used for some time, which has proved of value in septicæmia, erysipelas, ulcerative endocarditis and carbuncle. Its action seems to be rather uncertain, and experiments with it in the pyrexia of phthisis have not hitherto been successful. But it seems to me that this is a step in the right direction. When the various toxic elements producing death in phthisis are better understood, it is surely possible that a compound serum or vaccine may be prepared that may prove antidotal to the poisons, and enable the recuperative powers of Nature to assert themselves. This will doubtless have to be employed in the stage of softening of lung tissue, when the tubercle deposits are degenerating and commencing to form cavities; when it may be hoped to enable the tissues to resist the efforts of streptococci to promote suppuration. The subject at present is of course in its infancy, but any day may throw light upon what is now obscure and discouraging.

In conclusion, I think the most important deduction from these various considerations for us, as homœopaths, is the importance of early constitutional treatment in the tubercular diathesis, and of early diagnosis and treatment in phthisis. In both these conditions let us expect and hope to obtain valued aid from the new opsonic methods of Professor Wright. We need not suppose that serum-therapy will ever supplant or indeed rival our well-proved and simpler homœopathic methods in general practice. But, inasmuch as the new ideas are based upon the same principles that have been upheld and utilised by us for a century past, we may believe that they have come to remain as valuable advances in our general knowledge of the treatment of disease. They have come, perhaps, to occupy a similar sphere in tuberculous and certain other diseases, in relation to homœopathic treatment, as that now occupied by anti-diphtheritic serum in some cases of diphtheria.

A SEQUEL TO THINGS NEW BUT OLD. (THE TREATMENT OF TUBERCULAR DISEASE.)[1]

BY CHARLES E. HAM, M.D.LOND.

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I HOPE you will all forgive me if anything I say this evening may appear rather unorthodox, but you must remember that I am a very young homœopath and, like a newly-hatched chicken, have in all probability a little of the old shell still adhering to me.

Homœopathy has won many a brilliant victory, and that, I think, is due to its successful treatment of chronic diseases. It is undoubtedly true that good homœopathic prescribing will relieve and benefit to a very large extent acute cases, *e.g.*, bryonia will, if indicated, marvellously relieve pleuritic pains. But acute cases will often get well of themselves providing care be taken with the nursing and diet, and were this not so the mortality in the allopathic hospitals would be considerable. But it is the chronic cases which drag on for months and perhaps years. Those who have sought the consolations of many physicians and then come as a last resort to a homœopathic doctor, experience the sterling worth of homœopathy. Patients, for example, with long histories of dyspepsia and allied troubles, are thorns in the flesh to many an allopath, but are quite the reverse, or should be so, to a homœopath, for with a properly-chosen remedy one may often be able to cure cases which have proved incurable in the hands of others. In many of such chronic cases there seems to be some constitutional element, or elements, which hinders recovery and which must be removed before any satisfactory results can be obtained. Hahnemann in his "Chronic Diseases" was most persistent on this point. He showed conclusively that many a well-chosen remedy often relieved a patient of certain conditions, but it never entirely removed those con-

[1] Presented to the Section of General Medicine and Pathology, November 1, 1906.

ditions. There was some psoric state, as he put it, in that patient, which had to be touched by some deep-acting remedy before actual cure could be effected. Perhaps I can make it clearer if I may be allowed to cite myself as an example. I used to suffer from early morning vomiting, a condition which, as you all know, is carefully described in text-books of medicine, and which is generally thought to be produced by a rather too free use of alcohol. These attacks were nearly always relieved by nux vomica, but they were never actually cured till sulphur had been administered. There must evidently have been some psoric element in me which had to be reached before the vomiting could be permanently cured. Under the category of such deep-acting remedies may be included a group of substances, known as the nosodes, and which have been largely used by the older school under the term "opsonins." Some homœopaths have frequently used these remedies with good results, and still better results might have been obtained had they been worked out more carefully.

It is especially with one of these substances, namely, tuberculinum, that I wish to deal this evening. The treatment of tubercle has interested me for some time, and, although my results may not be very original, they are, I think, of interest. The investigations have been carried out on homœopathic lines, but in addition the opsonic index has been determined whereby I have been able to control my results in the same way as Professor Wright and his pupils. This index has been of great value in determining the most suitable time for giving the dose of tuberculinum. So far as my experience goes, tuberculinum does not appear to be of much value in those cases where the disease is active; this, I think, is borne out clinically, and the results obtained by an examination of the opsonic index also point to the same conclusion.

In acute tuberculosis our efforts are far from gratifying, and this may be due to the fact that the cells of the body have lost so much of their vitality that they are unable to respond to well-selected remedies. The question of acute tuberculosis brings us to what I believe is a most important

line of treatment, and that is prevention. We have very little power over acute tuberculosis, but what we, as practitioners, should aim at, is to prevent cases becoming acute, or even to prevent actual tubercular disease beginning at all. It is very difficult to carry this out, as patients are often brought to us with the disease in an advanced stage. But I believe that much might be done to prevent a recurrence of the disease were we but to recognise those cases where there is the tendency to tubercle, although no tubercle may be actually present. This disease has spread enormously, one has but to look at the death statistics to be reminded of this fact, and surely something should and could be accomplished to diminish the enormous death rate.

There has been a great deal of controversy as to the hereditary nature of tubercle. Some eminent authorities have maintained that there is an hereditary tendency; others, again, arguing chiefly from pathological evidences, have denied the existence of such a tendency. Clinically, it seems almost certain that these later observers are wrong, and here, again, the careful determination of the opsonic index corroborates the clinical evidence.

I have now examined the blood of the children of several families where a distinct history of tuberculosis had been obtained. Many of the children had an opsonic index below the normal, which points to the very important fact that such children, although they may not have actual tubercular disease, are very liable to contract the disease as their resisting power is deficient. Hence, if such in their struggle for existence get run down they may very easily become tubercular. It is at this stage, the stage when there is only this tendency, that tuberculosis should be attacked. The best line of treatment in these cases is to give tuberculinum in small doses, and under this treatment a visible improvement has been effected, and the opsonic index raised. This diminished resistance to tubercle is likewise found in nearly all infants up to one year old, which, again, shows the care that should be taken in the rearing of very young children, as at that age they are especially vulnerable.

It is quite possible, and indeed very probable, that their resisting power is also diminished by other organisms, but this, so far, I have not investigated. It is not quite certain how the existing power of the blood of these infants is raised, though it seems very likely that the necessary opsonins may come through the mother's milk.

Taking all these facts into consideration, it may be definitely stated that tubercular disease might in many cases be prevented by a careful administration of tuberculinum; and Burnett was not far wrong when he gave bacillinum to those who had a definite family history of consumption.

The next question for discussion is, What are the best lines of treatment to be employed when tubercular mischief has actually started? The patient should first of all be placed in suitable surroundings, where plenty of fresh air, sunlight, and good food can be procured. But these are not always available, and even if they were, they might be greatly aided by the suitable administration of medicines, one of the most valuable being tuberculinum, which was employed many years ago by Swan and Burnett.

It will be convenient, for the sake of clearness, to discuss the treatment of chronic tubercular disease under the following heads:—

(*a*) The preparation employed.
(*b*) The method of administration.
(*c*) The dose.
(*d*) The results of treatment.

(*a*) *The Preparation.*

There are several preparations employed homœopathically. Burnett's bacillinum, the tuberculinum, and, lastly, Koch's new tuberculinum. The preparation chiefly used in these investigations is the potentisation of Koch's new tuberculinum. The tubercle bacilli are killed by heat, and thoroughly rubbed up and potentised. This I prefer to the tuberculinum usually employed by homœopaths, which is made from the bouillon on which the organism has been growing, as the toxicity of this preparation is very uncertain. On the other hand, although bacillinum contains the bacillus

itself, it is mixed with other organisms, and is, therefore, not so suitable for scientific investigations. It is better to use a single substance and to know definitely the substance employed.

(*b*) *The Method of Administration.*

Tuberculinum may enter the system by three ways, namely, through the mouth, rectum, or by injecting it into the subcutaneous tissue. The best and most natural way would undoubtedly be by the mouth, and this is how it is generally given by homœopaths. The method favoured by the allopaths is injection into the subcutaneous tissue, and good results have certainly been obtained. The probable objection to giving tuberculinum by the mouth is that it might be destroyed in the stomach, and that its absorption in the system is not so certain as by injection. I have tried now in many cases to see if as good results as Wright has obtained could be got by the administration of the tuberculinum by the mouth. In twelve of such cases (chiefly gland and joint cases) the patients have completely recovered, and the opsonic index raised. In two or three of the cases I had better results by injecting the tuberculinum into the subcutaneous tissue. Why, in these instances, it failed by the mouth I do not know. Another method may further be employed, and that is the administration by the rectum. This method has been used by a few allopaths; but it is one that, for obvious reasons, is not usually employed.

(*c*) *The Dose.*

The question of dose is very important, and much of the success of the treatment depends on the dose given, which must not be large enough to produce aggravation. It was in the dose that Koch failed. The quantities injected were too large, and consequently aggravated the condition, thus doing more harm than good. The essential thing is to find a dose that will not markedly aggravate the condition, and even this dose may be moderated. What is required is to administer just such a quantity of tuberculinum as will give the cells sufficient stimulus to overcome the disease, and

a very small dose is often quite sufficient for this. The strength of tuberculinum I generally employ would correspond to a 3 or a 4 of the homœopathic scale, and with such strength I have had exceedingly good results. With the smaller dose the negative phase is not nearly so marked, and not so prolonged. In an injection of tuberculinum, I usually begin with $\frac{1}{5000}$ mgr., and my results are more satisfactory than with the $\frac{1}{1000}$ mgr.; in fact, in several cases, the patients did not respond to a $\frac{1}{1000}$, but did to a $\frac{1}{10000}$ and $\frac{1}{5000}$. In two cases I have gone as high as 30; but the results are not so good as in the lower dilutions.

The interval between the dose varies, and here the opsonic index helps considerably. The taking of the opsonic index is tedious and occupies a certain amount of time. But, for all necessary purposes, if the dose is small, this tedious process may be partially abandoned and the dose repeated every two to three weeks for the first few doses and the interval gradually increased as the patient progresses.

(*d*) *Results Obtained.*

During the last year about thirty cases have been examined which consisted chiefly of patients suffering with tubercular glands of neck and joint disease. In addition to these were two cases of tubercular disease of bladder, two of peritonitis, and one chronic pulmonary tuberculosis.

In nearly every case the tuberculinum was first of all administered by the mouth, and, if the results were unsatisfactory, injections into the subcutaneous tissue was tried. The results were very gratifying; many of the cases are quite well and most of the others are steadily improving.

Tuberculosis of the glands is the easiest to deal with, and especially if the skin be not broken, when no discharging sinuses are present. If, on the other hand, sinuses are present, the administration of tuberculinum alone will not always cure the case, the reason being that the gland has become infected with another organism which must be dealt with by its appropriate nosode. If pus is formed and the skin is red, a small incision should be made, the caseous material scraped out, and tuberculinum administered. The

abscess should not be allowed to burst of its own accord, as the patient is more liable to become secondarily infected.

In the case of joint disease, all the usual surgical precautions should be taken, and a cautious administration of the nosode given. In two of my joint cases tuberculinum has completely failed.

The tubercular peritonitis and bladder cases have considerably improved. They are very interesting cases in that they illustrate what may be called the double infection. Tuberculinum greatly improves these patients, but after a time they seem to remain stationary, no further improvement taking place. This is because the diseased part (in abdominal cases) has become infected with another organism, usually the *Bacillus coli communis*, and if cure is to take place small doses of the coli communis must be given as well. Another interesting point that had to be considered was whether the opsonic index could be raised by other drugs besides tuberculinum. Very few cases have been examined thus far, but some of the results obtained point definitely to the fact that such is actually the case.

The explanation as to how these small doses act is still forthcoming. The raising of the opsonic index is no explanation, that being only some change that may happen if the nosode is effectual. It will in all probability be shown later on that the raising of the opsonic index is due to some physical change brought about by the appropriate remedy. But as to how the nosodes themselves act is far more difficult to explain than the raising of the opsonic index.

To sum up, then: (1) tubercular disease might be very much diminished if those having a predisposition were treated with small doses of tuberculinum before the commencement of the actual disease.

(2) In chronic tubercular disease the most useful remedy is tuberculinum, which could be given by the mouth in doses corresponding to 3 or 4 of the homœopathic scale and at intervals of two to three weeks.

The PRESIDENT remarked that both papers contained individual experience, which, in his opinion, was what the members of

the Society essentially wanted. Both authors had dwelt very rightly upon the absolute necessity of constitutional treatment. Doctors ought to know that the children of tubercular parents, or parents affected with any other dyscrasia, required treating from the outset whether they showed signs of active disease or not. That was the great lesson which Burnett taught. Burnett brought forward bacillinum more as a remedy for consumptiveness than for actual consumption, and his observations had been well borne out by the papers. He (the President) thought Dr. Ord was a little incorrect in speaking of homœopathic treatment "and" opsonic treatment; for what was opsonic treatment if it was not homœopathic? von Behring himself had said there was no better word for it than Hahnemann's word "Homœopathic," and Pasteur agreed. The opsonic *treatment* was not an invention of Wright's. Wright invented the method of estimating opsonins, and very valuable it might be; but he did not invent homœopathy. In his opening address, he (the President) had mentioned the case of Dr. Mure, who was given up by the allopathic doctors as a hopeless consumptive. He went, however, under homœopathic treatment, which raised his opsonic index to such a pitch, that in two months he went home and startled everybody by his absolute cure. There was recently living in America an old gentleman, named Young, who, when a youth, after being given up by many doctors, including Sir James Clarke, went to Paris, where Hahnemann was then practising. Hahnemann treated him on the indications of his symptoms, and raised his opsonic index to such a degree that the derelict lived to be nearly a hundred. The opsonic index was nothing new, but Wright had discovered a valuable method of gauging it apart from the actual symptoms of the patient.

Dr. CHARLES WHEELER believed that in infants up to one year old the opsonic index was low to almost any disease. In families who were tuberculous there was very little doubt that the index remained low. Many families had a low index. In his own family of five people there were two cases of phthisis. He tested his brother, his sister, and himself, all three being quite healthy, and the opsonic index was low. He had been working in Somersetshire, and he saw Professor Wright, who, when he discovered that his (Dr. Wheeler's) index was low, wanted to give him an injection. He replied that he would try something else, and on taking arsenic found that the index was not raised. He took phosphorus, however, never more than once a day, and found the index went up to 40 per cent. in a fortnight. He discontinued the drug, and at the end of a month found the index was down

again. He again took phosphorus, and the index went up. He had had the opportunity of trying the experiment on another healthy person, a nurse, whose index seemed to be naturally low, and it also raised her's. He thought it would be found that a great many of the drugs which homœopathists found most useful did raise the index. He was fairly well convinced now, after two years' experience, that the raising of the index when a patient was getting better was probably not in itself the final and complete occasion of the cure. He had had a most extraordinary case of persistently high index with no improvement, but in the generality of cases when the index went up the patient improved. He had noticed the very ill effects of influenza on phthisis. The first case he treated by the new system did extremely well, as first cases always did. After being treated for two years, the patient died suddenly from hæmorrhage, influenza killing him. As a matter of fact, the patient began to improve a little before he had the hæmorrhage, but the case was an unsatisfactory one from the time he caught influenza. In such cases if homœopathists gave influenzinum in a high dilution they might improve the case. Phthisis differed entirely from other local tubercular infections. A local tubercular infection threw comparatively little poison into the main blood stream, and if the patient's index was naturally low, as it probably was, there was no particular stimulus to improve it. But with the enormous blood circulation of the lungs if a poison was introduced at an early stage, the opsonic resistance was called out freely, and that was the reason the index tended to be high. In such a case he thought the proper thing was to give tuberculinum in a much higher potency. He was inclined to agree with Dr. Ham's suggestion on that point, and the next time he obtained an acute case he should adopt it. He thought acute cases of phthisis were always most satisfactory to treat in a sanatorium. It was so much more satisfactory to have a case that had some reaction in it, and the acuteness of a case meant that there was a definite attempt at reaction, and a doctor then had something he could work on. He thought it was quite reasonable to give tuberculinum, at any rate for some periods, without necessarily making a blood examination every time, which was an exceedingly tedious piece of work. From a paper of Professor Wright's that he had read, he was encouraged to give the tuberculinum in acute cases as the best possible mode of treatment. Results were given which had been obtained in typhoid, by giving small doses of what the practitioner imagined to be an anti-typhoid serum, but which Wright gave

reasons for believing was a vaccine. About half a drop of that particular serum was given, which Wright believed to be a very small dose of the actual typhoid poison. It was really equivalent to saying that he was vaccinating his typhoid patients in the acute stage, and in some thousands of cases the mortality had been altered from about 19 per cent. to about 5 per cent.

Dr. WATKINS said he had made a good many estimations of the opsonic index, and so could speak from actual experience. His opinion was that in all chronic cases of tuberculosis the opsonins were low, but in acute cases there was a good deal of fluctuation. He had examined two patients who had suffered from typhoid fever twelve months previously, and in both those cases the opsonins were low. The dose of tuberculin he had been in the habit of using was a four-thousandth part of a milligramme. He very seldom used anything stronger. There was one difference between Koch's new tuberculin and the other preparations of tuberculin which had not been referred to, namely, that a part of the toxin which caused coagulation process had been separated from it. After the microbes had been comminuted by machinery the powder was mixed with a saline solution and centrifugalised. The upper clear fluid which was obtained by the first centrifugalisation was thrown away, and it was this which contained so much of the toxin which caused coagulation necrosis. He had had a case of acute pulmonary tuberculosis under his care following childbirth. He had the advantage of Dr. Moir's help, and they prescribed stannum iodide amongst other remedies. The case was acute for six weeks, the temperature fluctuating from 101° to 103°, but ever since that the patient has been getting better, and is now convalescing. During the treatment he tried tuberculin 30, and on each occasion found that it aggravated the symptoms most distinctly. His opinion was that no acute cases of tuberculosis ought to be treated by any preparation of tuberculin. The collection of blood for the purpose of making the opsonic observations was an important matter. When the pipette was sealed in the flame, great care should be taken that the blood was not heated, otherwise the opsonins were destroyed, and the estimation was wrong. He described a simple means of sealing the tube without over-heating the blood.

Dr. ROBERSON DAY remarked that the papers had interested him greatly, because they continued a subject on which he had written a paper for the International Congress. The staff of the Out-Patient Department had abundant opportunities of seeing tubercular lesions, and there was no drug which he administered

more often in that respect than tuberculinum. Cases which had been the round of the hospitals, and were disappointed and disgusted with the prolonged torture to which the children had been put, did most satisfactorily on tuberculinum. In some selected cases, in order to test the efficacy of that drug he had given nothing else. Dr. Ham very kindly made the opsonic estimation of several of the cases, and he (Dr. Day) told him he was convinced that good results would be obtained by the mouth, hypodermic injections not being used. At that time Dr. Ham professed himself to be rather sceptical, and now that gentleman had had the opportunity of seeing the cases, he (Dr. Day) was sure he was convinced. In one patient, a boy with lupus, who had been the round of the hospitals, in one of which he was scraped nine times, and in the last of which he was told that nothing could be done for him unless he underwent the light treatment, which he would not submit to, the lupus was very widely distributed about the body. The patient had been kept on the one remedy—tuberculinum in various forms, but always in a high dilution, with the result that he was practically cured. The Chairman had already commented upon the valuable position which Sir A. E. Wright's work occupied in homœopathic study. Professor Wright had explained the *modus operandi* of a medicine which homœopaths had used for many years, and had known to be a most valuable remedy clinically. To Professor Wright belonged the great honour of discovering the opsonic index, but not of introducing tuberculinum as the method of treatment, which had been known since the days of Constantine Hering, who may be said to have introduced the nosodes into medicine.

Dr. EADIE said that since he had been assistant surgeon at the hospital, he had had a number of cases of glandular abscess under his observation. In treating them he had drawn off the pus and given the patients silica internally, but not tuberculin, from which he had not seen good results in such cases. He did not agree with Dr. Watkins that acute cases did not benefit by tuberculin. In cases of acute bronchitis he had seen a distinct improvement in twenty-four hours, after giving one dose of tuberculin. Tuberculin produced acute fever when injected into animals, not a chronic fever, and therefore ought to be more homœopathic for acute attacks. He recently heard one of the surgeons at the London Hospital say that the drawing off of the pus alone as a method of treatment was absolutely useless; but he (Dr. Eadie) was quite certain, from the fourteen or fifteen cases he had seen in the hospital in the last ten months, that in

at least nine of them the glandular abscess had disappeared by that method of treatment and administration of the indicated remedy. There seemed to be a point at which it was quite useless to draw off pus to prevent overlying skin sloughing, but he did not know exactly when that point was arrived at. He had observed the results of its administration by others in a very large number of cases with disappointment, and attributed those results to the fact that the pathogenesy of the drug was not properly known.

Dr. HAYLE remarked that consumption was one of the greatest scourges with which practitioners had to deal in Rochdale, and in the course of his twenty-six years' practice there, he had never had less than ten cases of that disease under his care. He had not had much experience with the opsonins, or bacillinum, or tuberculinum, and when he had used them he had not been favourably impressed with the results obtained. Probably that was due to the fact that he had not used them early enough, because cases of consumption usually did not come to him before actual lesions had taken place, and it was useless to use those remedies then. He had great faith in the homœopathic medicines, and had seen undoubted results from the use of calcarea, phosphorus, iodide of arsenic, and sanguinaria. There was no doubt, however, that the greatest of all benefits was obtained from fresh air, sunlight, and good food, and without them medicines were of little good. He had been able to cure many cases by adopting that treatment. That could easily be accounted for, because consumption was a disease which showed that the system was breaking down in its vitality; and if by any means the vitality of the patient could be raised, he would resist the attacks of the tubercle bacillus. If everybody lived with their windows open, or in the fresh air and sunlight, consumption would be unknown. Medical practitioners in Rochdale had a great deal of the disease to cope with, because in the mills the air was laden with dust, the temperature was high, the china clay got into the lungs of the workers, and the hours of labour were long. Lowered vitality was the natural consequence. If the vitality could be raised to its normal point, no consumption would ensue.

Dr. SPEIRS-ALEXANDER thought the form of treatment referred to in the papers would be a valuable help in clearing away the dyscrasia in the diseases mentioned. All disciples of Hahnemann endorsed his experience that, although the indicated drug were given, yet in some cases it would only partially ameliorate the condition; and until the underlying dyscrasia had been neutralised,

there was failure to cure the patient. It therefore seemed to him that the great value of the opsonic treatment was, that it aided in getting at the root of the complaint from which the patient was suffering. Some of the statements made by both the essayists encouraged the expectation that, after the vaccines had been administered, it might be found that the more distinctly indicated drug might then act more efficiently than before. Dr. Ord's suggestion that in families where tuberculosis was hereditary preventive vaccination should be carried out, opened up a wide vista of hope for the prophylaxis or eventual extermination of that dread disease. The President had asked for personal experience, and he would endeavour to comply with that request. He could only speak of two cases, and they might serve to clear up one question that had been raised—whether it was always necessary or not to ascertain the opsonic index before beginning the treatment, and again before each successive dose. If the index had to be ascertained in every case, he thought it would be fatal to the general adoption of this special form of treatment, as in the bustle of every-day practice, and more particularly in country districts, where pathological laboratories were not available, it would hardly be practicable to have the index taken. He thought, however, the system could be carried out successfully without taking the index at all. The first case he would refer to was one of tuberculous enlargement of the cervical glands, and, in addition, an obstinate and widespread eruption on the skin of the face and neck, in a girl of about 19 or 20 years of age. The patient had been under his observation for three or four years; and though he had been able to reduce the glandular enlargement to a considerable extent, and to improve the eruption, yet he had by no means succeeded in curing her. When the opsonic treatment was introduced, he thought it would be a good opportunity of putting it to the test. He accordingly stopped all other drug treatment, and began hypodermic injections of tuberculin, the dose being half a cc. of Allen and Hanburys' vaccine, in the strength of the one-thousandth of a milligramme. He did not get the index taken, because he thought the clinical condition such as to justify the adoption of the treatment without doing so. In three weeks a considerable improvement had taken place. He then gave a second dose, and at the end of another three weeks there was a continuance of the improvement. In all, he gave five injections at intervals of about three weeks; and though the patient was not yet completely cured, yet she was very nearly so, and he thought that another injection would be enough. Not only had the erup-

tion and the enlarged glands almost entirely disappeared, but the patient's general health had improved to a marvellous extent. She had gained 8 lbs. in weight, and had been able to pass a medical examination before being accepted as a teacher by the School Board. The second case, a boy of about 18 years of age, was one of severe and long-standing acne vulgaris. The boy had also been the subject of tubercular peritonitis. In this case he had the advantage of the co-operation of his friend and colleague, Mr. Knox Shaw, who performed laparotomy, resulting in cure of the peritonitis. Before the operation was performed the patient had long suffered from acne, which became much worse after recovery from the peritonitis, the greater part of the face and the chin being covered with pustules. He had tried many remedies, such as iodide of arsenic, calcarea, hepar, and silica, without making any impression on the complaint, and so at length decided to try the opsonic treatment. Without having the index taken, he gave the patient an injection of Allen and Hanburys' staphylococcus vaccine, the dose being, as in the first case, the one-thousandth of a milligramme. In all, the patient had six injections, at intervals of between two and three weeks. The index was not taken between the doses, no negative phase was observed in the effect produced, but only progressive improvement from first to last. The boy was now absolutely well, with not a single pustule left on his face. These were the only two cases of which he had yet had personal experience, and perhaps his success was due to the circumstance, as Dr. Wheeler had suggested, that they were his first cases; but, nevertheless, he felt so much encouraged that he intended in such cases to continue the same treatment, and without taking the opsonic index. He wished to ask Dr. Ham—whom they welcomed in their midst as a member of the British Homœopathic Society, and whom they regarded as their pioneer in opsonic treatment—whether, after having given tuberculin for the dyscrasia in the treatment of suppurating tuberculous glands, he found it necessary afterwards to give a staphylococcus vaccine to overcome the suppuration? He suggested that the Society should adopt a standard preparation of tuberculin, as the use of bacillinum and tuberculin—particularly as the President had expressed the opinion that the action of both was practically identical—might be confusing.

Dr. GOLDSBROUGH thought the point made by the president in opening the discussion, as to the identification of the opsonic treatment with homœopathy, was very important. The opsonic treatment ought to be claimed by homœopathists as being based

on the homœopathic principle. He asked the authors two questions in regard to the practical use of the treatment, more especially in phthisis. Was it not of importance to consider how the infection of phthisis was conveyed or received? One would think that, according to the way in which the infection was received, that would most probably be the best channel for the administration of the medicine. The other question was, is it necessary to induce the negative phase of the influence of tuberculinum? Was not this condition a defect in treatment when it was produced by the drug given as a medicine? Had not homœopathists, in giving their medicines, aimed at avoiding the negative phase altogether? Years ago he brought forward some experiments by Dr. Waller on the nervous system, in which a very fine stimulus from a galvanic current was applied to living nerve, and the curve which indicated the response of the living tissue to the current was a curve similar to the opsonic curve; there was a negative phase, and afterwards a positive phase. He tried to argue from that that the dose ought to correspond to the positive phase, and not to the negative. If that were so, it would need a greater attenuation of tuberculinum than had been given. He desired to refer to the case of a patient at the hospital three or four years ago. She was a woman of about middle life, who appeared to have lupus coming on her nose, the symptoms being about two months old. Dr. Blackley confirmed the diagnosis. He (Dr. Goldsbrough) gave one dose of tuberculinum 30, and the patient returned in a fortnight or three weeks without a vestige of the irritation; it was quite cured. He had seen the patient that day, and found that occasionally she had a little irritation inside the nostril, which suggested that the diathesis or tendency to the disease was not radically cured. Since he first saw her he had given her about four doses of tuberculinum, and a dose generally disposed of any irritation that might be set up. He had given the patient a dose to keep at home in case irritation occurred, but she would not take it unless she could help it, because it made her feel ill. The patient was a chronic neurasthenic, but that did not get rid of the fact that she was sensitive to the drug.

Dr. T. Miller Neatby mentioned the case of a young girl, aged about 15 or 16, who attended the hospital, suffering from menorrhagia. The periods recurred every fortnight, and were very excessive both in length of time and quantity. He treated her for two or three months, giving phosphorus and calcarea; and from the first, although the local symptoms were not im-

proved, she benefited immensely in her general health. About the same time her sister came to him, and he found she was suffering from an early stage of phthisis, and a remarkable light was thrown upon the treatment and cure of the other girl. The previous patient was treated without any reference to phthisis, but simply for the menorrhagia; and she was quite cured, so far as could be seen, by anti-tubercular remedies. The second case was that of another tuberculous patient, as dark as the previous one was fair. She was a domestic servant in his own house, who had been under treatment for a couple of years. Before she came into his service several operations had been performed on her for the removal of the cervical glands; in fact, her neck was a mass of most disfiguring scars, all the scars being keloidal. Large glands recurred all over the neck, some of them almost breaking down. He hardly thought he could prevent them breaking down, but he gave her tuberculinum and also silica. Latterly he gave tuberculinum a good deal alone. That raised the question whether ordinary homœopathic remedies should be given along with tuberculinum, the latter being used once a week or fortnight, and some other medicine, such as silica or calcarea, day by day. Reverting to the case to which he had been referring, the improvement after the administration of tuberculinum was remarkable. He could not prevent one of the glands breaking down, and two or three months after he first saw the patient Dr. Beale removed the broken down gland at the hospital. The striking improvement which had taken place in the patient's condition was proved by the fact that the scar, although it was eighteen months since the operation had taken place, had never shown the slightest tendency to become keloidal, whereas all the other scars were exceedingly keloidal. He desired to ask whether, in cases where there was a slight rise in temperature, say to 99, and no definite lesion, it was right to give tuberculinum? It had been said more than once that where the temperature was raised at all, tuberculinum should not be given, but did that rule extend to cases where the temperature rose no higher than 99°? As a matter of fact he had given it with, he thought, good results in several cases.

Dr. GRANVILLE HEY stated that reference had been made to the fact that in one patient the tuberculinum had not acted until sulphur was given, and the President had referred to two cases where an attack of small-pox cured the phthisis. He had recently read of a case in one of the American journals where a physician was treating a child for diphtheria, and as a prophylactic measure

he gave the patient's mother, who was far advanced in phthisis, an injection of anti-diphtheric serum, with the result that improvement set in immediately and in a very short time she was perfectly well. It was evident that in some cases other diathetic conditions than the tubercular might affect the condition, and therefore affect the cure. Endocarditis was generally thought to be due to a streptococcus, but there were so many varieties of streptococcus. One or two cases had recently been put on record where several anti-streptococcic sera had been tried in succession, and had not given a good result. In cases where the injections did not give the anticipated result, would it not be a wise plan to prepare a serum from the patient, and thereby get the diathetic effect of the serum as well as the specific organism? One of the speakers had asked for an explanation of the breaking down of glands after aspiration of the softened contents. He had frequently met with the same thing after drawing off the fluid, the glands breaking down in spite of all that was done. He had come to the conclusion that in those cases the fluid had not been drawn off early enough, and that the overlying tissues had been so devitalised that they had not been able to recuperate. Dr. Alexander had referred to giving some other injection as well as the tuberculinum in cases of broken-down glands, but he thought it would be agreed that in most cases of breaking down tubercular glands, pus in the ordinary sense was not obtained, but what had been termed tubercular fluid, with none of the characters of pus. In other cases pus was obtained, and they were the cases which were more likely to break down after the fluid had been drawn off.

Dr. ORD, in reply to the discussion, first of all desired to join in the general chorus of praise which Dr. Ham's paper had brought forth, and to thank Dr. Ham for answering several questions of vital importance which he (Dr. Ord) had asked in his paper. He thought the successful opsonic treatment of the disease in the future must depend very largely on laboratory investigation. The points especially upon which Dr. Ham had thrown valuable light were, first of all, the fact that the opsonic index was raised by internal homœopathic medication; secondly, the fact that in children of phthisical parents a low index was met with in the earlier years of life; and, thirdly, that treatment by the mouth by means of tuberculin would raise the index, and was equally as successful as treatment by hypodermic injection and (presumably) rectal injection. He cordially endorsed Dr. Ham's strong feeling in regard to the value of homœopathy, especially in chronic cases, and when Dr. Ham's experience in general practice

was a little more extensive, he would also find that homœopathy was equally, if not more, successful in acute cases. Two acute diseases, in which homœopathy had been proved by statistics to be enormously superior to any other form of treatment, were pneumonia and cholera, in which two diseases the early laurels of homœopathy were obtained. Dr. Watkins had laid down the importance of not using tuberculin in fever. That, he thought, had been very thoroughly established. He was not qualified to speak positively in reference to Dr. Miller Neatby's question, as to whether it was advisable to use tuberculin with a temperature of only 99°, but he suggested the answer to the question was to try the index, and if it were low, then the temperature would not be a bar to successful treatment, but it must be proved by experience. Dr. Hayle's remarks brought them back to the fact that fresh air, sunshine, and good feeding, always remained the most valuable adjuncts in the treatment of tuberculosis, whether of the lungs or elsewhere. He would like to know whether it was a fact that in sanatorium treatment for phthisis, although the patients did exceedingly well and improved rapidly with that treatment, it did not raise the opsonic index. It was a point to discuss whether phthisical cases could get well with a low index. He thought probably they could. He thought that phagocytosis with a high opsonic index was not Nature's only method of cure. By raising the vital conditions of the tissues, Nature could doubtless cure whether the index remained low or not, and by raising the index they had an additional method. Dr. Alexander had shown from the cases he had mentioned that it was not always necessary to take the index; in fact in ordinary practice it was sometimes impossible to do so, but in most cases it was very advisable that it should be done.

A CLINICAL EVENING.

A CLINICAL EVENING was held at the Liverpool Branch of the British Homœopathic Society on Thursday, November 8, at which the following cases and specimens were exhibited.

Sarcoma of Femur.[1]

Dr. Alfred E. Hawkes exhibited a young woman who was suffering from a subperiosteal sarcoma in the upper end of the femur, which was regarded by the members assembled at the meeting, to adopt the words of Treves, "as hopeless from an operator's point of view."

Carcinoma of Rectum.[1]

A woman, the subject of malignant disease of the rectum. Early in the year the tumour, which was very painful, but too high up to admit of removal, had caused vomiting, and other symptoms of intestinal obstruction.

She was sent to the Hahnemann Hospital, where Dr. Hawkes had performed left iliac colostomy by Réclus' method. The results were in every way satisfactory, and although the track below the artificial opening remained more or less patent, as is so often the case, pain and discomfort were reduced to a minimum. The only point of interest besides was that the incision had to be rather larger than usual, some difficulty in pulling up the colon having been experienced.

No harm resulted, as this method admits of the wound healing before the bowel is incised. Dr. Hawkes mentioned that while one patient had only survived the operation six months, another had lived three and a half years.

Uterine Fibroid.[1]

A year or two ago the woman, aged 39, had been so blanched as a result of hæmorrhage as to render some operative interference necessary.

Dr. Hawkes found himself quite unable to remove the diseased parts by means of abdominal hysterectomy, and, before reluctantly closing the wound, he removed the only ovary he could find.

[1] Exhibited by Dr. ALFRED E. HAWKES.

On the clinical evening, the woman looked the picture of health, the fibroid could hardly be felt, and it was elicited that since the operation there had been a complete absence of sanguineous discharge.

Two Fibroid Tumours.[1]

The two fibroid tumours mentioned on page 16 of Dr. Hawkes' "Provincial Reflections" (Journal, 1906), constituting the only cases of his, as far as he knew, in which death had been due to uterine fibroid.

Abscess of Jaw.[2]

L. G., aged 30 years, chronic abscess above socket of left upper first molar, which filled up and discharged from time to time during twelve months. The dentist saying that there was no fault with the teeth, an X-ray was taken, and this showed distinctly a portion of one fang of the tooth still present with a light area of abscess cavity surrounding it.

Fracture of Lower End of Radius.[2]

A. J., aged 33 years. Patient fell on hand and, although no crepitus or deformity could be felt, it was diagnosed as a fracture of lower end of radius. The X-ray photograph confirmed the diagnosis, the first view showing a transverse fracture simulating separation of the epiphysis. The side view showed very slight displacement of the lower end, but, as the fragments were impacted sufficiently to retain their relative positions, it was treated in this way, and recovery has been perfect.

Absence of Left Arm.[2]

H. C., aged about 26 years. Patient is well formed except that there is absence of the left arm. She was born with a rudimentary hand about one and a half inches long, flaccid, and presenting only a rudimentary thumb and little finger with a gap between, giving it an appearance somewhat resembling a claw. This grew sessile upon the joint of the left shoulder and was movable voluntarily. An X-ray photograph showed curious bony structures representing the other bones fused into three irregularly-shaped masses, and apparently articulating beneath the spine of the scapula.

[1] Exhibited by Dr. ALFRED E. HAWKES.
[2] Exhibited by Dr. CHARLES HAYWARD.

Sac from Extra-uterine Pregnancy.[1]

A young woman, married, who had "passed over one period" was suffering from some hæmorrhage, and a lump to be felt behind and to the left of uterus. On opening the abdomen, an oblong, smooth, dark brown sac was discovered in the situation above noted. There were numerous adhesions, chiefly to appendices epiploicæ, from which the sac appeared chiefly to obtain its vascular supply; these were divided. The sac consisted of the distal third of the left Fallopian tube. The tube, ovary and sac were removed, the ligature being placed close to the ampulla. Continuous buried sutures to each layer of abdominal incision were employed, and no drainage tube was inserted. The patient lost practically no blood, and rapidly convalesced without causing any anxiety. She was ready to leave the hospital on the seventeenth day.

Ovarian Cyst Adherent to Iliac Blood Vessels.[1]

A woman, aged about 45 years, sent into the Hahnemann Hospital by Dr. Hynd from the neighbourhood of Wigan.

She was exceedingly anæmic, with a weak and thin heart systole. She had a lump in the abdomen doubtfully connected with the uterus, and had very profuse hæmorrhages. The symptoms and the signs largely suggested a fibroid, but on operation a very tense sac was discovered containing fluid. On trying to reach the pedicle, it was found impossible to raise the deeper parts without certain laceration. The hand was then placed in the sac and its connections investigated. It was found to dip deeply into the pelvis and to be strongly adherent at its deepest point, chiefly to the sheath of the iliac vessels, which pulsated strongly and were incorporated with the sac. Most of the latter was therefore cut away and the stump attached to the incision. Patient eventually did extremely well, but at first gave great anxiety from grave and persistent tachycardia which no remedy touched except strophanthus. The sac was kept aseptic with peroxide of hydrogen during its contraction, and the patient was by-and-bye sent home practically well.

Right Hemiparesis.[2]

A female, aged 19 years, the lesion dating from second year of life, and was probably an acute polioencephalitis, involving a large portion of the left side of the cortex. Family history shows early

[1] Exhibited by Dr. CASH REED.
[2] Exhibited by Dr. EDMUND HUGHES.

death of both parents (cause uncertain), one sister subject to hystero-epilepsy (?), another sister shows facial asymmetry and a large leukoma of right cornea. The patient presented right hemiparesis, including paresis of lower muscles of right face, moderate contractures, no athetosis, atrophy of disease only, slight imbecility, numerous epileptic fits with unconsciousness.

Amyotrophic Lateral Sclerosis.[1]

A female, aged 27 years, showing amyotrophic lateral sclerosis of spastic type. Case began as a progressive muscular atrophy of upper extremity. Bulbar symptoms up to the present limited to occasional difficulty in swallowing and partial aphonia. The case was a fairly typical one. Points of interest were a recent retention of urine for twenty-four hours, on one occasion only, the catheter having to be used, and the presence of scars of old tuberculous lymphadenitis in right posterior triangle of neck. This patient had had for at least a year past symptoms of intercurrent gastric ulcer (alimentary vomiting, hæmatemesis, and gastralgia after food), which had now apparently ceased. There was evidence of family tuberculosis on father's side.

A Case of Teratoma Obstructing Labour.[2]

The mother of this child first came under observation when about seven and a half months pregnant; she was a primipara, aged 20 years.

The patient was then suffering from severe vomiting, and there was a good deal of albumen in the urine; she was put on a milk diet, told to rest in bed, and arsenicum 3 was the medicine given. The patient was attended for ten days, by which time the condition was much improved and the albumen had disappeared.

Five weeks later the woman was again visited, as she complained of vomiting, abdominal tenderness with periodical pains, and could not pass her water. A quart of urine was drawn off with a catheter, and it was then noticed that there were marked varicose veins of the vulva, which was considerably swollen.

On making a P. V. examination, the os was found to be the size of a five-shilling piece, the head was presenting, and the membranes had ruptured.

[1] Exhibited by Dr. EDMUND HUGHES.
[2] Specimen shown by Dr. ERNEST HAWKES.

Late at night, the midwife attending sent for a doctor, as the labour was unduly prolonged and the child seemed to have stuck. The doctor waited about an hour, and then put on forceps and succeeded in partly delivering the child, but could not free the hips.

After repeated failures, the child was eventually delivered some hours after the head had first appeared at the vulva. The child was dead, of course. The cause of the obstruction was found to be a large sacro-coccygeal tumour, about one and a half times as large as a fœtal head at full term, and this had been partly wrenched from its attachment to the pelvis, in the repeated attempts to effect delivery. There was some *post-partum* hæmorrhage, but the patient made a good recovery and has since given birth to a normal child. The time intervening between the beginning of labour and the final delivery was fifty-two hours.

REVIEW.

The Test Proving of the Ophthalmological, Otological and Laryngological Society. A Re-proving of belladonna, being an experimental study of the pathogenetic action of that drug upon the healthy human organism. Conducted under the auspices of the American Homœopathic Ophthalmological, Otological and Laryngological Society, with the endorsement and co-operation of the American Institute of Homœopathy, and various State and local Societies. Arranged and compiled by the General Director of the Proving, HOWARD P. BELLOWS, M.S., M.D., Professor of Otology, and formerly Professor of Physiology in the Boston University School of Medicine. (Boston, The Ophthalmological, Otological, and Laryngological Society, 1906, pp. 665, with illustrations.)

THE first public announcement of the intention of the present work was made in a presidential address by Dr. Howard P. Bellows to the Ophthalmological, Otological and Laryngological Society in 1900, entitled "The Re-Proving of the Homœopathic Materia from the Standpoint of the Specialist." The work owes its origin and general direction to the effort of Dr. Bellows, and he is now to be congratulated on the appearance of a volume giving the results of his endeavour. It may be said at the outset, and as the title indicates, that the work has no merely local or specialist interest. Its inception and execution have involved a thoughtful consideration of the whole subject of the homœopathic materia medica. The circumstances of the origin of materia medica, its presentation and development calling for the planning of re-provings in the light of modern, scientific and medical diagnosis and research, the engagement of provers from various parts of the country, the medical examination of the provers and the collective systematised presentation of the results in a readable volume form, all find illustration in Dr. Bellows' work. The work is described as a "test-proving." Truly, only one drug is employed as the test, but both in material and methods the re-proving presented is intended as a basis of comparison for

other drugs. As will be pointed out later, all ways of considering the variety of effects of a drug on the healthy human organism have, in the present instance, been passed in review; and, as far as belladonna is concerned, are given in the volume. What may be anticipated more especially to interest British homœopaths in connection with this work, is its appearance as a result of collective effort. By the appearance of the present volume, the days of single-handed work in materia medica are numbered. The British Homœopathic Association have already recognised this fact, and some attempt at re-proving has been begun along the lines of the Ophthalmological, Otological, and Laryngological Society. The results of the original effort of the latter Society cannot fail, therefore, to be of the greatest interest and help in future investigations conducted collectively in this country.

There are three classes of persons for whom the presentation of a work on materia medica may be conceived to be important, namely : practitioners, students, and teachers. In Great Britain the practitioners' claim to consideration is paramount. But practitioners, if they are to be successful, will always be students; and although at present British teachers are few, it may confidently be hoped this will not be always the case. In America, the prospect appears fast towards realisation, that the homœopathic materia medica will become an essential possession of every medical practitioner. In the Old Country, enlightenment is slower, but the confidence of realisation not less certain. Thus here, as elsewhere, all classes who require knowledge of materia medica are entitled to relative consideration.

If the value of the present work is to be fairly estimated, it is necessary to keep clearly in mind the distinction between practice, study, and teaching. When seeking a remedy for a case of disease, for the busy practitioner to have to wade through a portly volume on one drug is more than can be expected of him. For ready reference the practitioner needs his material condensed, and only for purposes of study and research will he require a complete account of the effects of a drug. On the other hand, the student has to be met in all stages of the acquisition of knowledge. The present volume is not for the student in the days of his pupilage. As a graduate or practitioner he may turn to the work for maturing his knowledge, and for the scientific study of drug action in the light of previously-acquired information from his teachers. But for the teacher a work of this character must at all times be of supreme value. Indeed, if we mistake not, it will form the initial pattern volume for academical

medical libraries, and that in the future no college of medicine will be complete until it possesses a library of materia medica containing a volume on each drug proved and re-proved with the accuracy and thoroughness accorded to the present one.

On turning to the plan of the work, a brief introduction indicates the chief features of the chapters which follow. The points to be noted in the introduction are, that the work gives an account of a *pure* drug proving as distinct from a collection of the effects of the drug gained from poisonings, other provings, experiments on animals, or clinical sources. It is thus an original work on the subject; and, as previously mentioned, this re-proving is intended to be a "test" proving, that is, it will suggest for future work many directions, such as the preparation to be used, the dose, control tests, length of time, the value of examinations, and the best methods of recording and presenting results.

In the work itself, the basis of the study is narrative. Out of the 650 pages, nearly 300 are given to narrative with synopses of effects on each of 53 individual provers. The symptom narrative of each prover is first given in detail in the time order of its occurrence; and then in the synopsis which follows, the same detail is given in the same language of the prover or of the examiner under the different physiological systems of the body. In the conduct of the provings, each person was under the care of a director, and submitted at short intervals to examination by specialists, and all modern methods of diagnosis and research were employed. In addition to the detail of symptoms felt and observed, there is accordingly presented under the examiners' reports the condition of the reflexes, accurate descriptions of the appearances of the eyes and ears, with the acuity of vision and hearing, the condition of the respiration, temperature, and pulse, the circulatory and alimentary systems and special analyses of the urine and blood.

Next to the narratives come summaries of results. Under different plans or schemas are collected the material of the narratives, and this is represented in several different ways. It is around these schemas that much discussion may arise as to their utility to the practitioner, student, or teacher. The first division of the summary consists of "a new schematic form" devised, we presume, by the general director of the proving. Compared with former schemas this one excites our highest admiration in its analysis and arrangement of the material of the proving. Some account of the construction of the schema will not fail to interest readers of the Journal. First of all it should be said there is no condensation and

no alteration of language in this schema from the detail and language of the narratives of the provers. The detail is presented, first of all, under the following physiological divisions: (1) Mind and nervous system; (2) Eyes; (3) Ears; (4) Nose and throat; (5) Respiratory system; (6) Circulatory system; (7) Alimentary system; (8) Genito-urinary system; (9) Urine; (10) Blood; (11) Bones and muscular system; (12) Skin; (13) Tissue changes; (14) General systemic conditions. All symptoms of the narratives are presented under the foregoing divisions. Then follow some more general divisions, which, in our opinion, really constitute another schema under which the symptoms are again presented. These are: Regional conditions (*e.g.*, head, chest, abdomen, &c.) Sensations (given under separate anatomical regions as in the old schema). Pain (different qualities). Modalities (including time, temperature, and weather, length of attack, periodicity, direction, &c. Too much space would be occupied in describing results in detail, but some main features of this schema may be more fully indicated. For instance, under *mind and nervous system*, headache in its various aspects and varieties of detail is presented first, followed by mental states, sleep, dreams, and pain. The construction of a distinct rubric for "pain" in general is quite a new feature, and promises to be of great value. The psychological character of pain and sensation can never be left out in the estimation of morbid phenomena, and in the schema under review, pain in general, as presented by the mind of the patient, and distinct from pains and sensations in different regions, are given in detail in both this section and under the different regions as well.

At the end of each physiological division of the schema is given a summary of the examiners' reports. Under the division "ears," an additional condensed schema is presented to indicate how the material could all be readily condensed to render it available for prompt reference in practice. Such condensed schemas are anticipated to be of considerable use to specialists.

Much interest will attach to the sections describing the effect of the drug on the urine and the blood. These are given most thoroughly, according to the latest physiological standards. We miss, however, similar results on the saliva, the contents of the stomach, the stools, the sputum, or the sweat, which, in the instance of some provers at least, might have been anticipated.

The second "summary of results" consists of the symptoms presented under "the old schematic form" familiar to every practitioner. This is inserted so that the results of the new proving

as a "test" shall be adequately compared with previous knowledge of the effects of the drug. The third summary consists of the material "condensed in general terms." In fifteen pages, in language different from that of the provers, we have all the previous material abbreviated in a manner that, if attention were given to this section first, a very fair appreciation of the action of the drug would easily be obtained. In most volumes of materia medica this section would readily be placed first.

In all sections of the work an effort is made to give an impression of the intensity or range of the action of the drug by means of exponent numbers. For instance, the period in the case of each prover in which symptoms were noticed is divided into five nearly equal sub-periods, indicated by the letters A, B, C, D, E. Within these sub-periods each symptom is marked by a numeral indicating the number of days on which the symptom was noticed. Then in the summaries of results another numeral is added indicating the number of provers in whom the symptom occurred. A specimen of the plan adopted has already appeared in the Journal (July, 1906, p. 288), and need not now be repeated, but some further illustration is necessary to indicate the real significance of the exponent numbers. As it happens, the chief rubric for the drug is probably headache, and the symptom frontal headache occurred in thirty-one provers, and on one hundred and thirty-three days. This symptom is indicated as follows: Headache. Frontal $^{31\text{-}133}$. Again, right-sided headache occurred in eighteen provers, and on seventy-two days, so that under the sub-rubric "sides" the word right is inserted with the exponents $^{18\text{-}72}$ attached to it. After "sides right $^{18\text{-}72}$" occurs the following (f $^{8\text{-}57}$, h $^{4\text{-}6}$, g $^{1\text{-}1}$, v $^{1\text{-}1}$, p $^{2\text{-}3}$, s-o $^{1\text{-}2}$, a-p $^{1\text{-}2}$), the small letters with the numerals attached referring to regions previously described, and now with the fresh quality added. Under "duration," "character," the same letters occur again with the appropriate numerals attached.

Several points of criticism arise on the significance and practical utility of the adoption of exponent numbers. For instance, the first division into sub-periods is purely arbitrary. As the period of action differs in different persons the adoption of equal sub-periods can have no temporal significance whatever. With regard to the adoption of numeral exponents the question has to be asked, Because a drug produced a symptom on a number of people, and on a certain number of days, does this symptom necessarily indicate a more certain range or intensity of effect than the occurrence of one symptom on one prover only? In one

prover the symptoms of acute myelitis occurred with such severity that the proving had to be discontinued. This did not occur in any other prover. Were the symptoms in the single prover to be regarded as of less intensity or range than if they had occurred in many? Obviously not. Even if those symptoms were uncorroborated by other provers the intensity or range in one would be sufficient to render them more valuable than if they were less extensive and severe. It appears thus needful to guard against possible mental impressions produced by the adoption of exponent numerals. The true value of such exponents would consist in corroborating the alleged effects as real effects of the drug, but not to the disparagement of single effects, which can, with a certainty of a different kind, be as confidently asserted to be effects of the drug. The latter certainly consists, of course, in the reliability of the prover as an intelligent and not extravagant narrator of his symptoms, and in the scientific acumen of the examiners. Again, in the case of single well-defined symptoms, control could be exercised by subsequent experiments on the same provers at a date when all previous effects had worn off. On turning to the results "summarised in general terms" the cogency of the foregoing criticism will receive additional illustration. And also a feature may be pointed out where exponent numerals are of real value as indicators of genuine drug effects. It is intended that this summary should be used as a key for quick reference to the larger systemic schema. The paragraph on Headache may be referred to again (see Journal, July, 1906). Let the exponent numbers be omitted for a moment. The group of statements left appears to offer an excellent summary of effects of belladonna in producing headache. Re-introduce the exponents and what is the inference? *Nil* as regards quality, and relative only as to certainty and frequency of occurrence. The latter is unimportant when once the former is known, and in a case of disease the totality of the symptoms are presented in one patient and in one period of time. If, however, attention is turned to symptoms in which the modality of plus or minus or more or less occurs as part of quality exponent numerals become valuable. Take the symptom "hearing power for mechanical sounds," there is recorded unchanged ^{3}, increased ^{22}, decreased ^{9}, distinctly indicating that auditory hyperæsthesia is a marked effect of belladonna. Or in the instance of the patellar reflex we have exaggerated^{7}, diminished^{2}, showing increased myotatic irritability as another effect. Quality and modality thus appear to need more careful analysis than they have yet received, and exponent

numbers would then be of value when modality is an intrinsic element in the symptom.

Some reflections may be offered in conclusion on the general bearing of the present volume on the future of drug proving.

In the case of the multitude of different substances used in medicine, the length of time necessary for the exhibition of the effects of the drug varies greatly. Accordingly, judging from the nature of the present proving, drugs will need classification as to the duration of the conduct of a proving. For instance, from what is known of belladonna, lycopodium, phosphorus, silica, each would need separate consideration from this point of view. Again, it might be anticipated that in the conduct of a proving, some regard should be paid to the problem of remedial dosage. If attention is given to provings xiii., xv., and xvi. of the present volume, it will be noticed that the different effects were produced by a far different dosage, and by the same dosage in different provers. Results in these cases give no help towards an estimation of the remedial dose. And is this question one of clinical experience only? In the administration of the remedy, Hahnemann taught that the remedial effect should be exhausted before the dose was repeated. Should not this rule be followed in the conduct of at least some provings?

As soon as effects showed themselves, information on points of time and dosage would certainly be forthcoming, if no dose were repeated until the initial effects had ceased. On their cessation, and the re-administration of the same or a different dose, subsequent effects would indicate whether the effects of the drug were cumulative, or whether tolerance became established, two aspects of dosage surely most important.

Again, it might be anticipated that modalation, especially as to time, temperature, and weather, would be more accurately observed if the principle of exhaustion of effects were adopted. Many hints might be derived from modern physiological methods in muscle and nerve testing, in which tests are applied singly, repeatedly, and accumulatively, and the effects in each recorded and compared.

A review of this book would not be complete without reference to a short chapter (vii.) on the effects of belladonna on the animal tissues. This chapter consists of an account of original experiments on animals by Solomon C. Fuller, M.D., with autopsy records, control experiments, and microscopical investigations. In reference to the whole work as a *test* proving of belladonna, this chapter is to be regarded as an addition to the scope and purpose

of other parts of the work, as also would be records of clinical uses of the remedy in disease. On the basis of the re-proving, the latter will doubtless accumulate in time.

As a contribution to the knowledge of drug pathogenesy, the work of Dr. Bellows and his army of provers and collaborators will appear so far thorough and up to date; and it is no exaggeration to say that all future workers will naturally turn to this book for guidance or reflection on the material presented, or the methods employed for its compilation.—EDITOR.

The Editor submitted the MS. of the foregoing review with the volume to Dr. T. G. Stonham, who has given special attention to materia medica subjects, and requested his comments and further criticisms or remarks on the work, if thought desirable. Dr. Stonham's reply is embodied in the following letter to the Editor:—

I have read your criticism on the test proving of belladonna, and have had a good look into the book itself. I agree with your delineation of the book and with your criticisms, but would not myself lay so much stress as you do on the inutility of the exponent numbers. To my mind it is distinctly an advantage for a symptom to have occurred in many provers, and several times rather than in only one prover, however certain it may be that in that one it was a genuine effect of this drug. Symptoms are sometimes secondary; for instance, belladonna might quite genuinely produce in a certain prover a peculiar pain in the head, but this might be secondary to an abnormal condition of the eye, the drug acting on the abnormal eye, and reflexly producing this head symptom. This particular head symptom would not then be an indication for belladonna, unless it could be proved that the patient in whom it occurred had also the same abnormality of the eye. Yet this same symptom might be the primary symptom of some other drug. The fact that a symptom occurs in many provers eliminates the chance that it may be due to a condition of this sort.

I notice that nearly all the symptoms in the records are due to quite substantial doses of the ϕ tincture, and that dilutions were but little used.

Your point about duration of symptoms from single substantial doses I think a good one, and should be considered in any future provings.

Why should desires, aversions, appetites and thirst be classed among modalities unless they really are modalities? Several, in fact the majority, as classified on p. 462 *et seq.* of the volume are

not modalities. I consider it waste of space to place a synopsis at the end of each narrative, for the synopses are all collected in the schemata. One hundred and thirty pages would be saved by omitting them. Again, in the schemata, several pages are taken up by the heading "attack," quite uselessly, I think, because the material has already been given under the various systems. Take, for instance, on p. 479: "For twelve days; extreme nausea," occurring under heading of "Attack." This same information has already been given much more appropriately under the division of the schema devoted to the alimentary system under sub-heading Nausea (p. 398) where we read "extreme nausea $^{1\text{-}12}$", the exponent numbers giving the information.

However, criticism apart, I consider the volume a very good piece of work, well done, and hope we shall have many more like it. T. G. STONHAM.

In reply to Dr. Stonham, the Editor, in his remarks above, does not wish to convey the conclusion that the exponent numbers are useless as corroborative of the sphere of action of the drug, but that it is necessary to guard against a false impression as to the value of particular symptoms they may make upon the mind.

SOCIETY NEWS.

New Members.

AT the meeting in November, Charles Edward Ham, M.D.Lond., of 32, Weymouth Street, London, and Henry Prescott Fairlie, M.B., Ch.B.Glasg., Travelling Scholar of the British Homœpathic Association, were elected members of the Society.

OBITUARY.

William B. B. Scriven.

Dr. Scriven, Senior, late of Dublin, was an old and highly respected member of the Society. He was elected in 1858. He died at his home in Balbriggan on September 12 last, at the ripe age of 89. Dr. Scriven was not often seen at homœopathic gatherings in recent years, but he did valiant service for the cause of homœopathy in Dublin during the long period of his practice

there, sustaining a high reputation, and defending the position of the homœopathic practitioner as entitled to equal rights with the general body of the profession.

James R. P. Lambert.

The untimely death of Dr. J. R. P. Lambert, which occurred from accident on December 8, has deprived the Society of one of its most valued and industrious workers. Dr. Lambert was elected a member in 1893, and had held the post of Librarian from 1902 until his death. He was nearly always present at the meetings, and took part in the discussions with penetration and originality. He had contributed several papers. The trend of Dr. Lambert's mind turned towards materia medica as special study. He knew drug pathogenesy well, and was a strong advocate of high attenuations, and the theory of dynamisation. Having held the post of Assistant Surgeon in the Eye Department of the hospital, also that of Registrar, Assistant Physician and Anæsthetist, he was able to speak from several branches of experience, and he always did so with the courage of conviction. He was 39 years of age at the time of his death, and the Society will realise that in Dr. Lambert a worker in homœopathy of the greatest promise has passed from its membership.

Liverpool Branch.

Annual Report for the Session 1905-6.

Seven meetings were held in the course of the Session, at which papers were read and discussed.

The topics dealt with were: (1) "The Province of Homœopathy in Medicine," the President; (2) "The Resources of Homœopathy," Dr. Watson; (3) "The Question of the Dose," Dr. Gordon Smith; (4) "Medical Terms and Unreason," Dr. Edmund Hughes; (5) "The Therapeutic Uses of Tar and its Derivatives," the President; (6) "New, Old and Forgotten Remedies," Dr. Murray Moore; (7) "An Introduction to Anterior Colpotomy," Dr. Cash Reed.

During the Session one new member has been elected, and owing to his removal from Liverpool one member has resigned.

The former average attendance has not been maintained.

The funds in hand amount to the sum of £1 7s. 6d.

SUMMARY OF PHARMACODYNAMICS AND THERAPEUTICS.

Extracted from Exchange and other Journals by the Editor, in collaboration with J. Galley Blackley, M.B., and T. G. Stonham, M.D.

Lachesis in Diabetes from Suppressed Malaria.—Dr. C. G. Wilson, of Clarksville, Tenn., relates this case. A man, aged 60, and weighing 180 lbs., had not been well for a year, and previous to that had suffered for two more from malaria, for which he had taken large quantities of calomel and quinine. He was depressed, weak, and "bilious." For three months he had been passing about a gallon of urine during the day and more at night, getting up to pass some every half hour. Bad taste in mouth, dry, thirsty, constantly drinking water. Heat oppressed him. Wanted sour things and vegetables. Tired in the morning, and more depressed then, and often vertigo on rising. Urine showed an acid reaction, some albumin, and much sugar. He was given lachesis 200, one powder followed by a placebo. The next week he reported less urine and was in better spirits. Another dose of lachesis 200 was given. The third week he was still better and was given another dose. The next Monday he had a chill at 7 a.m. and the third day after a still stronger chill, the urine decreased to not over a quart in twenty-four hours, and analysis showed no clear trace of sugar with Haines' solution, and a mere trace of albumin. He was reported by Dr. Wilson as still improving at time of writing (presumably, he had no more chills). (*Medical Century*, September, 1906.)—T. G. S.

Luffa Ægyptica Mill (*Bitter Variety*). This plant belongs to the natural order Cucurbitaceæ and to the genus Luffa. The edible variety is cultivated in many parts of Bengal, and the fruits are largely eaten by the poorer classes, either simply boiled or made into a curry. The bitter variety is avoided as being poisonous; it can scarcely be distinguished from the edible plant except that the fruit is a shade darker in colour and the taste is extremely bitter. A case of poisoning by eating the bitter fruit

came under the notice of Dr. Rai Chuni Lal Bose Bahadur, F.C.S., of Calcutta, which led him to investigate the chemistry of the fruit. The history of the poisoning was as follows: A curry was made of the fruit with tamarised and other vegetables. This was served to two children, the latter of whom swallowed a little. She vomited her food immediately. No other symptoms followed. D. S., a man, aged 70, had a curry made the next day of a couple of the fruits, and took the whole quantity about 1 p.m. In 15 minutes afterwards he complained of feeling uneasy, and vomiting occurred. He brought up a large quantity of food. This was soon followed by diarrhœa. Up to 8 p.m. he vomited twice, and passed eight copious watery stools containing undigested fragments of the fruit. He was very low, pulse very small, feeble, rapid, skin cold and covered with clammy perspiration; there was extreme prostration; the patient was dull, but was quite conscious and answered questions rationally; he complained of pain in the abdomen and was getting cramps in the extremities. His voice was very feeble. Diffusible stimulants and calomel were given. He passed three more stools in the night and two the next morning, and made a slow recovery. The drug was submitted to chemical analysis by the ordinary alkaloidal extraction method and Dragendroff's method. More satisfactory results were obtained by the latter. Two distinct toxic principles were separated, one a severe emetic and another a brisk cathartic. Experiments were made on cats which produced these results. The cathartic produced likewise dysenteric symptoms. The active principles obtained from this fruit differed greatly in their physiological action from that obtained by the late Dr. Warden from the fruits of Luffa echinata, which also belongs to this genus, inasmuch as the latter was found to develop profound nervous symptoms, such as spasms, convulsions, and paralysis of the limbs, dilatation of the pupils, &c. These nervous symptoms were absent in the present case. From its physical properties, chemical behaviour, and physiological action, one of the active principles closely resembles colocynthin. Both the active principles are glucosides. (*Calcutta Journal of Medicine*, September, 1906.)—ED.

Mercurius Corrosivus in Inflamed Bladder.—Dr. W. S. Thompson, of Maine, relates this case: In May, 1905, I was called to see a gentleman suffering from inflammation of the bladder with the following symptoms: Frequent painful urina-

tion or attempts at urination with tenesmus and straining; fever, flushed face and glassy eyes. The recurring attacks of straining were prolonged and continuous, and affected not alone the bladder but the rectum as well, causing extremely painful efforts at defæcation. The first remedy given was bell. 3 x every hour. Relief followed, and it was continued on the second day. On the third day hæmorrhage occurred, which was relieved by hamamelis 3 x, but on the fourth day patient was much worse, particularly as to straining, the effects of which were seemingly unendurable. Remembering the rectal straining of dysentery, which has been so often relieved by mercurius corrosivus, I resolved to try it. It gave almost instant relief, and the patient had a good night (dilution of merc. cor. not given). (*New England Medical Gazette*, November, 1906.)—T. G. S.

Tuberculosis. *Homœopathic therapeutics.*—Professor W. A. Dewey has recently presented an acute analysis of the symptoms of certain well-tried homœopathic remedies for the tuberculous cachexia. These are *calcarea carb.*, *lycopodium*, *nitric acid*, *sulphur* and *sepia*. The following are to be regarded as the leading symptoms under each: (1) *Calcarea*, recurrent nose-bleeding, rawness of the throat, increased a.m., pain on swallowing, irritation in the trachea, spots and pimples on the face, sweat from the least exertion, especially of the head, sensitiveness to cold, sneezing, itching of the eyes and ears, falling of the hair, fulness and anxiety in the chest, hopefulness. The foregoing are basic symptoms. Of the essential symptoms of the disease nightly aggravation appears especially characteristic of calcarea. (2) *Lycopodium.* Similar basic symptoms with the following modifications: Evening aggravation, ulceration of throat, mental state characterised by anxiety or fear, sweat has an acid, offensive smell, deadness of fingers and blueness of nails, constipation, kidney complications, debility; (3) *Nitric acid*, bleeding of nose of especially dark blood and increased at night, throat symptoms prominent, especially in syphilitic subjects, bad odour from mouth, eruptions warty, and foul odour, hair falls from genitals, cough increased at night, diarrhœa in late cases, sweat of feet and breasts, of parts lain on, bad odour; (4) *Sulphur*, epistaxis attended with giddiness, swelling of glands of neck, diseased eyelids and discharges from the ears, cough increased p.m., excited by talking, headache during and after, sweat of head and chest increased a.m., fever midday and afternoon; (5) *sepia*, epistaxis, nose swollen and inflamed, yellowness of skin. Cough from pit of stomach and after meals, increased p.m. and

night, affections of generative organs. One of the foregoing remedies is, in the opinion of Professor Dewey, the constitutional remedy. Others should be given intercurrently as the condition demands. The most reliable indication for tuberculinum he regards as a disposition to take cold easily. (*The University Homœopathic Observer*, July, 1906, p. 154.)—Ed.

Tuberculosis. *Treatment by High Frequency Currents.*—In his presidential address before the National Society of Physical Therapeutics, at Atlantic City, Dr. William Harvey King gives an account of the treatment of tuberculous conditions by means of high frequency currents, and shows that in the cases published such treatment is immediately followed by a strong reaction on the part of the patient in the way of rise of temperature, &c., similar to the injection of Koch's tuberculin; but that after several applications, judged necessary according to the individual case, improvement sets in, shown by a lowering of the ordinary temperature of the patient, increase in weight, alteration of physical signs, &c. It is not claimed that this treatment supersedes any other, but that it is one that may go to make up a complete treatment. The methods employed are auto-condensation and derivative currents, or the direct application of the current from the D'Arsonval coil. In the latest cases treated, the free pole was applied direct to the affected parts by means of tinfoil instead of through the hands. If the chest is the seat of the trouble, all the part involved is covered with thin layers of tinfoil, and over this a piece of block tin having solid contact with the rheophore is applied. The dosage is governed by the conditions present, the keynote being the necessity to produce some reaction in the way of rise of temperature above that observed to occur before, as indicative of disease. In specially active cases, where the temperature is rising two or more degrees Fahrenheit, caution should be exercised in administering the first treatment. Not more than 150 m.a. should be given for 8 to 10 minutes. The rise of temperature should begin in a few hours, from 1 to 5, after the application. As a rule, the reaction is earlier and more severe in very active cases than in those not specially active. If in very active cases no reaction occurs, treatment will be of no avail. A report of cases treated follows a discussion of these details. (*North American Journal of Homœopathy*, October, 1906, p. 607.)—Ed.

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1863 Dr. QUAGLIO, Munich.
1863 Dr. LADELCI, Rue Delfini 14, Rome.
1870 Dr. IMBERT-GOURBEYRE, Clermont-Ferrand, France.
1875 Dr. S. A. JONES, Ann Arbor, Michigan.
1876 Dr. LEON SIMON, 24, Place Vendome, Paris.
1877 Dr. JOUSSET, 97, Boulevard Haussmann, Paris.
1878 Dr. A. CLAUDE, 43, Rue Caumartin, Paris.
1892 Dr. LAMBREGHTS, Rue Stoop 1, Antwerp.
1892 Dr. BONIFACE SCHMITZ, Longue rue Neuve 134, Antwerp.
1893 Dr. WINDELBAND, Koniggrätzerstr. 88, Berlin, S.W.
1896 Dr. G. BONINO, Via Ospedale 14, Turin.
1896 Dr. LEON BRASOL, Troitzkaja 5, St. Petersburg.
1896 Dr. CARTIER, 18, Rue Vignon, Paris.
1896 Dr. W. B. VAN LENNEP, 1421, Spruce Street, Philadelphia.
1896 Dr. J. H. McCLELLAND, Cor. Fifth and Wilkins Avenues, Pittsburgh.
1896 Dr. A. B. NORTON, 16, West 45th Street, New York.
1896 Dr. A. VILLERS, Lüttichaustr. 7, 1, Dresden.
1896 Dr. WALTER WESSELHŒFT, 26, Garden Street, Cambridge, Mass.
1896 Dr. JAMES C. WOOD, 122, Euclid Avenue, Cleveland, Ohio.
1898 Dr. W. A. DEWEY, University of Michigan, Ann Arbor.
1898 Dr. PEMBERTON DUDLEY, 1405, North 16th Street, Philadelphia.
1898 Dr. EUGENE H. PORTER, 181, West 73rd Street, New York.
1904 Dr. H. C. ALLEN, 5142, Washington Avenue, Chicago.
1904 Dr. H. R. ARNDT, 372, Sutter Street, San Francisco.
1904 Dr. CLARENCE BARTLETT, 1437, Spruce Street, Philadelphia.

1904 Dr. EMILE BATAULT, Rue Sénebier 10, Geneva.
1904 Dr. R. S. COPELAND, 317, S. State Street, Ann Arbor, Michigan, U.S.A.
1904 Dr. GATCHELL, 100, State Street, Chicago.
1904 Dr. SARAT CHANDRA GHOSE, 1, Kedar Bose's Lane, Bhowanipore, Calcutta.
1904 Dr. J. T. KENT, 92, State Street, Chicago.
1904 Dr. HARVEY KING, 64, West 51st Street, New York.
1904 Dr. J. KLAUBER, I. Maysedergasse, 5, Vienna.
1904 Professor CESARE LOMBROSO, Via Legnano 26, Torino.
1904 Dr. SATURNINO SOARES DE MEIRELLES, Ruo do Riachnelo 175, Rio de Janeiro.
1904 Dr. OLIVE, Barcelona.
1904 Dr. GEORGE W. ROBERTS, 170, West 59th Street, New York.
1904 Dr. SCHEPENS, 71, Rue Neuve St. Pierre, Gand.
1904 Dr. SEUTIN, Brussels.
1904 Dr. GEORGE F. SHEARS, 100, State Street, Chicago.
1904 Dr. JOHN P. SUTHERLAND, 295, Commonwealth Avenue, Boston, Mass.
1904 Dr. J. TESSIER, 240 *bis*, Boulevard Saint Germain, Paris.
1904 Dr. N. A. J. VOORHOEVE, Celebes Straat 93, The Hague.

FELLOWS OF THE SOCIETY.

ARCHIBALD SPEIRS ALEXANDER.
JOHN GALLEY BLACKLEY.
DAVID DYCE BROWN.
GEORGE BURFORD.
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MEMBERS OF THE BRITISH HOMŒOPATHIC SOCIETY.

Founded 1844.

EXPLANATION OF THE ABBREVIATIONS.

P.—President.	V.-P.—Vice-President.
T.—Treasurer.	L.—Librarian.
C.—Member of Council.	S.—Secretary.

Those marked thus (*) are Fellows of the Society, those marked (†) are non-resident or retired from practice, and those marked (‡) have not returned the circular.

Members are requested to communicate with the Secretary when corrections are necessary.

GENERAL LIST OF MEMBERS.

Elected

1888 *ALEXANDER, ARCHIBALD SPEIRS, M.D., C.M.Glas.; Consulting Physician to the Devon and Cornwall Homœopathic Hospital; Assistant Ophthalmic Surgeon to the London Homœopathic Hospital; 174, Haverstock Hill, N.W. (V.-P. 1904-1906.)

1890 ALEXANDER, SAMUEL PHILIP, M.D., C.M.Glas., M.R.C.S. Eng.; Tecumseh House, 20, Kent Road, Southsea.

1893 ARNOLD, FRANCIS SORELL, B.A., M.B., B.Ch.Oxon., M.R.C.S. Eng., L.S.A.; Hailey Sanatorium, Ipsden, Wallingford.

1899 ASHTON, JAMES THORNHILL, M.B., C.M.Edin.; Medical Officer, Electro-therapeutic and X-ray Department, London Homœopathic Hospital; 5A, New Burlington Street, W., and 13, Onslow Crescent, S.W.

1902 AVENT, ARTHUR, L.R.C.P., L.R.C.S.Ed., L.F.P.S.Glas., L.S.A.Lond.; Hon. Physician and Anæsthetist to the Birmingham and Midland Homœopathic Hospital and Dispensary; The Towers, Hamstead Road, Handsworth, Birmingham.

1906 BARNES, THOMAS HENRY, M.D.St. And., M.R.C.S., L.S.A., 148, Lavender Hill, S.W.

1894 ‡BARRETT, JOHN JAMES, M.D.St. And., L.R.C.P.Lond. M.R.C.S.Eng.; 170, Ramsden Road, Balham, S.W.

Elected

1891 BARROW, ROGER WILLIAM, M.D.Brux., L.R.C.P., L.M. Edin., M.R.C.S.Eng. (*Address not communicated*).

1899 BEALE, ARTHUR ARNOLD, M.B., C.M.Glas.; Anæsthetist to the London Homœopathic Hospital; 20, Winchester Road, Eton Avenue, N.W.

1868 BELCHER, HENRY, M.D.Univ. Erlang., L.R.C.P.Edin., M.R.C.S.Eng.; Fell. Obst. Soc., Lond.; Honorary Treasurer to the Sussex County Homœopathic Dispensary; 28, Cromwell Road, West Brighton.

1890 BENNETT, HENRY, L.R.C.P., L.R.C.S., L.M.Edin., L.A.H., L.M.Dub.; 323, Holloway Road, N.

1892 BIRD, ASHLEY, M.R.C.S.Eng., L.S.A.; Culverlands, 25, Victoria Square, Penarth, Glamorganshire.

1894 BLACK, GEORGE, M.B., C.M.Edin.; Greta Bank, Torquay.

1872 *BLACKLEY, JOHN GALLEY (*Treasurer*), M.B.Lond., M.R.C.S. Eng.; Senior Physician and Physician for Diseases of the Skin to the London Homœopathic Hospital; 29, Devonshire Place, W. (P. 1892. V.-P. 1884, 1891. S. 1885-1891. T. 1892-1906).

1901 BLAIR, JAMES ANDREW, M.D., C.M.Edin., D.Sc. (Public Health), L.R.C.P.Lond.; 16, Windsor Terrace, Newcastle-on-Tyne.

1892 ‡BLUMBERG, HENRY D'ARNIM, L.R.C.P., L.R.C.S.Edin., L.F.P.S.Glas.; Honorary Medical Officer, North-Eastern Children's Sanatorium; Warley House, Southport.

1903 BODMAN, CHRISTOPHER OSMOND, M.D., B.S.Dunelm, M.R.C.S. Eng., L.R.C.P.Lond.; Physician to Müller's Orphan Houses, Bristol, and to the Hahnemann Hospital, Bristol; 76, Chesterfield Road, St. Andrew's Park, Bristol.

1892 BODMAN, FRANCIS HENRY, M.D.Aberd., M.R.C.S.Eng., L.M.; Physician for Diseases of Women to the Hahnemann Hospital, Bristol; Linden House, Oakland Road, Bristol.

1896 BODMAN, JOHN HERVEY, M.D., B.S.Lond., M.R.C.S.Eng., L.R.C.P.Lond.; Physician to the Hahnemann Hospital, Bristol; 3, White Ladies Road, Clifton, and 7, Wine Street, Bristol.

Elected

1883 †BROOKS, SAMUEL BREWER, M.R.C.S.Eng., L.R.C.P.Edin., L.F.P.S.Glas., L.S.A., 2, Forest Grove, Colville Street, Nottingham.

1871 *BROWN, DAVID DYCE, M.A., M.D., C.M.Aberd.; Consulting Physician to the London Homœopathic Hospital; the Phillips Memorial Hospital, Bromley, Kent; and to the Leicester Homœopathic Hospital; 29, Seymour Street, Portman Square, W. (P. 1884. V.-P. 1883. C. 1892.)

1872 BRYCE, WILLIAM, M.D.Edin.; 34, Greenhill Gardens, Edinburgh.

1889 *BURFORD, GEORGE (*Council*), M.B., C.M.Aberd., M.R.I.; Senior Physician for Diseases of Women to the London Homœopathic Hospital; Consulting Physician for Diseases of Women to the Homœopathic Hospital, Tunbridge Wells; to the Devon and Cornwall Homœopathic Hospital, Plymouth; to the Phillips Memorial Hospital, Bromley; to the Lansdown Homœopathic Hospital, Bath; to the Homœopathic Cottage Hospital, Leicester; and to the Hahnemann Hospital, Bristol; 35, Queen Anne Street, W. (P. 1901. V.-P. 1898-1900. C. 1892, 1895-7, 1900, 1902-06.)

1873 BURWOOD, THOMAS WESLEY, L.R.C.P., L.M.Ed., L.R.C.P., L.M.Ireland.; Physician to the Ealing and West Middlesex Homœopathic Dispensary; Strathmore, Florence Road, Ealing, W.

1890 CAPPER, EDMUND, M.D., C.M.Edin., Medical Officer to the Leicester Homœopathic Cottage Hospital and Dispensary; 71, Evington Road, Leicester.

1891 CAPPER, PERCY, M.B., C.M.Edin.; Physician to the Hastings and St. Leonards Homœopathic Dispensary; Rocklands, 58, London Road, St. Leonards; Ellangowan, 2, Eversley Road, Bexhill-on-Sea.

1879 *CASH, ALFRED MIDGLEY, M.D., C.M.Edin., M.R.C.S.Eng., Physician to the Torquay Homœopathic Dispensary; Limefield, Falkland Road, Torquay.

Elected

1892 CAVENAGH, JOHN PAUL, L.R.C.P., L.R.C.S., L.M.I.; Thorneloe House, Worcester.

1873 †CHALMERS, ANDREW CRICHTON, M.D., L.R.C.S.Edin.; Stratheden, Cantelupe Road, Bexhill-on-Sea.

1895 CHAPMAN, GEORGE WILLIAM, M.R.C.S.Eng., L.R.C.P.Lond.; 18, Edgar Road, Cliftonville, Margate.

1880 *CLARKE, JOHN HENRY (*President*), M.D., C.M.Edin.; Consulting Physician to the London Homœopathic Hospital; 8, Bolton Street, Piccadilly, W., and 38, Cornhill, E.C. (V.-P. 1888.)

1861*†CLIFTON, ARTHUR CROWEN, M.D. (Hon.) New York, M.R.C.S.Eng.; 9, East Park Parade, Northampton, (P. 1898. C. 1894, 1899.)

1892 CLIFTON, FREDERICK WILLIAM, M.R.C.S.Eng., L.R.C.P., L.M.Edin.; 356, Glossop Road, Sheffield, and Rotherham.

1873 CLIFTON, GEORGE, J.P., L.R.C.P.Edin., L.M., L.F.P.S. Glas.; Consulting Physician to the Leicester Homœopathic Dispensary and Cottage Hospital; 60, London Road, and 7, Bowling Green Street, Leicester.

1892 ‡COLLINS, CHARLES PHILLIPS, M.D.Clev., M.R.C.S.Eng., L.R.C.P.Lond.; Norham Lodge, Leamington Spa.

1891 COMPSTON, EDMUND LEACH, M.B., Ch.B.Vict.; Crawshawbooth, Rawtenstall, Lancs.

1892†‡COOK, EDMUND ALLEYNE, Ph.D.Marburg, L.R.C.P., L.R.C.S. Edin., L.F.P.S.Glas.; Honorary Surgeon to the Melbourne Homœopathic Hospital; 88, Collins Street, Melbourne, Australia.

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1903 ‡COOPER, ROBERT MONTAGU LE HUNTE (*Council*), (*Librarian*), M.D., B.S.Durh., M.R.C.S., L.R.C.P.Lond.; 18, Wimpole Street, W., and 17, Stanley Gardens, Kensington Park, W.

1893 CORBETT, HERBERT HENRY, M.R.C.S.Eng.; 9, Priory Place, Doncaster.

Elected

1892 ‡Cox, Richard Percy, M.D., C.M.Edin.; Gwynant, Withington, and 80, Deansgate Arcade, Manchester.

1890 ‡Cox, William Spencer, M.D.Brux., M.R.C.S.Eng., L.S.A.; Assistant Physician to the London Homœopathic Hospital; Physician to the Kensington, Notting Hill and Bayswater Homœopathic Dispensary; 12, Sheffield Gardens, Kensington, W.

1892 ‡Craig, John, L.R.C.P.Edin., L.F.P.S.Glas.; Shelton House, Stoke-upon-Trent.

1862 Cronin, Eugene Francis, M.D.St. And., M.R.C.S.Eng., L.S.A.; Old Manor House, Clapham Common, S.W.

1892 Croucher, Alexander Henry, M.D., C.M.Edin., F.R.C.S. Edin.; Physician and Surgeon to the Leaf Homœopathic Cottage Hospital; to the Eastbourne Homœopathic Dispensary; and to the Eastbourne Homœopathic Convalescent Home; Onslow House, 6, Burlington Place, Eastbourne.

1867 †Croucher, Alexander Richard, M.D.St. And., M.R.C.S. Eng., L.S.A., L.M.; Consulting Physician to the Buchanan Hospital, St. Leonards-on-Sea; 26, Portland Terrace, Southampton.

1899 ‡Dawson, Harry George Frederick, L.R.C.P.I., L.R.C.S.I., L.M.; 23, Hamilton Square, and 35, Beresford Road, Birkenhead.

1887 *Day, John Roberson, M.D.Lond., M.R.C.S.Eng., L.R.C.P. Lond., L.S.A.; Physician for Diseases of Children, and Consulting Anæsthetist to the London Homœopathic Hospital; 35, Queen Anne Street, W. (P. 1902. V.-P. 1900-1. C. 1896.)

1892 *Deane, Herbert Edward, M.D.Dur., M.R.C.S.Eng., L.S.A.; Lt.-Colonel, Royal Army Medical Corps (*Retired*); Assistant Physician to the London Homœopathic Hospital, 33, Weymouth Street, W.

1875†‡Deck, John Field, M.D.St. And., M.R.C.S.Eng., L.R.C.P. Lond.; Ashfield, Sydney, New South Wales.

Elected

1906 EADIE, JAMES, M.B., Ch.B.Glas, Assistant Surgeon to the London Homœopathic Hospital; 7, Upper Woburn Place, W.C.

1893 EATON, HENRY ARNOLD, M.B., C.M.Edin.; 16, Eldon Square, Newcastle-on-Tyne.

1887 ELLIS, JOHN WILLIAM, M.B., Ch.B.Vict. and Liv., L.R.C.P., L.R.C.S.Edin.; Honorary Physician to the Hahnemann Hospital, Liverpool; 18, Rodney Street, Liverpool.

1900 ELLWOOD, THOMAS ASHCROFT, M.R.C.S.Eng., L.R.C.P.Lond., D.P.H.Camb.; 99, Tollington Park, N., and 12a, Finsbury Square, E.C.

1875 *EPPS, WASHINGTON, L.R.C.P.Edin., M.R.C.S.Eng.; Physician to the London Homœopathic Hospital; 55, Queen Anne Street, W. (P.1899. V.-P. 1896-98. C. 1893-94-97, 1903-04.)

1906 FAIRLIE, HENRY PRESCOT, M.B., Ch.B.Glas.; 2, University Gardens, Hill Head, Glasgow.

1904 †FALLON, ROBERT HUME, M.D., C.M.Aberd.; 6, Shamrock Terrace, Green Point, Cape Town.

1892 FINLAY, JOHN THOMAS, L.R.C.P., L.R.C.S., L.M.Edin., L.A.H., L.M.Dub.; Greystone House, Rawtenstall, Lancashire.

1881 ‡GILBERT, SYDNEY, L.R.C.P., L.R.C.S.Edin., L.A.H., L.M. Edin. and Dub.; Somersfield Cottage, Reigate.

1893 †GILES, FREDERICK WILLIAM, M.B.Durh., M.R.C.S.Eng. (*Address not communicated.*)

1881 *GOLDSBROUGH, GILES FORWARD (*Editor*), M.D., C.M. Aberd.; Physician and Physician for Diseases of the Nervous System to the London Homœopathic Hospital; 82, Wimpole Street, W., and Churchside, Herne Hill, S.E. (P. 1895. V.-P. 1893-94. C. 1897-98, 1901.)

1892 ‡GORDON, JOHN NEWLANDS, M.B., C.M.Aberd.; 70, Upper Parliament Street, Liverpool.

1886 ‡GOULD, EDWARD GARDINER, L.R.C.P.I.; Northcot, Grange Road, Sutton, Surrey.

Elected

1901 GRACE, NATHANIEL, M.D., C.M.McGill Univ., Montreal, M.R.C.S.Eng., L.R.C.P.Lond.; Hon. Surgeon to the Tunbridge Wells Homœopathic Hospital and Dispensary; 2, Calverley Mount, Tunbridge Wells.

1892 *GREEN, CONRAD THEODORE, M.R.C.S.Eng., L.R.C.P.Lond., F.L.S.; Fell. Roy. Instit. Public Health; Honorary Medical Officer to the Wirral Homœopathic Dispensary; Capt. Army Med. Reserve; Surg.-Capt. 1st V. B. Cheshire Regt.; 31, Shrewsbury Road, Birkenhead. (P. *Liverpool Branch*, 1896. V.-P. 1899.)

1892*‡GREEN, VINCENT, M.D.Edin.; Assistant Surgeon for Diseases of the Throat and Ear to the London Homœopathic Hospital; Physician to the Wimbledon and Merton Homœopathic Dispensary; Greyroofs, Wimbledon Hill, and 155, Fenchurch Street, E.C.

1906 GREENWOOD, J. W., M.B., Ch.B.Vic.; 1, Slade Lane, Longsight, Manchester.

1902 GREIG, CHARLES JOHN, L.R.C.P.Edin., L.R.C.S.Edin., L.F.P.S.Glasg.; Physician to the Ealing and West Middlesex Homœopathic Dispensary; Gordon House, 86, Gordon Road, Ealing, W.

1895 GREIG, WILLIAM, M.B., C.M.Aberd.; South Parade, Wakefield.

1876 ‡HALL, EDGAR ATHELING, M.B., C.M.Edin.; Physician to the Surbiton, Kingston, and Norbiton Homœopathic Dispensary; Seacombe, Adelaide Road, Surbiton.

1892 HALL, FREDERICK, L.R.C.P., L.R.C.S.I., L.M.; 18, Shakespeare Street, Nottingham.

1906 HAM, CHARLES EDWARD, M.D.Lond.; 32, Weymouth Street, Portland Place, W.

1894 HARDY, JAMES EBENEZER, M.B., C.M.Edin.; 2, Queen's Crescent, Glasgow, W.

1859 HARPER, JAMES PEDDIE, M.D.Edin., L.R.C.S.Edin.; 43, Hertford Street, Mayfair, W.

1902 ‡HARRIS, HENRY ARTHUR CLIFTON, M.R.C.S Eng., L.R.C.P. Lond.; Medical Officer to the Sussex County Homœopathic Dispensary; 12, Buckingham Place, Brighton.

Elected

1900 ‡HARRIS, LILLIAN MAUDE CUNARD, L.R.C.P.I. and L.R.C.S.I.; 12, Buckingham Place, Brighton.

1878 *HAWKES, ALFRED EDWARD (*Ex-President*), (*Liverpool Branch Representative*), M.D.Brux., L.R.C.P., L.M., L.R.C.S. Edin.; Medical Officer for Diseases of Women to the Hahnemann Hospital, Liverpool; 22, Abercromby Square, Liverpool. (P. 1905. V.-P. 1904-5. C. 1898-1906. P. *Liverpool Branch*, 1892, 1901. V.-P. 1893, 1903-4.)

1904 HAWKES, JAMES L., M.B., Ch.B.Vict. and Liv.; Anæsthetist to Hahnemann Hospital, Liverpool; 187, Edge Lane, Liverpool.

1905 HAYES, FREDERICK WILLIAM, M.B., Ch.B. Vict. and Leeds; Honorary Physician to Leeds Homœopathic Dispensary; 3, Reginald Terrace, Leeds.

1886 HAYLE, THOMAS HAHNEMANN, M.B.Lond.; B.Sc.Victoria; The Crescent, Rochdale.

1892 HAYWARD, CHARLES WILLIAMS (Barrister-at-Law), M.D., C.M.Edin., D.P.H.Camb., M.R.C.S.Eng., L.R.C.P.Lond.; Fell. Roy. Instit. Public Health; Surgeon, and Surgeon to the Throat, Nose and Ear Department, Hahnemann Hospital, Liverpool; 117, Grove Street, Liverpool. (V.-P. *Liverpool Branch*, 1902. P. 1903.)

1892 HAYWARD, JOHN DAVEY, M.D.Lond., M.R.C.S.Eng., L.S.A.; Consulting Surgeon to the Hahnemann Hospital, Liverpool; Leyfield Priory, West Derby, Liverpool. (P. *Liverpool Branch*, 1897. V.-P. 1899.)

1868*‡HAYWARD, JOHN WILLIAMS, M.D.St. And., M.R.C.S.Eng., L.S.A., M.D. (Hon.) New York; Consulting Physician to the Hahnemann Hospital, Liverpool; 61, Shrewsbury Road, Birkenhead. (P. *Liverpool Branch*, 1895. V.-P. 1897. C. 1892-97.)

1904 HEY, CLARENCE GRANVILLE, M.B., C.M.Ed.; Assistant Surgeon, Assistant in the Ophthalmic Department and Clinical Assistant to the Gynæcological Department, London Homœopathic Hospital; 96, Earl's Court Road, Kensington, W.

Elected

1885 ‡HILBERS, HERMANN GERHARD, B.A.Camb., L.R.C.P., L.R.C.S. Edin., L.F.P.S.Glas.; Honorary Physician to the Sussex County Homœopathic Dispensary; Honorary Physician to the Crescent House Convalescent Home; 49, Montpelier Road, Brighton.

1901 ‡HILL, WILFRED GRANTHAM, M.D.Brux., L.R.C.P.Lond., M.R.C.S.Eng., L.S.A.; Assistant Physician to the London Homœopathic Hospital; 49, High Road, Chiswick, W.

1887 HILL, WILLIAM REED, M.B., C.M.Edin.; 38, Berners Street, Ipswich.

1902 HUGHES, EDMUND, M.R.C.S.Eng., L.R.C.P.Lond.; Medical Officer to the North Homœopathic Dispensary, Liverpool; 125, Queen's Road, Liverpool.

1892 ‡HUXLEY, JOHN CHARLES, M.D., C.M.Aberd.; Honorary Surgeon to the Birmingham and Midland Homœopathic Hospital and Dispensary; 91, Harborne Road, Edgbaston, Birmingham.

1904 ‡HYND, ALFRED JAMES, M.B., C.M.Aberd., D.P.H., 89, Mount Pleasant, Liverpool.

1904 HYND, THOMAS CHALMERS, M.B., Ch.B.Aberd., 11, Standishgate, Wigan.

1882 *JAGIELSKI, VICTOR APOLLINARIS, M.D.Berlin, M.R.C.P. Lond.; 14, Dorset Square, N.W.

1894 *JOHNSTONE, JAMES, B.A., F.R.C.S.Eng., M.B., C.M., D.P.H. Aberd.; Assistant Physician for Diseases of Women to the London Homœopathic Hospital; 26, Sheen Road, Richmond, Surrey. (P. 1904-05. V.-P. 1902-04. C. 1896-97, 1900. S. 1898-1901.)

1887 †JONES, DAVID OGDEN ROEBUCK, M.D.Trin. Coll., Toronto, L.R.C.P.Lond.; Physician to the Grace Hospital (Homœopathic); Surgeon for Diseases of the Eye, Ear, Nose and Throat, to the "Nursing at Home Mission" Dispensary; 126, Carleton Street, Toronto, Canada.

Elected

1893 JONES, GEORGE REGINALD, L.R.C.P.Lond., M.R.C.S.Eng., Medical Officer to the Homœopathic Institution, Manchester; 73, Withington Road, Whalley Range, Manchester.

1866 ‡JONES, JAMES, M.D.Edin., M.R.C.S.Eng., L.R.C.P.Lond.; 157, Lewisham Road, S.E.

1881 JONES, THOMAS REGINALD, L.R.C.P.I., L.M., M.R.C.S. Eng.; late Consulting Physician to the Wirral Homœopathic Dispensary; Wayside, Colwyn Bay.

1901 ‡LEWIN, OCTAVIA MARGARET SOPHIA, M.B., B.S.Lond., M.D.Chicago; Registrar to the London Homœopathic Hospital; 25, Wimpole Street, W.

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1886 ‡MCKILLIAM, ROBERT, M.D., C.M.Aberd.; 6, Grote's Buildings, Blackheath, S.E.

1892 MCLACHLAN, JOHN, M.A.(Oxon.), B.C.L., M.D., C.M., B.Sc. Edin., F.R.C.S.Eng., L.S.A.; Physician to the Oxford Homœopathic Dispensary; 3, Keble Road, Oxford.

1893 *MACNISH, DAVID (*Vice-President*), M.A., M.B., C.M.Edin.; Physician to the London Homœopathic Hospital; Physician to the Kensington, Notting Hill and Bayswater Homœopathic Dispensary, W.; 4, Leinster Square, W. (C. 1901-02-04-05.)

1876 *MADDEN, EDWARD MONSON, M.B.Edin., M.R.C.S.Eng., Physician to the Phillips Memorial Hospital; Burlington House, Bromley, Kent. (P. 1896. V.-P. 1892-93. C. 1894, 1901-02.)

1895 MARCH, EDWARD GERALD, M.D.Brux., F.R.C.S.Edin., M.R.C.S.Eng., L.R.C.P.Lond.; Hon. Medical Officer to the Box Grove Sanatorium, Tilehurst; Camden House, Castle Hill, Reading.

Elected

1885 ‡MASON, HENRY, M.D., C.M.Glas., M.R.C.S.Eng.; Medical Officer to the Leicester Homœopathic Cottage Hospital and Dispensary; 66, London Road, Leicester.

1893 MEEK, WILLIAM OMBLER, M.B., C.M.Edin.; 240, Oxford Road, Manchester.

1893 MILLER, ROBERT GIBSON, M.B., C.M.Glas.; 10, Newton Place, Glasgow.

1902 MINTER, LEONARD JNO., M.D.Brux., M.R.C.S., L.R.C.P. Lond., L.S.A.; 36, Sillwood Road, Brighton.

1892 ‡MITCHELL, JOHN JAMES, L.R.C.P.Lond., M.R.C.S.Eng.; 1, Howard Place, Stoke-on-Trent.

1882 *MOIR, BYRES (*Council*), M.D., C.M.Edin.; Physician to the London Homœopathic Hospital; 16, Upper Wimpole Street, W. (P. 1894. V.-P. 1891, 1892. C. 1892-99, 1900-03-06.)

1892 MOIR, DOUGLAS, M.D., C.M.Aberd.; 333, Oxford Road, Manchester.

1889 MOLSON, JOHN CAVENDISH, M.D.Exam., Hering Med. Coll., Chicago; L.R.C.P.Lond., F.C.S., F.R.G.S.; 82, Wimpole Street, W., and 1, Pavilion Buildings, Brighton.

1877 MOORE, JOHN MURRAY, M.D., C.M., L.M.Edin., M.R.C.S. Eng., M.D.New Zealand, F.R.G.S.; Priory House, Church Street, Leamington Spa.

1867 MORGAN, SAMUEL, M.D.St. And., M.R.C.S.Eng., L.S.A.; Consulting Physician to the Bath Homœopathic Hospital; Physician to the Bristol Hahnemann Hospital; 15, Oakfield Road, Clifton, Bristol.

1897 MUNSTER, HAROLD VALDEMAR, M.D.Edin.; Medical Officer, Visiting Surgeon and Anæsthetist to the Croydon Homœopathic Dispensary; Hollywood, 109, St. James' Road, and 40, George Street, Croydon.

1882 MURRAY, JOHN, L.R.C.P., L.R.C.S., L.M.Edin.; Physician to the Folkestone Homœopathic Dispensary; 15, Trinity Gardens, Folkestone. (C. 1900.)

Elected

1895 NANKIVELL, BERTRAM WRIGHT, M.R.C.S.Eng., L.R.C.P. Lond.; Surgeon and Registrar to the Hahnemann Convalescent Home; Physician to the Cottage Home, Cotlands Road; Visiting Surgeon and Physician to the Bournemouth Homœopathic Dispensaries; Consulting Surgeon to the Victoria Home for Crippled Children, Westbourne; Honorary Physician, Y.M.C.A., Bournemouth; Honorary Surgeon to the Bournemouth Ambulance Association; Woodstock, West Cliff Road, Bournemouth.

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1893 NEATBY, ANDREW MOSSFORTH, L.R.C.P., L.R.C.S.Edin., L.F.P.S.Glas.; Earl Grey, Saskatschewan, Canada.

1885 *NEATBY, EDWIN AWDAS (*Hon. Secretary*), M.D.Brux., L.R.C.P.Lond., M.R.C.S.Eng.; Physician for Diseases of Women to the London Homœopathic Hospital; Consulting Physician for Diseases of Women to the Buchanan Hospital, St. Leonards-on-Sea, and to the Leaf Cottage Hospital, Eastbourne; 82, Wimpole Street, W. [(P. 1897. V.-P. 1894-95-96. C. 1896-1903-04. *Librarian*, 1890-1899.)

1904 NEATBY, THOMAS MILLER, M.A.Cantab., M.A.Lond., B.C. Cantab., M.R.C.S.Eng., L.R.C.P.Lond.; Assistant Physician to the London Homœopathic Hospital; 25, Petherton Road, Highbury New Park, N.

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Elected

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1883 PURDOM, THOMAS EADIE, M.D., C.M.Edin., L.R.C.P., L.R.C.S Edin.; Senior Physician to the Croydon Homœopathic Dispensary; Ellerslie, 25, Park Hill Road, and 40, George Street, Croydon.

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1895 ‡REID, ARTHUR LESTOCK, M.R.C.S.Eng., L.R.C.P.Lond.; Thornborough House, Clarendon Road, Watford. (C. 1900-01.)

1872 †REID, LESTOCK HOLLAND, M.R.C.S.Eng., L.R.C.P.Lond.; 472, Palmerston Avenue, Toronto, Ontario, Canada.

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Elected

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Elected

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1885 Shaw, Frank Herbert, M.R.C.S.Eng.; Surgeon to the Buchanan Hospital, and to the Hastings and St. Leonards Homœopathic Dispensary; The Gables, Pevensey Road, St. Leonards-on-Sea.

1888 Simpson, Thomas, M.D.St. And., M.R.C.S.Eng.; Honorary Consulting Physician to the Hahnemann Hospital, Liverpool; 17, Lancaster Road, Birkdale, Lancs.

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1896†‡Smith, Philip Douglas, M.B., C.M.Edin.; Launceston, Tasmania.

1892 Smith, Robert Gordon, M.B., C.M.Aberd.; Honorary Medical Officer to the Hahnemann Hospital, Liverpool; 164, Upper Parliament Street, Liverpool.

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1899 Stacey, Frederic George, B.A., M.B., B.C.Cantab., M.R.C.S.Eng., L.R.C.P.Lond.; 719, Ecclesall Road, Hunter's Bar, Sheffield.

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Elected

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1887 STORAR, WILLIAM MORRISON, L.R.C.P., L.R.C.S.Edin., L.M.; 5, Zion Hill, Ramsgate.

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1891 *THOMAS, HAROLD WYNNE, M.R.C.S.Eng., L.R.C.P.Lond.; Surgeon to the Phillips Memorial Hospital, Bromley; "Thornbury," High Street, Bromley, Kent.

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1886 ‡VAWDREY, THEOPHILUS GLASCOTT, L.R.C.P.Lond., M.R.C.S. Eng.; 8, Athenæum Terrace, Plymouth.

1891 WADDINGTON, CHARLES EDWIN, L.R.C.P.Lond., M.R.C.S. Eng.; 2, Marlborough Road, Manningham, Bradford.

Elected

1900 †‡ WARREN, WILLIAM, M.R.C.P.I., L.R.C.S.I., L.M.; "Wentworth," Glenferrie Road, Kew, Melbourne, Australia.

1895 *WATKINS, FRANK AUGUSTUS, M.R.C.S.Eng., L.R.C.P.Lond., L.S.A.; Pathologist to the London Homœopathic Hospital; Merton Lodge, 115, Denmark Hill, S.E.

1862 †WATSON, CHARLES GEORGE, L.R.C.S., L.R.C.P.I., L.M. (*Address not communicated.*)

1897 WATSON, JAMES (*President Liverpool Branch*), M.B., C.M. Edin.; Honorary Physician to the Hahnemann Hospital, Liverpool; 32, Princes Road, Liverpool.

1898 ‡WEBSTER, NORMAN PETER, L.S.A., M.R.C.S.Ontario; George Place, Guernsey.

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1861 †WHEELER, HENRY, L.R.C.P.Lond., M.R.C.S.Eng.; "Hazeldene," Christchurch Road, Eaton, Norwich.

1901 ‡WHITE, ADAM CRAWFORD, M.D., C.M.Glas., 31, Union Street Oldham.

1893 ‡WILDE, FREDERICK GEORGE STANLEY, L.R.C.P., L.R.C.S., L.M.Edin.; Physician to the Cheltenham Homœopathic Dispensary; Ingleside, Bayshill, Cheltenham.

1893 WILDE, HERBERT, M.B., C.M.Edin., L.R.C.P., L.R.C.S.Edin.; Medical Officer to the Brighton Homœopathic Dispensary; 18, Clifton Terrace, Brighton.

1891 ‡*WILDE, PERCY ROBERTS, M.D., C.M.Aberd.; Physician to the Lansdown Hospital and to the Bath Homœopathic Hospital; 23, Circus, Bath.

1891 ‡WILDE, ROWLAND STANLEY, M.B., C.M.Edin.; Physician to the Weston-super-Mare Homœopathic Dispensary; Park House, Weston-super-Mare.

1892 WILKINSON, ALFRED GEORGE, M.R.C.S.Eng., L.S.A.; 28, Newland, Northampton.

1892 *WILKINSON, CLEMENT JOHN, M.R.C.S.Eng., L.S.A.; 3, Osborne Villas, Windsor. (V.-P., 1905. C. 1898-99.)

Elected

1892 ‡WILLIAMS, LEMUEL EDWARD, M.R.C.S.Eng.; Surgeon to the Skin Department and Honorary Assistant Medical Officer to the Hahnemann Hospital, Liverpool; 239, Boundary Street, Liverpool.

1896 WILLS, REGINALD GRAHAM, M.D., C.M.Aberd.; late Visiting Medical Officer to the Bath Homœopathic Hospital; 8, St. George's Place, Canterbury.

1902 ‡WILMOT, PHILIP MCKINNELL CORBOULD, M.B.Lond., M.R.C.S., L.R.C.P.Lond.; Honorary Surgeon to the Devon and Cornwall Homœopathic Hospital; 6, Sussex Terrace, Plymouth.

1892 WINGFIELD, JOHN, L.R.C.P., L.R.C.S.Edin., L.F.P.S.Glas.; Honorary Physician to the Birmingham and Midland Homœopathic Hospital; Elmhurst, Wake Green Road, Moseley; and 60, Newhall Street, Birmingham.

1889 ‡WITHINSHAW, CHARLES WESLEY, L.R.C.P., L.R.C.S., L.M. Edin.; 149, Clapham Road, S.W.

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Meetings are held at the Hahnemann Hospital, Hope Street, Liverpool, on the Second Thursday in each month.

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THE CONSTITUTIONAL AND LOCAL SYMPTOMS OF DISEASE; THEIR RELATIVE VALUE IN THERAPEUTICS, WITH ILLUSTRATIVE CASES.[1]

BY DAVID MACNISH, M.A., M.B., C.M.EDIN.
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In this paper I wish to bring before the Society a few clinical cases which appear to have been treated with some success. This reminds one of the old story of the stranger visiting the Temple of Neptune and inquiring what good this god had conferred on humanity. The priest pointed to several offerings scattered about the temple, and said these were the grateful offerings of some whom the god Neptune had saved at sea. The stranger gazed upon them and asked if he might be permitted to see the offerings of the thousands who had been drowned at sea.

So in presenting these few cases you will naturally ask

[1] Presented to the Section of Materia Medica and Therapeutics, December 6, 1906.

where are the many others which have not been benefited by your treatment.

It would be profitless to discuss the significance of the terms constitution, diathesis, &c. The subject has been frequently and profitably discussed here in this society.

The constitutional symptoms, as distinct from the local symptoms of the disease, are well understood in their general sense. Of course there are cases where the two are intimately blended, but generally there is a fairly marked line of demarcation between them.

As an illustrative case, say a physician is called to see a patient suffering acutely from some local pain—for purpose of illustration, say in the chest. The patient presents to the physician a typical case of the tubercular constitution. Now, for treatment, should the physician treat the local symptoms of the pain, with all its modalities, by themselves, or should he treat the constitutional conditions alone, or should he blend the two and treat the local symptoms by the most similar remedy, at the same time giving the nosode suitable to the condition ?

All three methods are practised with varying success. I have tried all the three methods and seen successful results by each system. In most cases I have begun by one method and had frequently to fall back on one of the other methods for the successful treatment of the illness.

All roads lead to Rome, and all these methods lead to the cure—or at least do not unduly prolong Nature's methods of cure. The *vis medicatrix naturæ* is an important factor in our therapeutics. It is often the factor which is not given its due in some cases of cure which I have seen published.

As a practical guide in therapeutics, I have usually, where the local symptoms are acute, treated them alone, on their modalities, apart from their constitutional causes. In cases where life is in peril I have not dared to trust alone to any nosode; in chronic cases I do not hesitate to do so, and sometimes with satisfactory results.

Case 1.—C. B., a child aged 3½ years. Was brought to the Kensington and Bayswater Dispensary on September 3, 1906. The child, since the age of two months, had suffered fr· m an eruption

over the body. The alleged cause was vaccination, when the child was seven weeks old. The child had been quite well previously. It was a breast-fed child. There was no history of skin trouble in the family. Younger child, 1½ years old, free from eruption. For two months patient had suffered continually from these eruptions. Once also it suffered from a slight bronchial attack, and from a slight attack of vomiting and diarrhoea. On examination I found the typical eczematous rash scattered irregularly over the body, over the hands, arms, legs, neck, &c. The child perspired freely. During the three years the child had been continuously under allopathic treatment; all sorts of local applications had been tried, but the eruptions persisted in varying degrees. The mother, taking advantage of a visit to London, brought the child to the dispensary to see if homœopathic remedies could do anything to relieve the irritation, the most important symptom. Sulph. 30, tab. i. t.d.s., was prescribed. Pulv. amyli as dusting powder. All other applications to be discontinued, and its present dietary continued.

On September 10 the child was slightly better, but there was not any distinct benefit from the medicine.

Rep. sulph. 30 t.d.s. for another week, afterwards graphites 30, tab. i. t.d.s.

The child was returning to Cornwall October 22. Report that the child was worse. Then I decided to treat the constitutional cause—the vaccination.

I prescribed thuja 30, tab. i. t.d.s. November 5 report: child very much better; practically well. Rep. November 19 report: just a slight scaliness on one knee; otherwise well. December 3: quite well. Rep.

In this child's case during its medical treatment there had been times of slight improvement. This was the first time in its career that the eruption had disappeared. Of course it is quite possible this might be a natural cure, apart from the drug. Personally, I consider the thuja has for the present relieved, if not cured, the condition.

In this case the treatment of the local symptoms alone was in my hands inefficacious. The constitutional treatment was effectual.

Case 2.—M. J., male, aged 32. For ten years had been a constant sufferer from distension of abdomen, constipation, and severe depressions. His abdomen was never free from discomfort. He had suffered from the usual diseases of childhood; had been vaccinated twice. He had been married eight years, and was the

father of three children. He was a very temperate man, and smoked occasionally. His weight was 134 lbs. His meals, as result of his occupation, were very irregular, changing in rotation every week. His dietary was the ordinary mixed diet; fats, greens, and potatoes always gave discomfort, otherwise ordinary food was fairly well digested. He had been under continuous allopathic treatment under many different doctors.

The patient was first seen on May 24, 1906. He looked very weak and ill; very depressed. On examination I found he had a craving for food two to three hours after a meal, but no nausea nor vomiting. Flatulent distension appeared about three hours after a meal, and specially at 7 p.m., and then it would continue until bedtime. As a rule he was better in the forenoon. There was no acute pain, no eructation of fluid, continuous belching of wind, with no permanent relief of the distension. His bowels were never open except after the use of purgatives, cascara being most frequently used. He did not suffer from headaches, and had no nervous symptoms, except severe depressions and desire to be alone. He had palpitation after any exertion, and had been impotent for two years. On examination I found his tongue moist and fairly clean, his fauces were slightly red. In chest the first sound at the heart's apex was impure, the pulmonary second sound was not accentuated. The liver was normal in size. His stomach reached the level of the umbilicus, flabby in its nature. Succussion sounds were easily elicited. There was distinct dilatation of bowel in right groin. The knee reflexes were not increased. The urine was free from albumen and sugar, and gave a brown-red tinge with cold nitric acid.

I prescribed anacardium orientale 30 a.c. et p.c., an abdominal elastic band to support the stomach, and a continuance of his present dietary. On June 7 he reported himself a little better; his physical condition appeared the same. Report July 4: not so well; the flatulent distension had been excessive, and accompanied by faint feelings. Weight 131 lbs.; a loss of 3 lbs. On examination: stomach at higher level—about 1½ inches higher: felt less flabby; bowels were more regular. Nux vom. 30 a.c.

July 12. Worse. Sinking feeling; faint; the distension slightly less; temporary relief from food. On examination: stomach at least two inches above umbilical level; otherwise as previously. Anacard 30 a.c. et p.c. for first week; for second week chelid. 30 a.c. et p.c.

August 30. Much better for two weeks, but became afterwards very costive. Took some rhubarb; this was followed by

diarrhoea and faintness. Distension increased. Loose motion this morning, dark, fluid and offensive. Tongue: posterior third white fur, otherwise clean. On examination: marked distention, gaseous, of whole abdomen: no medicine for two days previous to visit. Nux vom. 30 a.c.; graphites 30 p.c.

Oct. 31. Quite well. No depression; free from all abdominal discomfort shortly after taking the two medicines, and has remained quite well since. The bowels acted daily. He has discontinued the medicine for two weeks now. On examination: abdomen better; distension slight; stomach two inches above umbilical line. Succussion sounds not elicited Tongue clean, moist.

Patient has since reported himself quite well.

In this case the treatment has not been brilliant by any means. The old-fashioned prescription of nux vom. before meals and graphites after meals was, however, successful. Graphites I consider a typical constitutional remedy of the greatest possible value in certain diseases. Its use in this case at once changed the sequence of events, and I regret I did not prescribe it alone.

Its combination with nux vom. I have often found of undoubted benefit in intractable gastric cases, and can confirm clinically Jousset's dictum of the great value of the two remedies in this combination.

The administration of a drug before or after meals raises many points of interest. A drug in high dilution, *e.g.*, 30, is not, as far as one can judge, hampered in its action by the presence of food in the stomach; in fact, it appears to me that when digestive processes are initiated the absortion of the drug is also hastened, and its action materially increased. A drug administered in large doses would be materially affected by the presence of the gastric secretions. As regards the medicine, one has to understand that there has been no absorption in the mouth or œsophageal tract during their administration.

Case 3.—A. B., aged 50, female. This patient has for years—ten at least—been at various times under treatment, especially during winter, for bronchial irritation—characterised by a cough—most persistent in its nature, and obstinate under treatment. It has been unaccompanied by phlegm. There have been indefinite pains over chest. All kinds of remedies had been tried. Allopathic and other various homœopathic remedies were used, and of them all phosph. 30 alone appeared to give any relief, and the relief was very slight. The patient gave the appearance of a calcarea patient.

Calc. carb. 200 was given, one dose, followed by a placebo. The relief was practically instantaneous; for three winters now, on the appearance of the cough, this drug is taken, and the irritation at once disappears.

The patient—a dispensary patient—now comes at once whenever she gets a cold, and she informs me that the cough quickly disappears.

Last summer, 1906, she came complaining of headaches of a bursting nature all over her head, persisting all day, and often preventing sleep. They were unaccompanied by sickness. There was no definite cause. She is now at least three years over the menopause. Several remedies were tried, but ineffectually, *e.g.*, glonoin, melilotus, lachesis, &c.

The patient again asked for her old cure for cough. Calc. carb. 200 was again given, and immediate relief was the result. So far, the headaches have not recurred severely. There has been an occasional heaviness in head which she regards as normal in nature. The calc. carb. invariably, in one dose, relieves.

The uncertain nature and irregular course of post climacteric headache prevents us awarding the relief entirely to the calc. carb.

In this case, should any acute illness supervene, even though it be of a critical nature, I am prepared to treat, as far as justifiable, the symptoms by calc. carb. 200.

Reverence for authority has ever been the bane of progress in medicine. For ages it has robbed the practitioner of his mental freedom, and interfered with his initiative in therapeutics. The homœopath fortunately has developed the natural law of cures, has done his own medical thinking, studied the symptoms of disease, and felt himself free to use any remedy, in accordance with the law of similars, no matter from what source it may be derived.

The PRESIDENT said Dr. Macnish could not have chosen a more valuable subject to bring before them. There were many ways of getting at the simillimum, and they had to be ready to adopt any one of them should the rest fail. One of the most important points was to get the constitutional simillimum. That, as Dr. Cronin told them at the previous meeting, was the first thing that the late Dr. David Wilson went for, and until he had cleared up the constitutional element in the case he did not attend

so particularly to the finer indications. That was the way with Hahnemann. He remembered reading Dr. Thomas Wildes' articles on the nosodes of gonorrhœa and syphilis. Dr. Wildes practised in one of the West Indian islands, and he said that the name of that island was a synonym for syphilis. In his practice, if the cure from any cause hung fire, Dr. Wildes always gave syphilinum, just as Dr. Macnish gave calcarea in his case, and it was almost certain to get the patient on the right road again. Dr. Macnish incidentally introduced another important subject, namely, the agreement of one remedy with another. It was a valuable piece of observation of Dr. Jousset's, the agreement between nux vomica and graphites. It was often the case that one remedy would help out the action of another; lycopodium, for instance, had its action helped by an occasional dose of carbo. vegetabilis.

Dr. WYNNE THOMAS referred to the case of a child suffering from eczema. He was present at its birth. Within a month it developed eczema, and vaccination was put off until it was about three months old. He tried the child with sulphur, graphites, and one or two other remedies, and it improved up to a point, but did not get quite well. Then he vaccinated the child, thinking that might pull it through, but the child got all the worse for the vaccination. He had the child under treatment for about a month later, and then it went out of his hands altogether. About eighteen months after the child was brought back to him in a very much worse condition, and the mother said she had taken it to the London Hospital, to Guy's, and to St. Bartholomew's, and they had given her all sorts of salves and lotions and medicines. He gave the child sulphur 30 for a week, one dose every night. He did not see much improvement at the end of the week, and he then went on to thuja 30, one dose every night, and the next week the child was better. Then he gave thuja twice a week and some sugar of milk between times, and at the end of three months the child was almost well. Another interesting case was a gardener, aged about thirty. This gardener milked a cow which had a sore, and shortly after the man came out with eczema on the legs and arms. He went to his local doctor and the London Hospital, where he was supplied with lotions and ointments, and then came to him (Dr. Thomas). He gave sulphur 30 for a week. The man then said he was rather better, though he (Dr. Thomas) did not see much improvement himself. Then he put him on thuja 30 once a week, and within a month, although this man had been suffering for eighteen months or two years, he

was practically well, and has had no return of his eczema since, now several years.

Dr. PULLAR thought that diathesis was always present as a factor, however local the morbid expression appeared; and if we could find the constitutional remedy it might be the key to the whole case. The great feature of homœopathy was that it enabled us to meet diathetic conditions which would otherwise be out of reach of therapeutics; and, indeed, the whole drift of Hahnemann's teaching, with regard to chronic disease especially, was to elucidate such constitutional factors with a view to the discovery of the appropriate remedies.

Dr. MILLER NEATBY said that a baker had come to him complaining of eczema of a very infuriating character; so violent was it that the exudation often trickled down the man's trousers to the ground. He had had it for three years, and had been treated by several local men. He had tried several proprietory articles for external application, including the much-vaunted Zam-Buk, but none of these things alleviated his condition. He (Dr. Neatby) had thought of graphites, but it did not seem altogether to match the symptoms. He had been very much struck with the description of the graphites eczema—glutinous, honey-like crusts. This man had nothing of that sort. Then he remembered the graphites type "an obese blond," and this man corresponded to that; he was an obese blond with a tendency to constipation. So he gave him graphites 30 and there was marked improvement in a fortnight, and in less than two months he had hardly anything to show for his eczema. He went on with the medicine for a little while, taking it infrequently, and then he turned up one day saying that he had no longer the eczema, but a crop of boils had come out on him. He recollected that a crop of boils had come out on his thigh a little more than three years before, which tallied very well with the appearance of the eczema. He had been to an allopathic doctor who had given him something to put on them, and the boils had promptly disappeared. It is about a year now since he was cured, and the man has remained ever since free from eczema. Another interesting case was that of a lady who had undoubted gastric ulcer. She had been under allopathic treatment and had become disenchanted with it, but when she came to him the after-effects of it, the tenderness in the gastric region, and severe dyspepsia and constipation, continued. He was not satisfied with the ordinary gastric ulcer remedies which he looked for at first, but looking at her from the constitutional point of view, he thought, "If ever there was a nux case on the face of the earth, it

is you." She had been treated down west by a homœopathist for a few weeks, and there had been some improvement. She had been having lycopodium, and so he tried lycopodium for a while, but being convinced that she was a nux case he gave her nux 3x. A week or two later she said she was not nearly so well, and although he had not told her what he had given her she asked him whether he had given her nux, because nux, she said, never agreed with her. So, unfortunately, he was put off nux for a time and he tried lycopodium again. There was improvement, but not so marked as he desired, so he thought he would try nux again. He gave her nux 30, and there was immediate and striking improvement. Within a couple of months she was able to eat a much more extended dietary than she had been able to eat for a long time, and since then (this was nine months ago) she had been extraordinarily free from all symptoms of indigestion, and the bowels had acted regularly without artificial help. An interesting incident happened during the course of treatment. The patient usually placed her silver watch at night on a chair by her bedside; but soon after beginning the nux 30 she found that when she put the watch under her pillow it was almost completely oxidised—a thing which had never happened before. She then left the watch on the chair for a night, to see what would happen. Nothing happened; the watch remained bright. It would seem as if the nux enabled her to eliminate something that had been impeding recovery.

Dr. GOLDSBROUGH said, speaking for himself, that he thought he was learning by degrees something about the dose question, but it took a long time. They ought not to be afraid not to give a repetition of the dose, even in the case of a medicine like nux. He found that he sometimes repeated his doses too often. He thought the principle to be adopted was to assume that directly improvement ceases the patient needs another dose or another medicine if he is not cured.

Dr. CRONIN said Dr. Wilson, who was a great anti-vaccinationist, used to say, "If you will vaccinate your patients, my dear fellow, always give them 200 to 500 of thuja a month apart for half-a-dozen doses, and then you will prevent the ill-effects of vaccination.

Dr. MACNISH, in reply, entirely concurred with Dr. Clarke's remarks. Thuja was a valuable remedy for which vaccination formed a symptom, but vaccination was not the only symptom which determined its application, as we inherited a certain amount of vaccinosis. A child was brought to him to vaccinate, but one

of the parents was opposed to vaccination, and as a compromise he gave the child malandrinum 30, one dose once a day for a week beforehand. He had tried to vaccinate the child twice, and had failed, to the great delight of the father. The third attempt had been put off, and though he had wished the father to discontinue the malandrinum, he supposed he would continue to give it to the child all the time.

REFLECTIONS ON THREE YEARS' EXPERIENCE IN THE SANATORIUM TREATMENT OF PHTHISIS.[1]

BY CHARLES EDWIN WHEELER, M.D., B.S., B.Sc.LOND.
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I FEEL I owe an apology to this Society for offering to its notice a paper on phthisis, when our last meeting was occupied with the same subject. I can only plead that the subject is a wide one, and that there is advantage in considering various aspects of it close together. There is a further consolation for me in the thought that it is a common disease, a familiar foe to all of us, and therefore what my paper loses in novelty it may gain in power of practical application. My paper deals with phthisis in general practice regarded from the standpoint of sanatorium experience, and I wish to bring that experience to bear on, first, the diagnosis; second, the prognosis; third, the treatment of the disease. It is the merest truism to tell you that the curability of this disease is in direct proportion to the promptitude of its discovery, but by a prompt discovery, I do not mean the recognition of crepitations by the stethoscope. If the infection is widely distributed on a moderately uncongenial soil—unless one of the patches of irritation happens to be near the surface—you may hear nothing. The tubercular islands are separated by much larger areas

[1] Presented to the Section of Materia Medica and Therapeutics, December 6, 1906.

of healthy lung, and it is a matter of chance if your stethoscope detects one. An X-ray picture may be of value to an expert, but considerable experience is required to draw confident conclusions from one, and it is not always easy to obtain. Tubercle bacilli are conclusive, but, like crepitations audible to the stethoscope, they belong to the second stage of diagnosis. They are often found very early, but we need to be earlier still to get the maximum benefit from treatment. A dry cough frequently precedes either physical signs or demonstrable bacilli, and a cough that is not improved by appropriate remedies in a week or ten days should rouse the gravest suspicions unless the cause of it is obvious. Especially in this connection, I would call attention to a peculiar "throaty" quality of voice that is often associated with the cough. The cough is irritative and apparently laryngeal, and both it and the voice quality will appear in cases that afterwards show unmistakable signs of phthisis, even though from first to last the larynx itself may show no definite evidence of tubercle, at most a slight general catarrh. I have a strong suspicion that the larynx in some of these cases is touched with tubercle and is fighting it. It is natural to think that the larynx must frequently meet the first of the invasion, and I have no doubt that it is considerably more resistant than the lungs, possibly from the fact that it cannot fail to get all the fresh air that is going. Therefore, in such cases as I describe the larynx may be successfully dealing with its own enemies, and incidentally giving warning of their presence; if we neglect the warning we may presently find the lung yielding to the same foe, while the larynx, having won its particular battle, remains free. The moral naturally is that the warning be not neglected. Let us, however, proceed a step further back still. There may be tubercle bacilli striving for a hold on the lung and no cough, the patient comes to us for vague feelings of malaise, loss of appetite, heavy or disturbed sleep, but no cough, no irritability of the throat. Yet we are not without means of diagnosis, or at least means of arousing or strengthening suspicion. First and foremost comes the thermometer. A daily rise of temperature, generally highest

in the evening, but occasionally highest in the morning, in a patient inclined to be dyspeptic and to lose weight, should cause tubercle of the lung to be thought of at once, and the suspicion is not to be lightly dispelled. As a matter of fact this is well recognised in theory, in practice the condition is not sought sufficiently regularly. The chart must be kept for a week, and three or four observations made each day, and I cannot urge you too strongly in these cases to take the rectal temperature. I know it is a trouble; patients make a fuss, but the superiority of the observation is incalculable. The rectal temperature gives nearly always a greater range and a more sensitive indication. In discussing the treatment of phthisis I shall return to the question of temperatures, but here I would lay stress on one or two points. First, the convenience of the centigrade scale, with its normal at 37°, a whole number; second, the fact that the rectal temperature on waking should be below 37° in an healthy individual. A so-called normal temperature *per rectum* the first thing in the morning is too high; if it is persistent it is pathological. Further, exercise modifies the rectal temperature considerably in healthy and in tubercular subjects, so in keeping a chart with a view to diagnosis, either prescribe rest or have no temperature taken within an hour at least of active exercise. The chart then should give the first note of warning in early tubercle. The estimation of the opsonic resistance to tubercle is a second valuable means of confirming a suspicion. It must be done on two or three occasions at interval of a day or two to get full value from it, and personally, I believe the index is more likely to go up after exercise in a tubercular subject, though to settle this point more observations are wanted on healthy individuals. I need not dwell further on this aspect of diagnosis, but refer you to the most excellent papers to which we listened last month.

To sum up: given a case with malaise, dyspepsia, tendency to waste and daily rise of temperature, one may at once suspect tubercle. If the voice is husky, if a dry cough is present, if the opsonic index is either distinctly low or inclined to fluctuate, we may feel considerable con-

fidence that the case is tubercular, and in my opinion we should not wait till the diagnosis is clinched by physical signs or presence of bacilli. It will do no harm to put a non-tubercular case under a strict *regime*, and it may do considerable harm to neglect the precaution till the case is obviously a phthisical one. The medicines present no difficulty, for they will be chosen by the symptoms whether or no the diagnosis be made, but I am certain they will act more quickly and more effectively if the patient is under the conditions desirable for every case of phthisis, and, therefore, I plead for a tendency to err rather by diagnosing too early than by waiting for positive confirmation. Of the cases sent to one sanatorium that could fairly be classed as slight, over 90 per cent. made cures with no other treatment. Aided by the appropriate remedy, there should be practically no failures. Before leaving the first division of the subject, I should like to speak of a few points in regard to physical signs in the chest in phthisis. If I seem to put them dogmatically, attribute the seeming to my desire to be brief rather than to any overweening confidence. They represent my experience, but more prolonged or different experiences might lead to some modifications. First, regard with the greatest suspicion physical signs of pleurisy. A great many at least of pleuritic inflammations are tubercular. The pleura deals with the infection more promptly and effectively than the lung, but nevertheless, a pleurisy is often the starting point of phthisis, and even the history of an old attack or the jerky inspiration that so often means adhesions, should make the physician very suspicious of newer chest symptoms. Be very cautious with areas of poor expansion, especially if the percussion note is the least bit dulled over them. Few people use their lungs to the full, and very few of those who do trouble the doctor with chest symptoms, so that there probably will be areas that will want consideration, but if they are at all sharply limited think of the possibility of tubercular deposit. Regard moisture as the gravest of danger signals, and remember it will frequently be heard in the inspiration that follows a cough when it is not audible on ordinary inspiration. Dry sounds are of much less grave

import. A lung that is healing well will frequently show loud dry râles, indeed, the replacement of moist sounds by dry ones is a most favourable sign, though I have known it cause great alarm to practitioners at first to find a patient return from a sanatorium with loud squeaking sounds. Naturally, it is always better when treatment can be continued till they disappear, as they will when healing is complete. In any case dry sounds are so widely conducted that they are unsafe guides in the early stages, but a definite moist râle means mischief. The characteristic crepitation is inspiratory. Catarrh of the smaller bronchial tubes will often give a kind of moist râle that is not always easy to distinguish. When in doubt incline to the graver diagnosis for safety, but as guides to a differential decision, remember that the sound that is equally distinct on inspiration and expiration is more probably bronchial and catarrhal, next, that the areas near roots of the lungs will probably be the chief places where bronchial sounds will be heard, and that a history of recent catarrh will help to an explanation. More or less bronchitis is common in phthisis, especially chronic phthisis, and many so-called chronic bronchitics will show tubercle bacilli if they are searched for, but the bronchitic element must as far as possible be distinguished from the phthisical.

Having then decided that we have to deal with a case of phthisis, what are the considerations that must guide us in prognosis? First, the extent of the disease naturally, and here the history of the duration of symptoms is almost of more importance than the physical signs. The chances are much against the discovery by the stethoscope of all the disease—fortunate are we if we find half of it, therefore, let us bear in mind that there is almost certainly twice as much disease present as we can find, and make our prophecies accordingly. The patient's statements, on the other hand, may be very useful; the history of an attack of influenza is always suggestive. Two attacks of influenza (so called) within twelve months is more than suspicious. Influenza has been far too satisfactory an explanation of many conditions to have been used with moderation as a diagnosis,

and the exacerbations of a mild, chronic phthisis are nearly always classed as influenza. I think it very doubtful if true influenza recurs more frequently than once in twelve months. Therefore, if the history gives reason for thinking disease may have been present for some time, do not let the slightness of the apparent physical signs lead you to class the case too readily as a slight one. Among physical signs, percussion is the most important for prognosis. There may be more sounds in a healing lung than in a breaking-down one sometimes, but an area flat to percussion has probably most of its trouble before it. Remember, too, that just as if we sow a packet of seed at one time, the seeds will germinate over a longish period, so the disease will appear in one lung and remain for a time latent in the other. If phthisis has once been diagnosed in one lung, the very smallest suspicion of the other becomes doubly grave, and the prognosis must be revised to a proportionate extent. Nevertheless, if the patient is promptly put under treatment, the later developments are seldom as serious as the first.

Besides the actual physical signs there are several indications of great value in prognosis. First, in an advanced or moderately-advanced case, the colour of the mucous membranes. I generally take the inner surface of the lower lip as a guide, and the degree of blueness here is a matter to be always considered in prognosis. The colour often improves markedly after treatment, and such an improvement is an excellent sign. The poorness of colour is only a rough measure of the amount of disease, but I have convinced myself that patients in whom the colour is persistently fair or quickly improves, do better than others in whom the opposite condition prevails, even if the physical signs are more marked in the former cases. A second point of importance is rapidity of wasting. Rapid loss of flesh is a bad sign, especially if there is no marked disinclination for food. If there is definite dyspepsia the outlook is not so bad, for this can be nearly always improved, and the patient may then get a fresh start. Very few consumptives get well without gaining weight, probably none, but the satisfactory cases are those that gain without any heroic feeding.

The next element in prognosis is the mental attitude of the patient. Men on the whole do better than women, I believe, because generally they have a more definite desire to get well, and this leads to a more definite exertion of will power in the same direction. A woman is willing to be made well, but regards her cure as something to be done for her by an outside agency. The man generally has people dependent on him, and grasps the fact that, if he is set on getting well every hour of the day, he is more likely to attain his end than if he confines himself to doing as he is told and leaving himself passively in the doctor's hands. The active desire to get well will beat the passive. It is a factor independent of sex, but from social and economical causes the male sex predominantly shows the active desire, the female the passive.

I need not dwell on the graver importance of albuminuria, persistent diarrhœa, emphysema, and other definite complications. Their influence on prognosis is sufficiently obvious. Fistula in ano is a troublesome complication, but not one that adds much to the gravity of a case.

But when all is said, there is no chronic disease so baffling to prophecy as phthisis. If you take twenty cases apparently of a like degree and prophesy concerning them, with all your care you are not likely to be right in more than fourteen or fifteen; the extent to which disease can be latent, and the multiplicity of constitutional factors, are the elements that beat you.

Finally, and of most importance, comes consideration of treatment. As far as I can I shall indicate any points that are specially suitable to special stages of the disease. Tubercle of the chest is exceedingly common, and a great majority of cases get well, many without even knowing the disease has attacked them. *Post-mortem* statistics establish this; therefore do not be in a hurry to alarm the patient by insisting on the presence of tubercle, if in your own mind you have formed a favourable prognosis. Be very suspicious of the presence of tubercle, be quite chary of mentioning your suspicion. With an early case, a really early case, a month or six weeks is a legitimate time to

employ treatment at home. If there is not definite improvement in a month, I hold that the patient should be given the benefit of sanatorium treatment. Less time than three months is no use for learning the principles and getting a start. Six, eight, or twelve months may be necessary for a cure. One or two months is hardly worth the expense. Failing a sanatorium, if a country life is possible under favourable circumstances, send your patient to the country, but not unless he or she can be under close observation by someone you can trust. Unless the circumstances of town life are very unfavourable, town life and strict care give a better chance than country life and no care. Stop all business, and regulate the day. In the morning, exercise, of which more anon; an hour's rest before dinner—lying down and not talking. In the afternoon a little more exercise, and before supper another hour's rest.

The exercise should be slow walking, if possible with a moderate uphill element in it—two miles and a half an hour is the rate; the clothing should be no more than the patient can keep warm in; the walk must not be done against a high wind. If no sheltered course is available, when there is much wind defer the walk for the day. The distance is to be graduated by the effect on the temperature, and here again rectal temperatures are the best and the centigrade scale the simplest to use. If the temperature the first thing in the morning is 37° or above there ought to be no walking, and if 37° or more is reached for several mornings in succession, send the patient to bed and keep him there till the temperature comes down. In the class of early cases this is unlikely, so we presume the temperature before rising to be 36·5° to 36·7°. It is important to remember that women at the menstrual period, or just before it, will show a rise of anything up to half a degree C. in the morning temperature. This rise is not abnormal and can be neglected as far as extra rest is concerned, though naturally most women are disinclined for much exertion at that time. It is interesting to note that the opsonic power drops at that time. After breakfast let the walk begin at once. Severe exertion is undesirable imme-

diately after a meal, but such walking as is here contemplated seems a positive aid to digestion. Begin with a walk of two or three miles, not taken at a stretch but interspersed with rests of some minutes. In town, it will be hard if there is no park available with seats for an occasional rest. Rain, unless accompanied by wind, need be no bar to walking. It is not pleasant to get wet, but by leaving off the ordinary coat, and wearing an overcoat over waistcoat and trousers, the patient will not be overloaded with clothes, and can throw off the wet overcoat on his return, and in any case wetness to most people is of very little moment, and I believe acts far more by suggestion than in any other way. We know that a thorough chilling lowers resistance temporarily, but the exaggerated fear of a few drops of rain is mainly a superstition. The moment the walk is completed the temperature must be taken again. If it is 38° or over either the walk is too long or the patient has walked too fast, it is for the physician to discover which is the factor at work, and modify distance or pace, or both, accordingly; 37·9°, 37·8°, are temperatures needing consideration—if repeated, try shorter walks—below 37·7° is satisfactory. The rise after exercise seems to be due to two causes: first, the heat produced by muscular exertion, in greater amount than the regulating mechanism can for the moment cope with; secondly, increased absorption of toxin from the freer circulation induced by exercise. It is easy to discriminate between the two factors. Immediately on returning the patient should rest at full length for an hour. At the end of that time, if the temperature is taken again, it will be found to have fallen, and the extent of the fall is a fair measure of the effect of muscular exertion alone in producing temperature. From this it follows that if the temperature after walking is 38°, and at the end of an hour's rest 37·3°, the muscular effect has been considerable; if, however, the temperature in the hour falls only from 38° to 37·7° the toxic element is the main one, for the muscular heat production is the more quickly regulated by the body heat mechanism. The latter condition is the more serious,

and in such a case the walk must be materially shortened. The former state of affairs matters less, though I prefer that a patient should not go much above 37·7° in any case for many days in succession. Now and again, when I can feel confidence that the rise is mainly muscular, I attach little importance to it. The morning walk being satisfactory, prescribe a shorter walk to be undertaken at once after dinner. For a day or two take the temperature after the afternoon walk to be sure that the exercise is not excessive, for some patients cannot manage two walks, but do well on one. From 6 to 7 again complete rest; then supper and early to bed. I have gone at some length into the question of exercise, for these are the general principles to apply to all cases of phthisis whose temperature chart permits exercise at all, whatever the grade of the disease. Do not be in a hurry to extend the distance covered, but if other symptoms concur with the course of the temperature, by slow degrees more and more may be done. Other forms of exercise demand a word. Deep breathing, in theory, is excellent; in practice, I think, we need to apply it with great caution. It is, I believe, possible to force air into parts of the lung that are much better let alone. If I am sure, or moderately sure, that active phthisis is present, I rely exclusively on uphill slow walking, the patient being told that the necessity for mouth breathing is to be taken as an indication that he is going too fast. The lung will expand quite steadily under this treatment. If there is reason to relax suspicions about a lung that at first roused them, or when conviction comes that good solid scars have formed, then let deep-breathing exercises be prescribed by all means, and if the patient has a voice by all means develop it by training in the art of singing if you can find a decent teacher; personally, I find most of them ruin more voices than they develop. I forbid golf for two years after the last signs of disease have disappeared; much more tennis, rowing and so forth. After two years' freedom from symptoms I think there is no risk; before then if there is any smouldering patch it can be lighted up by the more violent forms of exercise. If patients clamour for a pastime,

croquet is permissible, and billiards, if it were not that no billiard table takes kindly to the open-air treatment. A word in passing about open air. I assume throughout that all the living rooms of a patient have open windows night and day; a fire is permissible and aids ventilation, and, remember, a wide open window is easier to bear than a narrow chink. Even fog is no contra-indication; the fog will come in anyhow, and we may as well have what oxygen is going. A muslin screen across the open space will stop most of the particles, and, after all, carbon granules are not the worst things we inhale.

Next to exercise and fresh air comes feeding. Here, again, my statements hold good I believe of phthisis in any stage. It is necessary to discriminate carefully here between cases. A small minority will have a good appetite; they will be no trouble; weigh them if possible every week, and so long as they gain steadily, have no anxiety. I know no better sign in phthisis than a steady gain of weight. But the vast majority of patients have no appetite. Medicinal remedies will help very greatly, but eating with most phthisical cases is a weariness. Yet, although the regular over-feeding of early sanatorium treatment has been largely abandoned, there is hardly a patient that ought not to eat more than his inclinations would guide him to do. Personally, I have hardly ever known a case of phthisis do well that did not gain weight, and certainly progressive loss of weight is the worst of symptoms for prognosis, but (and here I am in opposition to most sanatorium physicians) I believe the gain of weight in a case that does well is more a sign than a cause of improvement. Gain of weight by itself is not sufficient to cure. However, since, though not a main factor, it is essential as an adjuvant to cure, every case must face the prospect of eating more than he or she wants to eat, and the extent to which the inclination must be forced depends on the weekly report from the scales. As long as weight is gained the food need not be pressed hard; if the weight remains stationary, or goes back, increase the pressure. Private cases have here one great advantage over sanatorium cases, that their likes and dislikes can be more

considered. I attach great importance to this point. Pawlow's experiments have shown how great is the psychical factor in digestion, therefore let us have it on our side and not against us. I prefer fairly big meals with good long intervals, three meals a day and afternoon tea thrown in—generally a mixed diet answers best, and plenty of fruit; milk is a great standby, a pint can generally be managed at each meal; if necessary, begin with half a pint. Professor Wright points out that the daily quantity of milk ensures sufficient calcium salts to keep blood coagulability fairly high, a consideration of importance in a disease that tends to hæmorrhage. Plasmon, sanatogen and maltine are in my experience the best of the patent foods. Maltine and cod liver oil I have given up. A small cup of clear soup half an hour before meals is a great help to the appetite, this again is a deduction from Pawlow's work. A certain number of cases have a dislike of meat, and a vegetarian diet may be tried if desired. I have seen several cases gain weight well on it and am always willing to let a patient try it. The success depends more on the cooking than anything else. A good vegetarian cook is a treasure rarely to be found, but there is a large series of macaroni dishes fairly well known now, and they are very useful in the mixed diets and indispensable in the vegetarian. At the other end of the scale is the raw meat treatment, much used, especially by Dr. Philips. It seems to increase leucocytosis; it is easy to take, and forms a very useful mode of treatment to be used intercurrently with the ordinary diet. The preparation of the meal is the chief factor in obtaining the consent of the patient. It must be perfectly free from fat or gristle and of the best quality. Put it through the mincing machine, not once, but at least three times, removing any fragments of tendon and fat after each mincing. Thus prepared there are three good ways of administering it. In sandwiches, between very thin slices of very dry bread. In rissoles, that is, made up into balls, the balls being rolled in dry bread crumbs—add pepper and salt to taste, and some people find French mustard pleasant; or, finally, serve in a tumbler with warm stock poured on

just before taking. The last is much the easiest way and the pleasantest. The stock must not be warm enough to blanch the meat. Begin with 3 or 4 ounces three times a day and increase if it seems desirable. In the later stages of phthisis the feeding is often a great difficulty, but to persist in it may be the patient's only chance. It is quite true that it is what a patient absorbs and not what he swallows that does him good, but you must be sure that you gave him a chance of absorbing his maximum, and his inclinations are not a safe guide. Milk, junket, plasmon and raw meat are the mainstay of the case, but in phthisis, at any rate, fever is no bar to the employment of solid food, and many cases do better on it. Vomiting is often a trouble at any stage of phthisis. Try and persuade the patient to take something, milk and dry biscuit is best, immediately after vomiting. It is nearly always retained, and, as a good deal of vomiting is a kind of bad habit the body has acquired, nothing checks it better than to disregard it.

One other feature of the general management is the treatment of cough when this symptom is bad enough to attract special attention.

Apart from the medicinal treatment of cough, much may be done to check it by impressing on the patient that the amount of it is largely under his control. The constant hacking cough is simply not allowed in a sanatorium, and is very little heard there. Even when there is secretion the ciliary mucous membrane will do much to bring it up, and if a patient is told that, broadly speaking, he need not cough much, in time he will reduce it to a minimum, even without any medicinal remedies. It must be bad for a diseased lung to be constantly shaken and jarred with cough, and if a patient grasps this fact, he will more readily turn his attention to controlling the tickling sensations that seem at first unbearable, but by constant effort come to be held in subjection and conquered. The special remedies for cough may be considered here. In ordinary sanatorium routine they are morphia, heroin, and codeine. The homœopath can usually dispense with these. Of the three, heroin is the

least harmful and the most efficacious. Hyoscyamus, conium, and verbascum are far more satisfactory remedies. They all cover cough, increased on lying down and at night, and generally dry, and these are practically the only circumstances which call for a special cough remedy. Their distinguishing indications, to my mind, are—for verbascum, definite hoarseness and relief from a deep inspiration; conium, aggravation from deep inspiration and pronounced tickling in the larynx in a patient of melancholy frame of mind. The hyoscyamus patient is more excitable, though often low-spirited; streaks of blood in the expectoration suggest it, though the hyoscyamus case has seldom much expectoration at night.[1] If the cough at night is much the same as in the day, and of a type that suggests a definite remedy, the remedy will probably influence the cough all the time.

Hæmorrhage is an incident calling for special treatment. The routine sanatorium treatment is morphia. Given under these circumstances, it seldom produces constitutional effects. Its first action is to contract the blood vessels, and this is probably the action that does good. If it fails at first, there is no use in pushing it. Nitrite of amyl is used, and I have seen some success. A big dose (40 grains) of calcium lactate will often stop oozing after hæmorrhage, but is no good to check a big bleeding at once. On the whole, there is nothing better than ferrum aceticum. I should put my faith in it, and perhaps a dose of calcium lactate with amyl nitrite for the immediate remedy. Certainly it will stop oozing generally with promptness. As a matter of fact, hæmorrhage is either so profuse as to kill at once before anything can act, or tends to stop of itself, and ferrum aceticum will deal with any oozing that continues after the main outbreak.

Night sweats are a text-book symptom of phthisis. They mean nearly always that the bedroom is too hot, or the patient under too many clothes. The rule should be, as few clothes on the bed at night, and as few clothes on

[1] Laurocerasus and ac. hydrocyan. may be useful, especially for night cough in a patient with cold feelings and blue tinge in the mucous membranes.

the patient in the day, as he can keep warm in. There is no advantage in having him or her shivering with cold, but most patients wear far more than is necessary to prevent this. Aim at getting the clothes to a minimum, and regard a night sweat as a sign that there are too many. It is quite possible to start with a fair quantity, and once the bed is warmed to throw some off. Extra clothes by day or night are only so much extra weight for a patient to drag along under. Be firm about corsets in women. If they cannot manage their clothes without something, the so-called ribbon corset is unobjectionable.

There is one more matter concerned with the general treatment of phthisis, and that is the importance of having the teeth thoroughly cleaned and, if defective, amended. No patient should be sent to a sanatorium without a preliminary course of treatment by the dentist, not only because hollow and ineffective teeth interfere with mastication, but because decayed stumps and pyorrhœa alveolaris are sources of infective poisoning which may react most unfavourably on digestion and general health. If the patient is treated at home the dentist's attentions can be readily procured. Once the mouth is thoroughly cleaned, the patient must be helped to keep it sweet and sound. No toothbrush is any use that cannot be used for rubbing vertically instead of horizontally, and that cannot be adapted to the inner surface of the teeth as well as the outer. The best pattern I know is called Dr. Horsey's. Tooth-powder should have (as it nearly always has) powdered chalk as its basis. Put no faith in the much-advertised washes, as being in any sense trustworthy anti-bacterial agents.

I have now briefly touched on the special features of treatment, air and exercise, food and rest, and the treatment of cough, hæmorrhage and sweating. Before concluding with a brief survey of the main medicinal remedies suitable to most cases of the disease, let me say a special word upon tubercle of the larynx. This used to be considered mainly a late manifestation and a very bad sign. There is such a class of case, and where ulceration of the larynx appears late in the disease in a case that has not done

well, it is generally rapidly progressive. But a tubercular deposit in the larynx may appear very early, or particularly after a lung attack has subsided, or is beginning to subside. In any of these circumstances it is curable in a majority of cases. It is important to recognise it early, and the larynx should be examined as part of the routine of a first overhauling. The commonest site for early tubercle, I believe to be the inter-arytenoid space and the neighbourhood of either arytenoid. A general catarrh is common in the early stages of phthisis. I have hinted that this may sometimes be a sign of an attempt of bacilli to lodge on the larynx, and of the larynx's resistance, but equally it may be an ordinary catarrh, and no diagnosis of tubercle can be made from a symmetrical affection. On the other hand, a pallid larynx is always rather suspicious, and if you see it, drosera is a remedy to think of. Asymmetry—either redness or swelling, or both—should always rouse suspicion, and if constitutional features correspond and syphilis can be excluded, justifies a provisional diagnosis of tubercle. The treatment is the general treatment for phthisis and rest of the larynx. This means silence, not even whispering, for as long as the physician judges needful, and voice exercises, when speaking is allowed gradually to be resumed. Use no irritant sprays, no tobacco (by the way, speaking of tobacco, phthisical patients may smoke in moderation if the smoking does not make them cough), and, in my opinion, no operation in the earlier stages. I think a soothing spray relieves irritation, and I have not seen it interfere with the action of remedies. I use weak terebene, ol. eucalyp., and menthol in paroleine. I have not tried hydrastis, but it might do very well. With these internal remedies, the larynx reacts generally well, tuberculin is especially prompt in affecting it, and the administration can be governed by the local appearances of reaction; $\frac{1}{5000}$ mgm. is plenty to begin with once every ten days. In future, after Dr. Ham's researches, I should give it by the mouth. For the rest the sheet anchors are phosphorus, iodine and iodide of arsenic. My indications are: iodide of arsenic when there is little redness, but rather an œdematous look in the larynx and not much irritation, or

ulceration with œdema and sluggish appearance. Phosphorus for more active redness in the larynx with streaks of blood in the expectoration, tickling cough increased by cold air, and when there is hoarseness and inclination on the patient's part to whisper; iodine with irritating cough increased from warmth, otherwise much like phosphorus. There are plenty of other remedies that may be indicated from time to time, but laryngeal tubercle will mostly require one or other of these. In the later forms of laryngeal phthisis, the practically incurable forms, phosphorus will relieve the pain better than morphia. After the larynx has much improved there is often a stage when there remains a kind of slough on the place of the tuberculous deposit which is slow to be shed. A small operation at this stage to remove it and slightly stimulate the surface below often expedites matters. It is more often required in vocal cord ulcers, which are much slower to heal than ulcers elsewhere in the larynx, and require more prolonged silence from the patient. But given care and perseverance they will heal.

And now, though I have already kept you an unconscionable time, I must speak briefly of medicinal remedies in tubercle of the chest. Let me relieve our President's mind at once by saying that any remedy may be indicated in any case of phthisis. This is a truism to us, but one that I need, for one, to remind myself of frequently. Therefore if I pick out a few well-known remedies and give you my personal favourite indications for them, I wish my statements to be regarded rather as a rough map of the territory of the phthisis remedies, upon which each of us must superpose his details according to the case that comes into his hands. The remedies for phthisis are constitutional and intercurrent, and the two spheres overlap considerably.

Tuberculin.—This remedy was discussed at length at our last meeting, and I refer you to the papers we heard there. I will not detain you with it further now beyond saying that I think there are few cases that should not have the benefit of it one time or another, and that it is the remedy for doubtful cases, acting if the symptoms indicate it, whether we can swear to tubercle or not.

Sulphur.—This drug is one we are always warned to use with care in phthisis. It is often indicated in the early stages by the general symptoms, the flushings, morning sinking feelings, and discomfort at night in bed, constipation, dry cough. This picture is not an uncommon one, but with the warning for care before my mind, I have generally in these cases compromised by giving hepar sulph. Especially, I try to remember the abnormal sensitiveness of hepar: hoarseness is a great indication for it, and the tendency to suppurative skin troubles that affect a percentage of phthisis cases. Enlarged glands, too, speak for it, though also for iodide of arsenic and iodide of calcium.

Calc. carb.—This remedy is, with tuberculinum, most often wanted in the pretubercular or early stages of phthisis. It covers the tickling cough, the fleeting pains in the chest; but especially I value it for the early dyspepsia, the pain and nausea, the sour risings and the dislike of fat, that are so common. That dislike of fat, by the way, is very characteristic in phthisis; if a patient likes fat, I always think well of his chances of recovery, and I regard the strong dislike as an indication for calcarea. Calc. carb. belongs to the chilly patient, often with glands enlarged and flabby constitution, the patient who will often put on weight under treatment and be little the better for it. Silica, on the other hand, more likely will suit the patient whom no effort will fatten.

Arsenic.—I always use the iodide of arsenic, and most cases want it one time or another. If calcarea fails, if wasting supervenes, with a clean tongue, some thirst, but no constipation (constipation is usual in early phthisis, diarrhœa is a late and serious symptom), aggravating cough, with expectoration tending to increase—this picture inclines me to think of arsen. iod. It follows phos. well, and phos. again is indicated in early, rather acute, phthisis, with blood-stained expectoration, but not much pus, or in intercurrent local exacerbations that tend to take on a pneumonic type. Besides the expectoration, it will be indicated by hoarseness and laryngitis, pains, especially in the left lung, cough generally, increased by cold. Iodine is very like phos. in indica-

The PRESIDENT said they might fairly congratulate themselves upon the return of Dr. Wheeler to London. The time he had been away had not been idly spent. Hahnemann's first aphorism was that the physician's high and only excuse for existence was that he should cure his patients; his next aphorism was that he ought to see particularly that all hindrances to cure are moved out of the patient's way. The recent development of the open-air cure and sanatorium treatment were very excellent measures for putting out of the patient's way the hindrances to cure; but as Dr. Wheeler told them, they ought to do something vastly better, and when they had got the right conditions then they could set to work with their remedies in ways which others could not.

Dr. NEBEL, late of the Homœopathische Sanatorium, Davos, Switzerland, was present at the meeting, and exhibited enlarged photographs of the micro-pathology of phthisis. He also exhibited photographs of the Sanatorium. In joining in the discussion, Dr. Nebel said that at Davos, except in a very few cases, he was able to make a prognosis in three weeks. In the case of every tuberculous person who came to Davos there happened one of three things. If the patient was a person who had a temperature of 38° C. and the temperature fell the first day, and if when the patient came he had no appetite, but the appetite came almost the first day or within the first week, and amelioration set in immediately, that was one of their best cases for prognosis. A second class of cases was where the patient's condition was aggravated for from eight to fourteen days, and then amelioration set in. Those cases would get well also. Then there was the third class, where the patient showed some amelioration for some days; perhaps at the end of the first week he felt much better, but afterwards there was a relapse. Such patients must be sent back to the lower land. Davos itself acted as a homœopathic remedy, and these three classes of cases might be summed up as (1) amelioration which went on without aggravation, (2) aggravation followed by amelioration, and (3) amelioration for a few days or some hours, followed by aggravation. As to diet, at first they gave the patients too much food at Davos, and not enough exercise. At first he had often seen a patient going on well for four or five weeks and then going back, losing his appetite and suffering from vomiting or diarrhœa, or something like that. He attributed that to over-feeding. Although now they did not give as much food as before, they had better results as to weight. As to symptoms and their treat-

ment, he might perhaps suggest some medicines which he thought were not too well known. A very fine remedy, especially in cases of heart complaint and also in cases of hæmorrhage accompanied with an aggravated cough, was laurocerasus. Only once had he ever employed morphia, and that was in a case of very severe hemorrhage, with incessant cough. He had seen great good done also by a remedy which was very little known, galeopsis ochroleuca. That was a remedy which was much employed in the middle of the last century in Germany. It seemed really to touch the lungs. He gave it always in the pure tincture or second dilution. When the patient had a greenish sputum and the characteristic cough and infiltration of the right lung, he had seen good effects from the use of galeopsis. He had also seen wonderful effects from the use of creosote. A man came to Davos with his temperature at 40°. He had been treated for half a year by a homœopathist, who gave him every day, in the morning phosphorus, and in the evening tuberculin 30. Those two remedies had too strong an effect on the patient, as he had one hæmorrhage after another. He (Dr. Nebel) stopped medicines for fourteen days, and then gave him sulphur and phosphorus, which brought about a good result. During the treatment, whenever the patient performed any violent motion he had extremely severe hæmorrhage, but that was stopped with hamamelis 200. The effect of that, however, did not last, and he had a return of the hæmorrhage with bloody sputum for four weeks. Then he complained of a sensation of foul pus coming up, with hæmorrhage. When the patient scratched himself he bled profusely. These were indications for creosote, and he received creosote with good results. In Davos they had no sweating at all. The patients who came with sweats lost them in one or two weeks. He had only one case where the sweating was so profuse that the sweat ran through the bed. That he thought was a fine case for silicea. In that case the silicea did not stop the sweating, and, indeed, he did not wish to stop it, because he thought it was necessary. After six weeks of treatment with silicea 200—1000 the sweating ceased, and the patient made a very good recovery. He would draw their attention also to another remedy little known, streptococcinium semilunaris or seleninum. Professor Klebs introduced it, and he (Dr. Nebel) had used Klebs' preparation in a case where there was a very liquid greenish sputum, where the temperature rose with each movement, and there was an enlargement of the glands in the neck. The sputum was liquid and quite greenish, like grass, and sometimes of a bluish-black colour. He had also seen good results from

capsicum in a very high dilution. Generally, in tuberculosis with fever he did not like to give a dilution above 200, though sometimes he had seen, especially from silicea, a very good effect from a thousandth dilution in the advanced stage. As a rule he preferred 30 and 200 in cases with fever. He had also found that giving his patients the water of the neighbourhood to drink cold had a very good effect. In the beginning, when a patient first came to Davos, he had found good come from using arsenicum iodatum. With old people he had seen very good effects, especially in cases of florid phthisis, from causticum; one or two doses might sometimes arrest the whole case. As to tuberculinum, he had seen very important effects from tuberc. T.R. He had often known the bacilli rapidly decrease and disappear under that treatment.

The PRESIDENT acknowledged the Society's obligation to Dr. Nebel for giving his experience, and referred to him as one of the best microscopists on the Continent, and one of the closest observers of the action of tuberculin homœopathy possesses.

Dr. GRANVILLE HEY asked for a little more light on the meaning of very low temperature in phthisis. His attention had been called to the fact by a case he had at present. The patient complained that her temperature frequently ran down to 95° F. (35° C.).

Dr. WHEELER began his reply by thanking Dr. Nebel for his speech. The air in Davos was very different of course from the air in England, and he should not like to make a prognosis here quite as early as within three weeks, as was done by Dr. Nebel. He had never seen a patient who had been under homœopathic treatment at Davos, but he had seen many who had done well at Davos, but when they came back to England got their cough again. He had never been very keen on sending patients to Davos until he had, at any rate, tried the effect of England, because, if they once got into the habit of going there, it might mean that they would have to be more or less constantly there, which would hamper them a good deal in their life. At present they could not calculate what the addition of homœopathic remedies to sanatorium treatment would do, because they had next to no data on which to go, and what Dr. Nebel had told them pointed to results which they could hardly estimate at present. The pulse does follow the temperature in early cases of phthisis, and is a very important indication, though on the whole he (Dr. Wheeler) laid more stress

on temperature. Unfortunately in the early sanatoria cases the patients had hardly any exercise at all; they were carried about and spared every possible muscular exertion, consequently they put on fat to an enormous extent, and when they got away that was reduced almost at once. But if the treatment is combined with exercise, then the patient puts on muscular tissue. He had very often seen a case pulled round the corner by the patient being stimulated in every possible way to eat a good deal more than his inclination would lead him to eat. In regard to Dr. Granville Hey's question, he (Dr. Wheeler) did not attach any particular importance to low temperature except accompanied by signs of actual collapse.

A CLINICAL EVENING.

A CLINICAL EVENING of the British Homœopathic Society was held on January 3, 1907, under the auspices of the Section of Surgery and Gynæcology. Cases and specimens were exhibited and discussed, the notes of which follow below.

CASES.

Tumour in Right Loin.[1]

Emily R., aged 32, single, milliner, was quite well until two years ago, when she got a severe chill on a long railway journey. Two days later, on resuming work, felt "internally cold," and urine on being passed felt hot. Seven days later there were increased desire and frequency of micturition, and then followed an attack of cystitis, which lasted from March until November, 1905. During this time the menses ceased, and have not reappeared; always regular before. In November, 1906, again caught cold; this was speedily followed by severe pain in the right renal region, which was radiating and exhausting, causing her to feel faint and sick, and to perspire profusely.

When admitted to the hospital there was an obvious swelling in the right renal region, which did not move with respiration, was fairly circumscribed, and somewhat tender on pressure; it

[1] Exhibited by Dr. GALLEY BLACKLEY.

was uniformly dull on percussion. Has been recently examined under X-rays, but no stone could be made out. Urine contains some pus cells, but no crystals or *Bacillus tuberculosis*.[1]

Remarks on this case were made by Drs. Blackley, Byres Moir, Goldsbrough, Wynne Thomas and Granville Hey. The consensus of opinion on the nature of the growth was that it was probably tubercular.

Dermatitis Exfoliativa.[2]

Dorothy McC., aged 15. Skin began to be affected when she was 11 years old. Had a glandular abscess in neck at 4 years old. When first seen as an out-patient in the summer of 1906, had dry seborrhœa of scalp and generalised moist exfoliating dermatitis of neck, trunk, and limbs. Since her admission to the hospital, under the influence of arsenicum and ol. morrhuæ the eruption has become quite dry, but continues to peel in papery scales of varying thickness.

Dr. BURFORD enquired whether thyroidin had been used in this case.

Dr. BLACKLEY replied in the negative. Only two medicines had been used. During the summer, for a couple of months or more, the patient was given rhus, and now she was having arsenic in the third decimal, 1 grain doses. He had tried thyroidin in one or two similar cases, one in particular of an old lady with general exfoliating dermatitis, who was exceedingly ill for a very long time, and he thought it made her distinctly worse. It may have been that she was a bad subject for thyroidin, because it was not every patient that could bear that drug. She did not have large doses, only receiving a grain at a time; and although the dose was further diminished, he found the condition was aggravated; there was some vascularity about the skin, and she was very uncomfortable in her general state.

Dr. MADDEN enquired what was used for the discharge?

Dr. BLACKLEY replied that nothing had hitherto been used, except a dusting powder of boric acid, starch, and oxide of zinc.

[1] An exploratory laparotomy was performed on this case by Mr. Knox Shaw on January 22. The growth was found to be mainly below the kidney, and firmly fixed to it and surrounding parts, extending to the vertebral column on the left and to the flank on the right, and up to the under surface of the liver. Many of the mesenteric glands were much enlarged. One of these was removed and sent for examination to Dr. Watkins, Pathologist to the Hospital, who reported that it was undergoing caseous degeneration, but no tubercle bacilli were found.

[2] Exhibited by Dr. GALLEY BLACKLEY.

Rheumatic Heart Disease.[1]

Rheumatic heart disease in a girl aged 14, showing the result of peri- and endo-carditis. Large area of dulness extending from right of sternum into left axilla, in transverse measurement 8 inches. No reduction in dulness after rest, medical treatment, and Nauheim baths.

Dr. BYRES MOIR remarked that his case was not a controversial one, as everybody agreed the condition was very bad pericarditis.

Dr. GOLDSBROUGH enquired whether colchicum had been given.

Dr. BYRES MOIR replied that both colchicum and colchicin had been frequently given, but no satisfactory treatment had yet been found.

The PRESIDENT asked whether crataegus had been used.

Dr. BYRES MOIR replied that he had not tried it, because he did not think it was indicated.

The PRESIDENT thought crataegus had a very wide sphere of action, not in the pericardial, but in the myocardial aspect of such cases.

A Case of Osteosarcoma.[2]

D. L., aged 56, engineer. Patient states that in June, 1905, he had stoppage of the bowels, with fæcal vomiting, said by doctor to be due to liver disease. He has lost 28 lbs. weight in the last six months, and has suffered from acute pain in the ilio-lumbar region for some months, both day and night.

When seen, October 23, 1906, patient was pale and thin, and felt worn out for want of sleep and from constant pains. Bowels acted daily whilst living on milk. Urine free and yellow. Present weight 10 st.

On examination a large hard tumour was found in the right iliac region, firmly attached to the ileum. The mass was rounded, smooth and tender on moderate pressure. The distance from iliac spine to the umbilicus was 6½ inches, and the tumour occupied 3½ inches. Rectally the tumour could be felt as a round mass attached to the ileum.

Symphytum ℘ ♏iii., t.d.s., was ordered, and a compress of crushed comfrey root to be applied every night. The relief to the pain was immediate, the second night patient slept the whole

[1] Exhibited by Dr. BYRES MOIR.

[2] Exhibited by Dr. WASHINGTON EPPS.

night, and he has since been able to continue his work as an engineer.

The improvement has continued up to date, January 1, 1907, and the tumour appears by careful measurement to have decreased in size. Patient himself says he is sure there is less fulness. The patient's weight has slightly increased, whereas previously there was a continuous decrease, being, October 23, 10 st.; November 20, 10 st. 4 lbs.; December 4, 10 st. 2 lbs.

The internal medicine has been symphytum ϕ ɱiii., October 23 to December 4; hecla lava 6, December 4 to January 1. The comfrey poultice was continued the whole time.

Dr. BYRES MOIR thought that in this case hecla lava should be kept in reserve.

Dr. EPPS stated that the compress was continued until last week. A month ago he gave hecla lava 6, but during the past week the treatment had somewhat passed out of his hands, the doctor giving cancerinum 200, one dose.

The PRESIDENT enquired if the symphytum had been stopped.

Dr. EPPS replied in the affirmative. It was given for two months in three-drop doses, and as a compress. Then the compress was continued, and hecla lava was given in the sixth trituration from that time up to January 4. The improvement consisted in the absence of pain, possibly reduction in the size of the tumour, a stoppage in the loss of weight, and a general improvement in the man's feelings and condition.[1]

Caries of the Spine.[2]

Caries of the spine under treatment by a new method. The child (A. K.), aged 1 year and 8 months, is on a modification of Bradford's frame. This position is maintained constantly for twelve to eighteen months, while medicinal treatment is given, and until the disease is cured.

Lupus.[2]

Extensive tubercular disease of the skin (lupus) in a boy (Ernest W.) aged 5. When 2 years old the eruption first

[1] Since the meeting of February 26, symphytum ϕ only has been given, with occasional compresses of the crushed comfrey root. The tumour is, without doubt, smaller; the man looks almost in robust health, is doing full work, and has increased in weight to 10 st. 11 lbs.

[2] Exhibited by Dr. ROBERSON DAY.

appeared. He has had treatment at the Royal Free Hospital, where the patches were scraped seven times, and again at University College Hospital, where the operation was repeated under an anæsthetic.

Since March 15, 1906, he has been taking tuberculinum *by the mouth only*, in varying dilutions from 6 c. to 200 c., *and nothing else*. Photographs taken before and during treatment show the progress of the case.

Chronic Myelitis with Remissions.[1]

E. F., aged 49, female, cook, has suffered nine years, admitted to hospital on December 22. Onset of symptoms gradual. Cannot ascribe a cause. Illness began with numbness in the lower extremities, tightness round waist and failure of walking. Was treated in the National Hospital, and in two months nearly recovered, except girdle sensation remained. With slight symptoms she continued until three months ago, when numbness and failure of walking returned. No history of other illness. Father died of paralysis, mother of cancer.

Present condition.—Is rather depressed. Has occasional frontal throbbing headache. Speech and organs of vision normal. Sensation diminished in all qualities, nearly symmetrical in upper extremities from middle of arms, trunk from third or fourth intercostal spaces, and thighs from upper two-thirds. Can feel warmth, but nearly insensible to cold; no dissociation. Complains of tight sensation round trunk from mammæ to waist. Cannot stand with eyes closed. Hand-grip weak, especially right. Gait paretic and inco-ordination well marked. Plantar reflex delayed and diminished, nearly lost on right side. Abdominal and epigastric reflexes absent, knee-jerks present, nearly equal. Micturition is slow at times, at others sudden and uncontrollable. Bowels always confined; skin dry, especially of feet. Fairly well nourished generally. Bruises easily without her knowledge. Menstruation ceased for seven months until past week.

Questions for diagnosis: Is the case myelitis, tabes, syringomyelia, or a functional neurosis? Suggestions for treatment.

Dr. GOLDSBROUGH remarked that this case was rather a difficult one to diagnose, because of the mixture of the symptoms, but the reason he came to the conclusion it must be a chronic inflammatory state rather than a systemic degeneration was that the onset

[1] Exhibited by Dr. GOLDSBROUGH.

of the symptoms nine years ago was followed by a fairly rapid recovery in the National Hospital. The patient remained in that condition, with slight symptoms, until three months ago, when the present symptoms came on again. The diagnosis was based on the mixture of the symptons rather than the definite sequence of motor or sensory development, and the absence of the pupillary signs. There was a question whether the case was purely functional neurosis, but he did not think that that opinion could be held in view of the very definite symptoms pertaining to the sensory and motor regions, and also the reflexes and sphincters.

Dr. MADDEN enquired whether there were any optical symptoms.

Dr. GOLDSBROUGH replied in the negative, and that there was neither nystagmus nor speech derangement.

Spasmodic Torticollis.[1]

F. G. C., aged 31, male, clerk and subsequently traveller. Six years ago began to have neurasthenic symptoms, fear of being out of doors, rush of blood to the head, and tremor. He changed his occupation, went to Canada, and undertook manual labour. Was better at first, but overworked himself and returned home worse. Could not trust himself alone; went into business and failed. Spasmodic wry neck then ensued gradually. The head was rotated to the left, and fixed. Was treated in the National Hospital with rest, massage, and general faradism. The spasm disappeared, except that he could not lie on his back or left side. In January, 1905, it returned, and he attended the London Homœopathic Hospital in February. He improved under ignatia until May, when he discontinued attendance. Two months ago the spasm began again on the left side. The head was rotated and fixed, except when lying on the opposite side in bed. Admitted December 22 in that condition; has since acquired partial control of equilibrium. Very excitable, and anxious about his health. Fears every trivial event; hands always damp. Functions otherwise normal. No history of rheumatism. Family history good, except father neuropathic.

Dr. GOLDSBROUGH asked for suggestions in regard to the treatment of the case. Personally, he thought it was a case where suggestion might be of use. He had not used hypnotic suggestion, but he had tried to explain to the patient the con-

[1] Exhibited by Dr. GOLDSBROUGH.

dition he was in. He believed the condition was almost entirely a psychical one. The patient was of a very highly neurotic temperament, and if he only knew how he could maintain his equilibrium, good results might follow. Ignatia had been given, which relieved the patient very much on a previous occasion. Dr. Goldsbrough intended to apply the faradic current to the muscles on the opposite side to the spasms.

Dr. BYRES MOIR suggested that a course of exercise for the purpose of building up the patient a little would be of benefit, as the man was physically unfit. Failing that, he recommended aurum, as he had seen spasms removed with that remedy.

Dr. DEANE thought that if the patient received a month's drill under a sergeant his condition might be improved, especially as there was a sergeant at present in the hospital.

The PRESIDENT suggested that if aurum and exercise failed, tetanum, the nosode of tetanus, from the live bacillus, might be used as a possible remedy.

General Paralysis.[1]

W. D., aged 47, a window cleaner, always a very sober man and has never had syphilis.

About eight years ago fell from the top of a folding ladder (7 to 8 feet), with his chest across a bed, not much hurt at the time, and went on with his work. About a year later had scarlet fever, soon after which his present illness began with at first backache, then gradually he got weak and thin all over, for which, in February, 1901, he was an out-patient at the London Homœopathic Hospital, under Dr. Goldsbrough, and subsequently an in-patient under Dr. Blackley. The diagnosis then made was the early stage of general paralysis. The medicine he had chiefly was phosphorus. After about three weeks he went out much improved, and for a time seems to have resumed his work as a window cleaner.

The symptoms of general muscular and mental weakness soon began to return, however, and for the last three or four years he has done nothing, and has practically been dependent on public and private charity for his support.

On December 8, 1906, he came into the Phillips' Memorial Hospital, Bromley, his condition then being: His mind seemed always in a state of confusion. He seemed dazed if asked a question, and answered after a long time with great hesitation and

[1] Exhibited by Dr. MADDEN.

some trembling. He says his head feels misty, but he has not much backache. Back and legs are weak, and he can hardly walk or stand more than a few moments, and then staggers. His gait is markedly ataxic, and he cannot hold up at all with his eyes shut; pupils sluggish. The knee-jerks are exaggerated, and all reflexes are obtainable, though not very well marked. Backache not severe. No paralysis of anus or bladder. Appetite is very poor. He is not sick, but constipated. Sleeps very poorly as a rule.

He was put on ign. 1x gtt. v., t.d.s., and bell. 1x at night, and he is now very decidedly better. He stands and walks much more strongly and steadily. Appetite is good, and, as a rule, he now has very good nights. He has never had any fits or convulsions, nor any mental delusions of the usual character; has no fibrillary twitchings in the cheek and tongue; and, as you see, is little if any worse than he was five to six years ago; so that it seems as if his disease has been arrested for a very much longer time than is at all usual.

Dr. MADDEN remarked that the chief interest of this case was its long, lasting character. The case was of over six years' duration, and the patient had not advanced beyond the initial stages of general paralysis. The question was, was it possible there had been any mistake in the diagnosis? Personally, he did not think there had been, unless it were a case of very unusual history. If it were a case of arrested general paralysis, it was very unusual for it to be arrested for so long. He thought it must be largely due to the fact that the patient had neither of the two great toxins in him which were usual in such troubles; he had never had the specific disease, nor had he been an alcoholic. The patient's condition was one very rarely seen six or seven years after the onset of the trouble.

Dr. BLACKLEY said the patient appeared to him to be very much in the condition he was in when he left the hospital in 1901. He desired to enquire whether it was the opinion of those who saw him that his gait was an ataxic gait, because during his stay in the hospital his gait was examined on several occasions, and the conclusion come to was that it was not characteristic of anything in particular; it was a shuffling gait, but nothing more. Personally, he did not regard it as a distinctly ataxic gait.

Dr. WYNNE THOMAS thought it was an open question whether the phosphorus and ignatia had had very much to do with the patient's improvement. While the man was in the hospital he improved considerably up to a certain point, but soon after he

went out he got worse again. Since he had been in the hospital for a second time he had received proper nursing and good food, and he had improved up to a point, but it was a question whether he would not go back to his old condition after he had been out of the hospital a week or two.

Dr. BLACKLEY stated that the patient was only in the hospital for three weeks in 1901, although Dr. Goldsbrough had him under observation for a short period previously.

Dr. GOLDSBROUGH stated that the symptoms rapidly improved when the patient was in the hospital. He thought the patient was an example of a negative kind of general paralysis, *i.e.*, what was described in books as paralytic dementia, which followed, as a rule, the active symptoms of general paralysis. There were a certain number of cases who had negative symptoms right through, and they were generally much slower and less conspicuous in their symptoms than the active ones. He did not see why the patient should not go on for ten or fifteen years longer in his present condition if he was not cured. When he was in the hospital under Dr. Blackley's care he received phosphorus 6x for some time, and certainly improved very much. The failure of memory and powers of attention, which were the chief paralytic features of the patient at the present time, indicated, in his opinion, that phosphorus would still do him good.

The PRESIDENT enquired whether phosphorus had been given.

Dr. MADDEN replied that phosphorus had not been given lately. He had only had the patient under his care for a month, and during that time he had received ignatia.

Dr. GRANVILLE HEY thought the symptoms of the patient indicated that suggestive, or hypnotic, treatment might do good. He remembered a case, treated by Professor Fraser in Edinburgh, where the symptoms entirely disappeared under the hypnotic influence.

Dr. GOLDSBROUGH enquired whether the patient in that case had lost the power of attention, because that was a very important point.

Dr. GRANVILLE HEY replied that, so far as he remembered, the case was very similar to the present one.

Dr. GOLDSBROUGH remarked that in the present case the patient's power of attention was very weak; he could not fix his mind on anything.

Carcinoma of Breast.[1]

This patient, aged 42, presented the following history: Some years ago she came with an advanced scirrhus of the left breast. Operation was undertaken by Dr. Burford, and the patient made a good recovery. Thyroidin and cacodylate of soda were administered at various times. In nine months recurrence took place. A nodule was removed, and this occurred again and again until a fresh hard knot showed itself almost before the last scar had healed. Removal of both ovaries was now advised and carried out, and the patient at once put on cacodylate of soda. The latter was steadily continued for over two years. Occasional courses of X-rays were also given. *During this time no further recurrence had developed;* the patient had put on over 2 st. in weight, was now perfectly well, could move her arm with ease, and go through her daily duties without let or hindrance.

Cancer of Cervix Uteri.[1]

Dr. Burford also showed a case of vaginal hysterectomy for cancer of the cervix uteri. The operation showed a threatening condition of the broad ligament tissues on the left side after the uterus had been removed. She was also put on cacodylate of soda, ¼ grain thrice daily. Eleven months had now elapsed; the scar was perfectly free from any nodular thickening, the patient suffered no pain, had no discharge, and was perfectly well.

Microscopic Demonstration of Cancer of the Breast.[1]

In the case from whom this specimen was taken the patient, who was unfortunately unable to be present, had had repeated courses of X-ray application, covering some years anterior to operation. On expert examination the pathologist enquired if the growth had not been subjected to X-ray treatment, pointing out that the cancerous cells showed ample evidence of abortive power of the cathode rays, which, in fact, had arrested the proliferation of the cells under examination. The growth did not involve the skin, and the breast was well supplied with adipose encasement. The X-rays had to traverse these intermediate tissues before impinging on the diseased structure.

[1] Exhibited by Dr. BURFORD.

Dr. MADDEN remarked that he had been exceedingly interested in Dr. Burford's case, in which Dr. Burford had acted in consultation with him (Dr. Madden) and in which Dr. Burford had been successful in dissipating the final remains of the recurrence by the removal of the ovaries and the use of cacodylate of soda. Dr. Burford did not mention that at the time of the operation there were still some unremoved nodules round about the scar, which entirely disappeared without operation after the removal of the ovaries. He had examined the patient that evening, and found there was not the slightest trace of any nodule or pain near the scar. The treatment had resulted in an absolute cure. Had the operation been performed after the last perceptible trace of the nodules had been removed, it might have been supposed that they had exhausted themselves; but there were nodules present at the time of the operation on the ovaries which had disappeared, and had not returned after two years, Dr. Burford's report of the pathological condition showing the effects of the X-rays under an unwounded skin being most encouraging. Hitherto the impression had been held by many doctors that X-rays did not penetrate through a sound skin, but in the case under discussion they had certainly done so. With regard to the suggestion that breast cases should be carefully watched before the help of a surgeon was sought, he thought practitioners should be entirely guided by the condition of the case at the time. If the case were an early one, or if there were any doubt as to whether it was malignant or not, he thought it was their duty to give the patient the benefit of a thorough course of homœopathic treatment; but if the case was at all an advanced or progressive one, after a month or two's treatment he did not think any hesitation should be shown, because an immense deal could be done with treatment after an operation with much greater hope of preventing recurrence than if an endeavour were made to dissipate the disease in its primary condition.

Dr. BYRES MOIR enquired whether, in the case in which the ovaries were removed, the cacodylate of soda had been given for any length of time after the operation, because so much depended upon whether the operation effected the cure or the cacodylate of soda.

Dr. BURFORD replied that cacodylate of soda was given before the operation, but not for long, alternating with thyroidin. The cacodylate of soda had not prevented the recurrence previous to the operation, but the patient had not received the soaking with cacodylate that she had had since the operation.

Dr. EPPS asked how many times the X-rays had been used.

Dr. MADDEN replied that the patient had the X-rays two or three times a week for months together.

Dr. EPPS asked what dose of cacodylate of soda was given.

Dr. BURFORD replied that the dose was a quarter of a grain three times a day.

A Case of Breast Tumour.[1]

Miss D., aged 44, first seen October, 1906. She had a swelling in left breast of nearly twenty years' standing. No history of injury. Some pain for two years, but none the last four months. It has been bathed with phytolacca, and has decreased during the last two months.

She has slight hæmorrhage occasionally from rectum. Has piles. Bowels regular. Catamenia less than formerly. Amenorrhœa two months and two years ago.

Examination.—Lump occupies whole of left breast; size of a cricket ball; hard, but very elastic in places; not tender. Nipple very small, slightly retracted; there has been some blood-coloured discharge from it, none now. Big gland in axilla.

Father died from operation for lump under arm, "thought to be abscess, found to be tumour."

December 19.—Until three weeks ago some blood-stained discharge had been taking place. Since it stopped, tumour had increased 1 inch in circumference and ½ inch in vertical measurement.

Patient feels much better in general health since she began the treatment.

Dr. NEATBY said that the case he exhibited was not of the kind to which Dr. Burford had been referring, but he would like to make a remark on Dr. Burford's cases before alluding to his own. In the first place, it was always gratifying to hear of a series of successes in cases of cancer. It was very rare that one could bring forward cases of such a genuine nature where the evidence was so satisfactory both as to the previous nature of the disease and as to the cure, as far as time allowed one to speak of cure. With regard to the use of cacodylate of soda, it was always difficult to allot the precise amount of influence to any one item in the treatment of a case. Cacodylate of soda had failed very often, and it was not known exactly in

[1] Exhibited by Dr. EDWIN NEATBY.

what cases it was really indicated. He had seen it of very great use in inoperable cases where pain and hæmorrhage had been conspicuous. At the same time he had never been able to adduce a case where it was really curative. He desired to subscribe most fully to what Dr. Burford had said, that if a clean sweep could be made it should be done in addition to any treatment, old or new, which had so far been brought forward. With reference to the influence of the removal of the ovaries, at one time great hopes were raised by that treatment. He had performed two cases of the kind, but the patients had both died subsequently. One was published by Mr. Stanley Boyd in a set of cases he collected. He thought the time had come when a good deal of attention should be given to treatment by the neoformans vaccine. He was quite free to say he had not seen a case of his own cured by it, but he had been very much struck by the improvement in several cases which had taken place, and the apparent prolongation of life. If cases could be obtained much earlier than they were, and particularly if they were able to make the growth from the patient's own tissues, the chances of success would be very considerably greater than they were at present. All the cases handed over to medicinal treatment were apparently hopeless cases, and there had been but few cases really cured by the method. At the same time, he felt it was a very encouraging method, and that it was based, as far as it went, on homœopathic principles. His own breast case was not one with any striking features, except the length of time it had been in existence. He believed it was an ordinary case of cystic breast, which had been going on with various ups and downs for more than twenty years. It had now become of large size and uncomfortable weight, and was definitely increasing. Whether the increase, which amounted to 1 inch in circumference, was due to the retention of secretion or not he could not say. During the time the increase took place, the secretion, which was now escaping again, was retained, and it was therefore possible it might now go down again and get smaller. The patient had been under phytolacca for purely empirical and not for homœopathic reasons, with the result that the general health was better and the tumour smaller.

Cystic Adenoma of the Breast.[1]

Cystic adenoma of the left breast in a woman, aged 45. The growth had been present several months before coming under treatment, and was growing steadily.

[1] Exhibited by Mr. DUDLEY WRIGHT.

Scirrhinum 3 every second day, and bryonia 1x, had caused diminution in the size of the tumour.

Mr. DUDLEY WRIGHT did not think the cyst itself had got smaller under the treatment so much as the peripheral part of the cyst, which was possibly made up of inflammatory tissue. As a result of that diminution, the different nodules of the breast were more distinctly felt than they were before.

The PRESIDENT remarked there was nothing commoner than tumours in the breasts of women. They were occasionally seen in men, but it was rare. He had himself cured a case of tumour, which was of a considerable size, in the right breast of a male. He traced it to a vaccinal origin; but although it had existed for a number of years, it yielded rapidly to treatment by thuja. With regard to the relation of surgery and medicine, his own view was that, with the great powers practitioners had in homœopathic remedies, they ought to attack every case from the physician's point of view *first*. A very large number of cases yielded to homœopathic medicines, and the patient ought to be given at any rate the benefit of that chance. If homœopathic medicines evidently failed in a case, then was the time to call in the aid of the surgeon, but he did not think it should be regarded as surgical from the beginning. In his opinion Burnett's position was the correct one: "always try to cure everything." The experience of Dr. Burford with cacodylate of soda, and also his experience in the after-treatment of operative cases, was extremely important. It was a point where homœopathists could score over allopathists straight away. It was the business of homœopathists to do things which allopathists could not do. In the present instance homœopathists could treat constitutional cases after operation, and the sooner the treatment was begun, the better would be the result.

Osteoma of the Upper Maxilla.[1]

This patient was exhibited as an illustration of an unusual form of overgrowth of the bone. It was the case of a female, aged 15. A photograph was shown of an upper jaw, removed by Mr. Wright from a young woman, aged 20, the subject of a similar complaint. In this latter case the antrum of Highmore was entirely obliterated by the overgrowth, and the mass formed a

[1] Exhibited by Mr. DUDLEY WRIGHT.

large projection on the cheek. In the case of the patient now exhibited, the projection of the cheek was less; the whole of the alveolar margin on the right side was affected, and there was slight thickening of the hard palate.

In both cases the growth was unilateral; it was not proposed to do any operation, as the deformity was not very conspicuous.

Fracture Dislocation of the Elbow.[1]

A case of fracture-dislocation of elbow joint (in a girl, aged 10), complicated by injury to the nerves in the vicinity, resulting in rapidly-forming trophic ulcers, marked limitation of movement at elbow joint, atrophy of muscles of fore-arm and hand with paralysis, and formation of "main-en-griffe."

Has been treated by ordinary fracture methods, partial excision of elbow joint, faradism, galvanism, high frequency current, and massage. Some attempt at improvement (*e.g.*, slight return of sensation and a little more power) after three and a half years.

SPECIMENS.

Carcinoma Uteri.[2]

A specimen of malignant disease of the body of the uterus—the cervix being free—mounted, after hemisection, by the American method, in transparent gelatine.

Carcinoma Uteri.[3]

Microscopic demonstration of fragments curetted for diagnosis from Dr. Burford's specimen of malignant disease of the uterine body.

Uterine Fibroid.[4]

The tissue shows marked *hyaline degeneration*, spreading radially from various centres, corresponding with the nodules of the tumour.

Active-looking connective tissue cells lie in the homogeneous tissue.

Uterine Fibroid.[5]

Fibroid removed by *hysterectomy* from patient aged 50 years. Married.

Tumour reached to the level of the ribs on either side; its presence was discovered accidentally; there were *no symptoms.*

[1] Exhibited by Dr. C. GRANVILLE HEY.
[2] Exhibited by Dr. BURFORD.
[3] Prepared and exhibited by Dr. FRANK WATKINS.
[4] Exhibited by Mr. ELWOOD and Dr. ED. NEATBY.
[5] Exhibited by Dr. ED. NEATBY.

Menstruation was still going on. Patient made an uninterrupted recovery.

Table showing Opsonic Indices (Neoformans) in Cancer Case.[1]

Ellis, R.—Cancer of breast.

Index, November 2 = ·56.
,, ,, 20 = ·94.

Injection 5 m., November 21.

Index, November 21 = ·85.
,, ,, 26 = ·59.
,, ,, 29 = ·85.
,, December 8 = ·82.
,, ,, 17 = ·59.

Injection 5 m., December 20.

December 20 (8 hours after) = ·93.
December 31 = ·67.

With specimen of *Micrococcus neoformans.*

Malignant Growth of Orbit.[2]

Microscopic section of malignant growth of the orbit successfully removed by surgical operation.

Lingual Thyroid Tumour.[3]

Microscopic section of lingual thyroid tumour removed by operation.

Septum Forceps.[4]

A new form of septum forceps, adapted for cutting a U-shaped flap, for the correction of deviations of the nasal septum. Made by Mayer & Meltzer for Dr. Speirs-Alexander.

[1] Exhibited by Dr. EDWIN NEATBY.
[2] Exhibited by Mr. KNOX SHAW and Dr. FRANK A. WATKINS.
[3] Exhibited by Dr. JAMES EADIE and Dr. FRANK A. WATKINS.
[4] Exhibited by Dr. SPEIRS-ALEXANDER.

THE PLACE OF PHYSICAL TREATMENT IN THERAPEUTICS.[1]

BY JAMES SEARSON, M.D.

Assistant Physician to the London Homœopathic Hospital.

MR. PRESIDENT AND GENTLEMEN,—I desire first to express the deep sorrow I feel, and which we all share in common, at the sad necessity which brings me before you to-night. Dr. Lambert was to have stood in the place which I occupy; an unexpected fate, which we all deplore, and by which we are all losers, has taken him from us, and someone had to fill the gap; otherwise I should not now be here.

In the justifiable belief and enthusiasm in which we all share, regarding the curative application of drugs to disease, as practised by our own particular school, we are, I imagine, sometimes apt to overlook other methods, such as what is called physical treatment, in dealing with our cases.

This is in a way understandable; drugs applied on the homœopathic principle have won so many laurels, and have earned such deep-seated faith from those who have, like ourselves, seen their remarkable results, that we may almost be forgiven for assuming, if we go so far, that nothing else is needed.

Yielding as I do to no one in my absolute faith in drugs carefully selected according to our principle, I am yet here to contend that there are many other agents at hand, the utility of which has been so clearly proved as to make their non-inclusion as adjunctory measures unpardonable.

This especially, as there is no hindrance either in our charter or our pretensions to making use of any methods, in addition to our drugs, which may appear called for. This is well expressed in the definition adopted by the American Institute of Homœopathy, that "a homœopathic physician is

[1] Presented to the Section of General Medicine and Pathology, February 7, 1907.

one who adds to his knowledge of medicine a special knowledge of homœopathic therapeutics; ALL THAT PERTAINS TO THE GREAT FIELD of *medical learning is his by tradition, inheritance and right.*

Thus, the administration of anæsthetics, the flushing of a bowel obstructed by fæcal accumulation, antitoxin injection for diphtheria, the application of heat and water and sun and air and light and electricity and exercises, to diseases, is quite within our province, and the practitioner who makes use of them freely is guilty of no heterodoxy, and merits no covert sneer. I go farther, and contend that he is the more practical homœopath, inasmuch as he demonstrates to the critics our freedom from narrowness and petty sectarianism.

During my visit to the States, over three years ago, I was much impressed by the excellent results of electrical treatment, which I had the privilege of seeing in some of the homœopathic hospitals and colleges; this was especially the case in New York and Chicago. On my return home I studied at the electrical department of several of our London hospitals, took out special courses on the subject, and I had the great advantage of being permitted by my friend Dr. Ashton to act as clinical assistant in the useful department which he ably superintends at our own hospital.

The more I thus saw of the practical results obtained, the more I became impressed with the possibilities of physical treatment as an addition to our armoury. I therefore gradually equipped myself with the necessary appliances; and if any of you care to favour me by seeing the rooms in which I carry on treatment at 64, Seymour Street, I think you will find them adequately furnished with the necessary means for the administration of all kinds of electricity, galvanism, faradism, and combined with high frequency, static, X-rays, electric vibration, and baths.

The latter are carried on in combination with my friend Dr. Percy Wilde, to whom I am in this connection much indebted for kind help, advice, and instruction.

The bath we have in use at Seymour Street is after the pattern which has been in use for many years at Lansdowne House in Bath, and its fitments are the result of many years

of patient observation and experiment on the part of Dr. Wilde. The aim is to obtain an elevation of the body temperature, which is taken to be the measure of the metabolic changes produced, and as a result of which effete matters are eliminated, and the toxæmias and symptoms arising therefrom are cured.

The construction of the bath is simplicity itself, and I have to publicly thank my friend, Dr. Percy Wilde, for permitting me to describe it as follows:—

The bath is formed like a couch or bed; the upper part of the couch is made of wire netting, below this there is a large sheet of iron and a self-filling boiler, in which two pipes are connected, and the steam passes up through the wire netting and circulates all over the couch. On the couch is placed a piece of felt to cover the netting, then a double blanket and bath sheet to protect the patient; there are two reflectors, one on each side of the couch, and shaped to it, each one containing four electric lamps (eight-candle power); then there is a third reflector, which is larger than the others, and covers the lower half of the couch, and forms with a round-shaped rod, a cradle, which takes the whole of the weight of clothes off patient. The large reflector contains eight lamps, four each side (eight-candle power); all the reflectors are easily moved, not fixtures; on top of all a bath sheet is placed and a blanket, then a mackintosh and then a large covering blanket. The whole looks like a very comfortable bed, and the temperature can be easily regulated from 90° to 150° F.

My experience with this particular bath has been entirely satisfactory. I find it particularly useful and curative in the toxæmias, such as gout, &c.; it causes gouty deposits to disappear, removes stiffness and pain, and is the best remedy I know for chronic skin eruptions.

I have in attendance here two patients who have been so very kind as to come at much personal inconvenience to allow us to see their present condition.

The first case is a patient who in June, 1904, came under my treatment, suffering from small multiple growths on the forehead and the bridge of the nose. They were hard and unsightly, and the deformity was increased by

some scars which remained after an operation performed many years before for their removal, which was only partly successful, and on the site of the scars fresh growths had appeared. The patient came under the X-ray treatment, which he persevered with faithfully and regularly for about six months. At the end of that time, to my horror, a fresh growth suddenly appeared on one side of the nose. It seemed to spring up quite rapidly, and within a few days it assumed the size of a walnut, and was rather larger than the other growths already alluded to. The patient became anxious, and his friends also becoming anxious, he was led (without mentioning the matter to me) to seek the advice of a surgeon connected with one of the London hospitals. This gentleman apparently took a very serious view of the case, and advised his going into hospital for immediate operation. Happily for the patient, as it turned out, he rather feared this ordeal and came and confessed to me what he had done. At my suggestion he then saw Mr. Dudley Wright, who diagnosed "multiple sarcomata" of the spindle-celled variety, and who favoured the continuance of the X-ray treatment. In three months' time the swellings had virtually disappeared, and I now have pleasure in showing him to you after a lapse of about fifteen months, and you will see for yourselves the result, the growths have quite disappeared.

The second case I have pleasure in exhibiting to you is that of a gentleman who has suffered practically all his life from skin eruption covering the entire body. The eruption, although varying in appearance in different parts, was chiefly of an "eczematous" type, and presented many of the characteristics of this form of skin disease, being red and hot and weeping and itching. I have in my hand a history kindly supplied by him, in which he says that from 1870 to 1885 he attended several doctors in Perth, who dosed him with arsenic, mercury, and iron. For the two following years he was under the care of our late colleague, Dr. Edward Blake; the next year he was under Dr. Skinner; the following four years no treatment; the following two years at St. John's Hospital, Leicester Square; the next two years

at the London Homœopathic Hospital; the next year no treatment, the next two years under a herbalist; the next three years under doctors at Cardiff, then a course of six weeks at the Middlesex Hospital, then three months at Leicester Square Hospital. He came under my treatment on August 31, 1906, sent by his brother, a doctor in Cardiff. He had baths and electrical treatment, and from the very first began to get better, and I have the pleasure of showing him to you now, with, as he declares, his skin in a healthier condition than it has ever been before.

I have had many other cases which I should like to have shown to you, but, as you know, it is not easy to induce patients to come for the purposes of demonstration, but I will with your permission narrate some of them.

A lady from Brighton, three years ago, came under my care, suffering from what afforded every clinical evidence of being cancer of the breast of the scirrhus type. The swelling was about the size of a small orange. It was hard, adherent to the skin, and just under the nipple there was a distinct puckering, with induration. There were no deep adhesions and no glandular enlargement. This patient absolutely refused an operation and decided to undertake a course of X-ray treatment. She persisted in this regularly for one year. At the end of that time no swelling was apparent. The skin puckering had become less and the patient's health generally improved. I may say that in this and in all other cases I gave at the same time what I considered appropriate homœopathic remedies. This patient was seen whilst under my care by eight different medical gentlemen, who were good enough to examine her at my request, including Dr. Percy Wilde, Mr. Dudley Wright, Dr. Harvey King, of New York, Dr. Alexander Angus and others, who all concurred in the diagnosis. Up to this date I have heard both directly and indirectly of and from the patient, and there has been no return.

I am now treating a somewhat similar case sent on to me as a recommendation from the last case described. This lady had an almost similar condition, only the swelling was not quite so large, but the superficial adhesions were pronounced,

and a distinct puckering and induration under the nipple. She was under the care of a local doctor in Worthing, and had seen an eminent consulting surgeon in London; both diagnosed cancer and recommended immediate removal. This the lady refused. She came under my care two months ago, and at once began to show signs of improvement. At the present moment no tumour can be felt. There is, and has been, no glandular enlargement, her general health is very much improved, and the patient and her relatives look upon her as being virtually cured, and in this view I myself concur.

I have applied X-rays with success for superfluous hairs on the face of a young lady, who had quite a beard and moustache. I did not administer the rays long enough to produce erythema, although that course is recommended. The hairs, however, soon began to drop out, the areas covered became thinner as regards the growth of hair, and the patient has now very little left. I am now proposing to give longer exposures to produce, if necessary, erythema, and I quite hope all the hair will entirely disappear.

To return to treatment by special baths. A gentleman came to me from the country stiff and racked with pain, the result, in my opinion, of an exacerbation of chronic gout, to which he is subject. The night before he came to me his pain was so acute that he had to call up his local doctor in the night to inject morphia. I at once started him on a course of baths, for which he remained specially in town. After the first bath the improvement was definite, and at the end of a week he went home, as he said, feeling quite a young man.

A further case was that of a gentleman who for years had been suffering from a morning headache, which, as he said, made life almost unbearable. The headache was throbbing and gnawing in character, and he had for four years been under different treatments seeking a cure. Amongst others he had been for a considerable time under Dr. Haig, but no improvement was effected. I first tried various remedies that suggested themselves, and although he seemed somewhat to improve, he never got quite well. I then advised him to take a course of baths, followed by electricity. He

began these three weeks ago, and has distinctly improved. The attacks have been absent for several days at a time, which was quite unusual, and on the mornings when they do appear they have been much more mild than usual.

I trust I have said enough to indicate to you the genuineness of the cases treated. I have endeavoured, in all cases where possible, to corroborate the diagnosis by obtaining the opinion of others; the fact that in cases of neoplasms there has been no recurrence to date is, I trust you will agree with me, highly satisfactory and encouraging. Similar results have been reported by other workers. Some months ago Dr. Dieffenbach, who is connected with the New York Homœopathic College, and is second in charge of the electrical department there, reported a case of uterine fibroid. The lady came to him, having resisted all advice to allow operative interference, and he held out no hope to her of being able to benefit her by X-rays. She, however, insisted, the treatment was begun, and at the end of six months the growths had disappeared.

I think, gentlemen, we may now feel that with these facts before us (and I think they must be regarded as facts), we may feel encouraged to advise the use of this line of treatment more widely and more hopefully than we have hitherto done. I am not prepared to recommend that the surgeon's knife is to be in every case superseded, but I do suggest that in cases where patients absolutely refuse operation, they may be recommended to adopt this method of treatment, with a reasonable hope of success in some cases. I would further suggest that in all cases where a patient is waiting an operation the treatment might be applied, and that the treatment should always be applied after an operation, and continued for a reasonable time.

I need hardly point out that great care is necessary in administering the rays. So many patients are dissatisfied unless they get a long exposure, by which I mean an exposure of from ten to fifteen minutes, and they often demand it. But in this matter I am always quite firm; for I find that one gets the best results by short exposures of three or four minutes, and the risk of burning the patient is practically *nil*.

For many reasons erythema of the skin is to be avoided; first, because one never knows the precise susceptibility of any particular patient, as they vary much in this respect: and secondly, because if you burn patients you lose them. I had an interesting experience of this kind about a year ago, with which two of my colleagues are familiar. A lady sent to me by one of them with breast carcinoma, not satisfied with the length of the exposure, clamoured like Oliver Twist for more. I remained firm, however, happily for my own peace of mind. On my return from a short holiday, I learned that, finding me away, she had called one of my colleagues in to see a rash which had appeared on the breast. He, not knowing who had administered the rays, was possibly somewhat more strenuous in his denunciation than he might otherwise have been, and a very unhappy time for me followed. I saw the lady, went thoroughly into the case, and found that she had at the time, without my knowledge, been using a local application of violet leaves; and in view of the fact that the administration had never exceeded five minutes, and that they had been administered with long intervals between, I was compelled to the conclusion that the violet leaves and not the X-rays were responsible for the rash. The lady did not agree with me, and I was dismissed fee-less and crushed.

I had hoped to have brought some other appropriate facts before the Society bearing on my subject, but my time has expired, and I shall hope to avail myself of some future opportunity for doing so.

THE PRESIDENT said he was sure all members present had been deeply interested in seeing the patients brought forward by Dr. Searson, and in hearing his communication. Of course, members of the profession were entitled to use anything which came to their hands which promised help to their patients. The only difficulty he, Dr. Clarke, had in the way of what might be called accessories was, that it took him all his time to find the simillimum for his cases. He had not time to administer baths, but he was happy to know he could obtain such valuable curative aids for his patients whenever they required them.

Mr. DUDLEY WRIGHT asked the author one or two questions.

First, when patients were in the steam and light baths which had been described, did they perspire much, and how long were they allowed to remain in the bath? Also, what was the exact action of the bath in relation to the temperature of the body, the pulse-rate, and the respirations? With regard to the X-ray treatment, in which he was himself very much interested, he noticed that Dr. Searson believed in very short exposures. He would like to hear what tubes he used, and, if he measured them at all, what strength. He (Mr. Wright) had been in the habit of using very much longer exposures, but probably his tubes were much softer than Dr. Searson's, thus enabling him to use the longer exposures without risk of causing erythema. Sometimes he continued the exposure for fifteen or more minutes, in rodent ulcer and similar conditions. Perhaps Dr. Searson would give his reasons for abandoning long exposures.

Dr. ASHTON congratulated Dr. Searson on the success which he had had, especially in the case of sarcoma on the forehead. Dr. Ashton had had only one case at the hospital which was undoubtedly multiple sarcoma, but it was in such an advanced stage that it was impossible to treat it thoroughly; in fact, the man was almost dying when he was sent in from another hospital. The abdomen and both arms and legs were implicated. Dr. Searson said he used a Cox's tube, which was a very powerful form, and it was necessary to have a screen of some kind. In the early days each patient had to have a lead screen, lead being considered the most suitable. He (Dr. Ashton) had used in the hospital, with the greatest success, a Cossar's tube, which had several advantages: that the patient could not get too near the anode, and the window through which the X-ray passed could be chosen to suit lesions of any size. The window is at the end of a projecting part of the tube, and was to regulate the distance. He had heard of patients being actually in contact with the tube, but he did not allow his patients to do that, for one reason, that they might occasionally get a slight shock. With the arrangement Dr. Searson used, the anode might move from the axis of the opening in the screen without being noticed, and the screen added to the weight of the tube. It was necessary to avoid anything which might frighten patients, or they might cease coming. He would like to hear at what distance Dr. Searson had the patient from the anode, and what method he used for gauging the intensity of the rays being employed. There were several ways of doing that. He would also be glad to hear by what means the lesions on the man's forehead were diagnosed as spindle-celled sarcomata. He was glad to hear

that Dr. Searson found short exposures had many advantages, because he (Dr. Ashton) did not think it depended entirely on the softness of the tube. In the early days the tubes were often soft. He believed more depended on the distance, and on the susceptibility of the patient, as well as on the frequency of application. Other factors were the intensity with which the coil was working, and the rapidity of the interruptions. He believed Mr. Wright had been using the new apparatus by Gaffe, of Paris, not the ordinary coil, with a milliampéremeter in the tube circuit. The new apparatus gave a much smaller variation in the tube. He was sorry that the room he had at the hospital did not allow him to go in for the refinements such as he had mentioned. One had to use the same coil for a number of different cases. Perhaps before his arrival a dozen cases, which were straightforward, had been treated by the nurses. In regard to the light bath, he asked whether Dr. Searson used the ordinary incandescent lights, and whether the glass was glazed, or were they anything like the Dowsing light, or the Dowsing lamps themselves? Dowsing claimed a combination of heat and light for his lamps. He (Dr. Ashton) had had some cases in which the temperature of the bath had been 300° F. or more, but of course it was not kept up long. He had the temperature taken by means of a special solar thermometer, and he had no doubt it was correct. Did Dr. Searson gauge the temperature of his baths, and if so, at what part of the bed was the reading taken? He would also like to hear what was the position of the reflectors. He would like to hear in what posture patients were placed in the bath Dr. Searson mentioned, and on various matters connected with the baths.

Dr. JAMES WATSON (Liverpool) said it was known from the experience of American experimentalists that the application of X-rays had given rise to local troubles of a nature exactly similar to those for which Dr. Searson had used X-rays; and it appeared to rather complicate matters to use medicinal remedies at the same time as the X-ray treatment. For all that was known at the present, the X-rays might be the simillimum. Two agencies were being used, and one did not know to which to attribute the effects produced. With regard to skin conditions of a chronic nature, he was in the habit of looking upon them as a kind of outlet or vent for deleterious matter within. Probably for saying that he would be regarded as behind the times, but that was his belief, and he had therefore discarded all local medication in such cases, whether due to vaccinosis, or gout, or other toxæmia. He would like to hear whether Dr. Searson had measured the excretory

capacity of various organs, such as the kidneys and skin, before, during, and after the local skin manifestation. In other words, was the eliminative function of the body increased or diminished?

Dr. MADDEN said he remembered Dr. Wilde demonstrating his bath some years ago, which consisted of hot air produced by hot water above and all round the patient. He now heard with interest that that had been altered to hot water below, and electric lamps under the bedclothes. He would like to hear whether Dr. Searson or Dr. Wilde thought that there was any difference in the effects of the heat produced by one means as compared with another. He (Dr. Madden) could not find any difference in the effect of sweating produced by hot air, by steam, or by electric light. He believed Dowsing claimed that there was a therapeutic effect in light, and, moreover, that there was a peculiar advantage in electric compared with other forms of light. His own view was that it was the effect of heat and nothing more. He congratulated Dr. Searson on the result of treating presumptive carcinoma of the forehead by means of X-rays. He had tried many cases himself by the method, but he confessed that although he had arrested the growth in some he had cured none. He had cured by that means cases of malignant ulceration, and malignant warty excrescences, but not an actual malignant neoplasm beneath the skin. He wished to enforce Dr. Watson's remark concerning the relationship between the use of physical measures in small doses and their effects in large doses. The fact that Dr. Searson got better results from short than from long exposures was suggestive in that direction. The fact mentioned by Dr. Watson that in America and in this country there had been malignant lesions, apparently due to the over-use of X-rays, opened up a suggestive line of thought on the subject, and he thought it would eventually come to be recognised that there was the same law governing the effects of physical agencies as well as of drug powers.

Dr. WYNNE THOMAS said there were many questions which naturally arose out of the paper which had been read. With the case of multiple sarcomata on the forehead, he would like to know whether a small piece was removed and examined under the microscope, and if not, how the opinion was arrived at that it was a spindle-celled growth. He wished also to know what kind of apparatus was used by Dr. Searson for his X-ray work. What kind of current did he employ, and did he get it from the main or from the accumulator? Also, did he project the rays directly on to the skin, or did he interpose something between the skin and the tube? He stated that he used Cox's "Record"

tubes, with a shield in front, and not the tube mentioned by Dr. Ashton, leaden glass, with a small window at the end of the tube. He would like to hear whether Dr. Searson had had any experience of treating enlarged glands with X-rays. He had treated several cases of enlarged glands by the method, and found the result very satisfactory.

Dr. McLachlan desired to relate a case of cure of rodent ulcer of the nose by X-rays at the ordinary infirmary at Oxford. It was that of an old lady, whom Dr. Blackley would remember, and who came from Manchester. He (Dr. McLachlan) tried medicines once or twice, and then recommended her to go under the X-rays at the infirmary. She did so, and after eight or ten sittings the lesion disappeared. That occurred some years ago, and she was now perfectly well. Only a slight scar was visible.

Dr. Burford said, in regard to the influence of X-rays in controlling malignant lesions, he showed at the last Clinical Meeting (see p. 122) under the miscroscope, a specimen of a simple adenoma which had become malignant. When the specimen was examined after the operation by a very expert London pathologist he asked whether X-rays had not been used in the case. He called upon the gentleman and asked why he put the question. The reply was that appearances were present in the specimen which he only noticed when X-rays had been used in the treatment of the growth. In that case the use of the rays had been almost but not quite successful: there were a great number of cancer cells in the specimen which had been successfully aborted by the treatment. As the patient was constantly changing her residence—she was recently staying in Switzerland—Dr. Madden, who had charge of her, could not keep her under continuous treatment, but had he been able to do so there was reason to think that the condition would have been cured by the rays. It was not generally known that the X-rays could go through an intervening layer of soft tissue and exercise their curative influence deeply in the tissues.

Dr. Searson, in reply, said there could be no doubt that X-rays constituted a very powerful agency, and it was at Dr. Ashton's feet that he had learned to be cautious. The more experience he had with X-ray apparatus, the more he felt that it was the man who was cautious and patient who was successful. It was a mistake to try and hurry matters in X-ray treatment. With regard to the kind of case to submit to the treatment, he thought it was either the slow-growing or the stationary growth. Cases which were likely to be rapid in growth, or where there was a history of rapid growth, should be at once referred to the surgeon. There might be

a professional reciprocity in this matter between the surgeon and the X-ray operator, the object of both being to do the best for the patient. He used a tube of moderate hardness. The two important points were the distance of the patient from the tube and the duration of the exposure. He never exposed at a shorter distance than twelve inches, and frequently went beyond that distance. He never exposed for longer than four or five minutes, and only that time when he had satisfied himself by a preliminary trial that the patient would tolerate the rays. All would agree about the varying susceptibility of the patients. The current he took from the main. There was nothing placed between the tube and the lesion treated. The Cox's tubes he used were the "Record." The part next the patient was protected by a rubber semicircle. Coming through that was a chimney of lead glass which allowed the rays to come through a given area, and to be focussed on to the particular part to be treated. That was the best way of administering the rays with which he was acquainted. The Cosser tube he had never taken kindly to, as he never seemed to get on well with it, and he had now discarded it. The advantages which Dr. Ashton claimed for it, that it kept the patient at a proper distance from the tube, was achieved by using the new method, namely, having a long funnel, from the end of which the rays bore on to the patient's skin. He had been asked about the diagnosis of the case which had been shown, the multiple tumours of the forehead. He would refer members to Mr. Dudley Wright for the reason of that diagnosis. In addition there was the fact that the man was seen by an eminent surgeon, the name of whom he would supply to anyone afterwards if he asked for it, and who looked upon the case very gravely. He wanted the patient to be taken in at once to have it surgically dealt with. The evidence was overwhelmingly in favour of it being sarcomatous, and members had had the opportunity of seeing that the growths had disappeared. He did not think he could produce further evidence of the *bona-fides* of the case. With regard to the other case, she was seen before and after treatment by eight experienced men, and he had quoted Mr. Dudley Wright, who was one of those who saw her. Dr. Wilde saw her, as also did Dr. Harvey King, who was at the head of the electrical department in his hospital in New York, and those gentlemen confirmed the diagnosis. The question of baths as a form of treatment had interested him for a long time, and he had always felt that the medical man's equipment was incomplete without baths. Various kinds of baths had been brought under his notice—sunlight baths, electric baths, Dowsing baths, and

other kinds. The features of the Wilde bath he had tried to explain in his paper. The point to which Dr. Wilde attached importance was, that the steam which came up through the network of the bath spread itself over the skin, thus preventing the heat of the body from rapidly escaping, and hence the body temperature was raised. His view, and he thought that of others also, was that the height of the temperature was the measure of the metabolic activity. Dr. Wilde argued that if a patient with a dry skin were put into a hot-air bath of that kind he promptly began to perspire, and that rapid perspiration was hostile to the increased metabolism. But coating the patient's body with vapour retarded perspiration, which occurred later, and so the metabolism was increased. At his (Dr. Searson's) rooms there were two nurses whose duty it was to take careful notes of temperature, acidity, &c., and there was now a collection of charts which should become very valuable, and for which there might be some later opportunity of presenting to the Society. In the gouty cases he found that the patient almost invariably started with a sub-normal temperature, but when they commenced the bath it rose to 101° or even 103° F., and that increase was taken to be, in a way, a measure of the metabolic activity. After remaining in the bath for about twenty minutes, the patient was passed on to an ordinary bath room, where water at a temperature of 98° to 100° was used, and after remaining there for a time the patient was taken to another room, where he rested, dressed, and left. Dr. Wilde had encouraged him to pay attention to the reaction of the excretion, for which they used a specially prepared litmus paper. It was very interesting to watch the course which the reactions took. After the first two or three baths the litmus paper was scarcely touched at all, though the reaction was slightly acid. But after five or six baths the litmus paper was markedly affected. After the acidity had risen to a high degree, it gradually descended, and that descent was concurrent with the general improvement of the patient. What the acid was, nobody seemed to know. He made some experiments a short time ago, in which he had the co-operation of Mr. Collings. But there was no opportunity of collecting the sweat, and that was the one thing which they did not examine. Almost everything else was examined: the urine was examined for urea and uric acid, before and after; the fæces before and after; the blood, the pulse, and temperature. Those results were published in the *North American Journal of Homœopathy* in the form of a paper which he had read at the International Congress in September, in Atlantic City. He had been anxious to find out the relative value of the different

baths. He had tried the sunlight bath, the Dowsing bath, the ordinary hot-air bath, the Turkish bath, the hot bath; and he had tried, as a control test, the effect of a four mile walk, in which he was himself the victim. The results of those investigations would be found in the paper to which he had referred.

Mr. DUDLEY WRIGHT, in further explanation, said the case of tumours of the forehead he regarded as sarcomata, and he suggested it might be a spindle-celled growth because of its slow increase in size. It certainly was not gumma, at least such as was ordinarily met with, and the fact that it had spread down from the original site was much in favour of the view that it was malignant.

REMARKS ON MODERN CONCEPTIONS OF NERVOUS STRUCTURE.[1]

BY A. E. HAWKES, M.D.

Honorary Medical Officer, Hahnemann Hospital, Liverpool.

MR. PRESIDENT AND GENTLEMEN,—I have been asked by the secretary to take the place of an absent friend on this occasion, and to give you a short paper.

Like Rip Van Winkle, the general practitioner, unless he is unusually alert, from time to time wakes up to find a change in his nosological environment. In no department is this so manifest as in that pertaining to diseases of the nervous system.

I have referred elsewhere to the almost stealthy way in which the term "patellar reflex" came to be used after I had commenced the study of medicine. Moreover, I venture to say that there is hardly any one present who has not thrown over some ballast, no longer worth carrying, so progressive is the art to which, with more or less ardour, we devote our lives. Alas! our books rust out before wear and tear destroy them. With a view to the clearing up of some expressions relating to the nervous system which have come into general use, I throw upon the screen a diagram of Dr. W. Bevan

[1] Read before the Liverpool Branch, February 14, 1907.

Lewis's,[1] whose experience as director of the West Riding Asylum makes his contributions so valuable.

The figure 1 is placed near a nerve cell of the cortex cerebri. A neuron is a protoplasmic centrum, the cell body with its nucleus and nucleolus. The figure 2 is near its axon, a nerve process given off from an extension of the cell or from the cell body. This axon may be naked, and terminate in free arborisations, or it may be ensheathed.

The figures 3 and 4 indicate its collaterals, ending in arborisations around cells of anterior cornu. *Coll.* shows a collateral, passing as a callosal fibre to cortex of opposite hemisphere. *Str.* collateral passing to corpus striatum.

The nucleated nerve cell, its naked or ensheathed axon and terminal arborisation, constitute the essential elements of the neuron.

The figure 5 shows the axon of cornu cell, ending in muscular fibre (m).

A further development is seen in certain protoplasmic extensions from the cell body. These plume-like divisions are the dendrons. They probably serve the purpose of collecting impressions brought from a wide area to the nerve-cell.

In adendritic cells the cell body itself receives such stimuli. The dendrites function towards the cell, the axons away from it. In other words, the axons convey nerve impulses to distal cells or peripheral organs—muscle, vessel, or gland. The axon varies much in its distribution, as may be seen by a reference to the diagram. In certain cortical regions it may divide and subdivide, ramifying over an extensive tract (Golgi's sensory cells), or it may form a rich plexiform distribution around neighbouring cells (basket cells, &c.). The nerve cell may have many axons ; these may give off branches or collaterals, these also terminating in free arborisations.

Neither arborisations nor dendrons anastomose, so that the neuron from axon to dendritic twig is an anatomical unit. The axons and collaterals of the cell embrace the dendrons and the body of another nerve-cell, without establishing organic unity.

[1] "Allbutt's System of Medicine," vol. vi., p. 490.

Chains of neurons are thus formed which in the cerebro-spinal system increase in complexity from the cord to the medulla and thence to the brain cortex.

The cell body consists of a structureless substance, and of fibres of reticular meshwork, the cystoreticulum of writers. The fibres of the cystoreticulum are regarded as the lines along which nervous impulses travel.

The chromophil bodies of Nissl and the peculiar chromatin particles of the nucleus must not detain us, however much the activity of the cell depends upon changes in the latter.

It appears that the old idea "of consolidated cell groupings structurally united again with distal cell groupings, associated as they were with functional co-operation," must go. Now, each unit or neuron is looked upon as independent of its fellow, organically independent, functionally co-operative. This limiting, so to speak, of the connection between different neuron systems, also limits the disease area. For instance, "focal lesions of the motor cortex, medulla, or cord, lead to a secondary parenchymatous degeneration, which exhibits the same tendency to systematic limitation."

I must now pass from this part of the subject, for the elucidation of which I have been absolutely dependent upon Dr. Lewis's contribution; but before doing so we may ask ourselves whether the term axon conveys more to our minds than the old term axis cylinder, and it may be remarked that the word neuron does not quite convey to others the meaning Schäfer in 1893 sought to attach to it. The terms neuraxon, neurite, dendrite, need no explanation.

I next put upon the screen an excellent diagram from Ashby's Physiology. An easy transition brings us from the subject we have just been considering, to the cortex cerebri with its motor centres.

The diagram, originally obtained from Landois and Sterling's work, shows a transverse section of a cerebral hemisphere made in front of the optic thalamus.

The corpus callosum, caudate nucleus, lateral ventricle, lenticular nucleus, internal capsule, internal carotid artery,

and the lenticular striate artery, "the artery of hæmorrhage" of Charcot, are well seen. The motor centres governing the movements of the face, arm, leg and trunk, the fibres of which converge to pass along the internal capsule, are also well seen.

Into the functions of these parts we cannot now enter, but the corpus striatum is believed to act as centre for the higher reflex movements (Schäfer).

"The corpus striatum translates volition into action, or puts in execution the commands of the intellect; that is, selects, so to speak, the motor nerve nuclei in the medulla and cord appropriate for the performance of the desired action, and sends down the impulses which sets them in motion" (Broadbent). These cortical areas are still better seen in the slide taken from Bryant's Surgery, Bryant of New York, I mean.

Returning to the former diagram, it will be seen that the internal carotid artery divides into the anterior and middle cerebral arteries.

Among the branches of the middle cerebral is the lenticulo-striate, which runs up between the lenticular nucleus and the external capsule, perforates the internal capsule, and terminates in the caudate nucleus. "It has," says Morris, "so often been found ruptured, that it is called by Charcot the artery of cerebral hæmorrhage."

Let us suppose that the actual vessel we are looking at has ruptured, then obviously more or less interruption of cortical impulses will have taken place. This will have resulted from injury to the internal capsule. I cannot find out exactly when the portion of the brain under consideration was first described as the "internal capsule." It is a broad band of fibres which connects the cortex of the brain with the crus, and in which lie both the motor and sensory paths.

The anterior limb separates the caudate and lenticular nuclei; the posterior limb lies between the latter and the optic thalamus. The motor path occupies the anterior two thirds of the hind limb. It is obvious that the fibres passing from the motor centres of the cortex, along the internal capsule to the anterior pyramids and on to the pyramidal

tracts, must have their function seriously impaired by a hæmorrhage which destroys or damages the internal capsule.

Reference to the cortical areas of face, arm, leg, &c., will show the *rationale* of the phenomena observed. The paralysed lower half of face, of the leg and arm, and the escape of the muscles of mastication, respiration, and of the trunk, is explained by their probably being excited to act by the nerve-centres which supply their fellows.

We may recall the earlier part of this paper, and remark after Osler, that a voluntary motor impulse starting from the brain cortex must pass through at least two neurones before it can reach the muscles, and therefore the motor tract is spoken of as being composed of two segments—an upper and a lower. The elements of the neurones of the lower segments have their place in the different levels of the ventral horns of the spinal cord, and in the motor nuclei of the cerebral nerves. The neurones of the upper motor segment have their cell bodies, protoplasmic processes, in the cortex of the brain near the Rolandic fissure.

Those who wish to prolong the study are referred to the writings of Lewis, Osler, Ashby, Schäfer, without which this sketch would have been impossible.

SOCIETY NEWS.

New Member.

At the meeting in February, Horace Leigh Deck, L.R.C.P. Lond., M.R.C.S.Eng., of the London Homœopathic Hospital, was elected a member of the Society.

New Fellow.

At the meeting in February, William Clowes Pritchard, B.A., M.R.C.S., L.R.C.P., of St. Leonards, Surgeon to the Buchanan Hospital, St. Leonards, elected member in 1898, was elected a Fellow of the Society.

Tributes to the late Dr. Lambert.

At the meeting in February, on the motion for condolence with the widow and family of the late Dr. Lambert, the following tributes to the character of the deceased were expressed.

The President remarked that their late colleague devoted himself to the Materia Medica side of homœopathy more than most practitioners had done, and his work in the Hospital had been most conscientious and successful, in the same manner as his work in his private practice had been.

Dr. Blackley said the Hospital had lost one whom it could very ill spare. Dr. Lambert had been for the last eleven years a power in the Hospital, being a man upon whom all insensibly relied, with the absolute certainty that if his help were invoked for any purpose he was always to be depended upon, and that in the face of an unassuming simplicity of manner and self-forgetfulness. He was, as Mr. Knox Shaw very happily said in some reminiscences printed in the *Monthly Homœopathic Review*, an ideal hospital man. Dr. Lambert had also been a constant attendant at the deliberations of the Society, and what he had to say had always been well thought out. His remarkable memory had been a great help from time to time, and all his colleagues felt that had he lived he was destined before long to become a power in the Society and in homœopathy. They were undoubtedly the poorer for his being so untimely called away.

Mr. Knox Shaw desired to reiterate what he had stated in the pages of the *Homœopathic Review*, namely, that he looked upon Dr. Lambert, through the whole time that he knew him, as an ideal hospital colleague. His loyalty to his colleagues and his devotion to the Hospital were a delight to witness. On the present occasion they ought to speak of Lambert more in reference to his work in connection with the British Homœopathic Society. Having had an official connection with the Society for a great many years, he (Mr. Knox Shaw) was able to say that Dr. Lambert carried out his devotion to homœopathy, to the Hospital, and to the Society, in an equal manner. Whenever a paper was required, Lambert was always ready to give from his large therapeutic experience, an interesting and informing communication to the Society. He was a member of the Council on several occasions, and for the last six years had been the Librarian. Under his care the work of the Library, which was begun by Dr. Neatby so many years ago, had been continued. In the discussions that took place at the Society, Dr. Lambert's remarks were always to the point, and showed very distinctly his earnest belief in the therapeutic views he held.

Dr. Spiers Alexander said he felt that Dr. Blackley had made a remark which conveyed to his own mind one of the leading characteristics of their late friend. Reliability was exemplified in every department of work with which he was associated. In

the out-patient department his work was exceedingly successful, so much so that he had gathered about him a large number of patients who were appreciative of the help he gave them. Those who had had practical experience of his help as an anæsthetist could testify to his reliability in that respect; in many cases both his courage and his presence of mind being seriously put to the test.

Additions to the Library.

The following volumes have been added to the Library:—

"The Test-Proving of Belladonna," by the Ophthalmological Otological Society of America. Howard P. Bellows, M.D., Director of the Proving.—"*Transactions of the Homœopathic and Laryngological Society of the State of New York*," vol. i.

SUMMARY OF PHARMACODYNAMICS AND THERAPEUTICS.

Extracts from Exchange and other Journals.

Ampelopsis Quinquefolia. *Proving.*—A preliminary proving of the Virginia Creeper points to the plant having distinct pathogenetic properties which deserve further investigation. Dr. Emmerson, of Marshall, Mo., took progressively increasing doses of the tincture at intervals of hours. The following symptoms were developed: Soreness round left costal region, sensitive to touch, little soreness in back, uneasiness in back, lips dry, throat dry and a little sore. After sitting, limbs numb, tingling after standing five minutes, then burning of soles, rumbling in abdomen, pulse accelerated six beats, dreams of the dead, sluggish in the morning. These were the second day. On the third day, the doses being continued and increased: Had ravenous appetite for dinner, pulse accelerated eight beats, dull frontal headache, right temple, head stopped up like coryza, light-headed in warm room, restless at night, dull pain in right abdomen, rumbling at times and sharp pains. Fourth day: Belching often, head confused, slept well, did not want to get up, tired, dull headache in the temples after breakfast. Fifth day: Doses 20 drops and upwards, friends note a pallor of the face, stool large and hard, drawing down in left breast and cardiac region, always feels worse about 6 p.m., could not sleep, restless, dull frontal headache, dreams of what happened in day, soreness of knee after pain left. Sixth day: Dull pain in elbow joints, cough dry; fever, blister on lip, frontal headache comes and goes, roof of mouth feels scalded, tongue white with red edges, taste bitter, heaviness in lumbar region, coughs up little tenacious mucus, soreness of all limbs, especially joints, decrease on motion. Seventh day: No more tincture, limbs continue sore, damp day, prover feels as if cold beginning. (P. W. Shedd, M.D., in *Cleveland Medical and Surgical Reporter*, February 1907, p. 72.)

Cactus Grandiflorus.—An interesting paper on cactus discusses the question whether it should be given an official

position in the United States Pharmacopœia, and illustrates very markedly the different points of view from which the orthodox and homœopathic schools regard pharmacology. The arguments summed up would relegate this valuable remedy to an unofficial position on the following grounds, namely, the genuine plant is difficult to procure, only the tender shoots of the flowering time can be used for making a tincture, and they require to be collected in its natural *habitat*. The tincture contains calcium oxalate and tartaric acid as its chief constituents; an alkaloid has not been isolated, therefore it has no active principle. In a series of experiments on the hearts of frogs and dogs, there seemed an increase in amplitude of the heart beats and an indication of increased force, but the physiological action was extremely slight, and may be considered practically *nil*. (*Therapeutic Gazette*, December, 1906, p. 812.) Contrast this point of view with the full directions given for the preparation of the medicine in the homœopathic pharmacopœia, the excellent provings of Dr. Rubini, and the great use the increased force and amplitude of the heart beats become as a symptom, in states of hypertrophy and other conditions in organic disease, and in functional states, when prescribed according to the rule *similia*.—ED.

Gnaphalium polycephalium in Sciatica.—E. A. McAdam, of the N.Y. Homœopathic Medical College and Hospital, reports three cases of sciatica in which gnaphalium proved curative, and attaches importance to "numbness" and "cramps" as characteristics of the pain in preference to the modalities given in Hering's Guiding Symptoms. The actual conditions of the pain noticed in these cases were as follows: (1) X., male, 30, pain decreases sitting in chair, walking at first increases, continued decreases, lying down entire decreases; (2) Mrs. X., Considerable decrease lying in bed, increase first getting up in the morning, some decrease moving about, temporary decrease sitting in chair; (3) Male, aged 60, increase sitting, decrease moving about, entire decrease lying in bed. (*The Chironian*, December, 1906, p. 159.)

Magnesia Phosphorica. *A Proving.*—Dr. B. R. Johnson presented a re-proving of magnesia phosphorica to the International Homœopathic Congress. It had been undertaken for the most part by students at the College of Homœopathic Medicine of the State University of Iowa, in March, 1906. Eight persons in all took part—six men and two women. The proving extended

over four weeks, and the rules of the O. O. and L. Society were adopted, various dilutions being used (30x to 1x). The following are the results in schema form. *Mind:* Indisposition for mental exertion, mental confusion, could not grasp anything, despondent, gloomy, apathetic, restless. *Sensorium:* Vertigo on moving head, on stooping; falls forward on closing eyes, while ascending, decrease while walking in open air, returns when sitting down. *Head:* Sensation as if contents were liquid sloshing around, as if parts of brain were changing places, as of a cap or weight on the head; headache dull, frontal; darting pains from occiput to forehead, intermittent neuralgic pains, mostly left-sided, decrease on pressure and walking in open air throbbing through whole head, head hot, extremities cold. *Eyes:* Eyes tire easily, can only read a few lines, eyes hot and tired, lids heavy, as of weight on them; vision blurred, varied coloured lights before eyes, sharp pains over both eyes, shooting pains from eyeballs backward to the head, eyelids congested, of a salmon-pink colour. *Ears:* Fulness and heat in ears, roaring, impairment of hearing. *Nose:* Stopped up, mucous membrane congested, glairy stringy mucous discharge, thick greenish plugs, blood-streaked mucus, epistaxis bright red. *Mouth:* Dry, with sticky mucus, gathers on teeth like sordes, foul odour from mouth. *Tongue:* Coated brown. *Teeth:* Sensitive to pressure, shooting pains through lower left teeth, increase warm food. *Throat:* Inflamed, salmon-pink colour, viscid mucus, sweetish taste, throat feels dry, as if scraped, pain extending to right ear. *Thirst:* For very cold drinks. *Hunger:* With disgust for food. *Nausea:* With vomiting of stringy mucus. *Abdomen:* Cramping pain in lower abdomen, comes on before and lasts after stool, decrease on pressure, colic in umbilical region, cramp as of a knot, decreasing slowly after stool, sharp pains come and go, lasting several hours; soreness of abdominal walls. *Stool:* Hard, dry, dark, expelled with difficulty, long, thin, ribbon-like stool, blood-streaked mucus, expelled with great difficulty; much flatus of offensive odour, burning fulness, pressure in rectum. *Urine:* Dribbling, splinter-like sensation at close of urination, urine not uniformly or markedly abnormal. *Male Sexual:* Desire, with relaxation of organs, nocturnal emissions. *Female Sexual:* Flow dark, clotted, in long shreds, intermittent; before menses, pain left side of head, nausea and faintness, sharp cutting pains in abdomen extending to back, decrease by heat; with menses, severe cramping pain over whole pelvis, with sharp cutting pains in ovaries and small of back, decrease lying on back. *Larynx:*

Soreness and rawness of larynx, voice hoarse, vocal cords congested. *Chest:* Soreness and rawness under sternum, weight on chest, constriction about chest, especially in warm room, weight of clothing causes sensation of suffocation, respiratory muscles weak, chest collapses during inspiration, shooting pains in lower left-chest, worse on inspiration. *Cough:* Dry, hacking, increase night and morning, sputum sweetish. *Heart:* Action easily excited (? by cough), irregular and tumultuous, pulsating " or throbbing " through entire body, apex beat visible through clothing, increase lying left side and sitting, decrease walking about, constricting pain about heart, increase in warm room, pain from apex shooting upwards, pulse full, bounding, irregular, skips 4 to 5 beats per minute, sphygmographic tracing shows rounded apex. *Back:* Sensitiveness of fourth dorsal vertebra, aching in back as if kidneys were pressed out, severe pain under right shoulder blade. *Extremities:* Weakness in arms and hands, trembling of hands, finger tips stiff and numb, cold hands and feet, shooting pain in left elbow, increase on motion; cramping of outer left hamstring, itching of left heel, aching left sciatic nerve, general muscular weakness, easily exhausted. *Sleep:* Sleepy and drowsy in daytime, restless at night. *Temperature:* Very sensitive to cold air, whole body seemed to chill. Open air relieved vertigo and pains in head, warm food aggravates toothache, warm applications relieve pains in abdomen, warm room aggravates chest symptoms. (*North American Journal of Homœopathy*, February, p. 78.)

Natrum Muriaticum.—In a paper entitled " Introduction to a Study of Natrum Muriaticum," Dr. Fournius, of Philadelphia, brings together the conclusions of physiologists and clinicians relating to the important *rôle* chloride of sodium plays in normal metabolism, also in the production of morbid states, and the effect of dechlorisation upon those states. Dr. Paul Reyner employed with success a solution of chloride of sodium spring water in cold abscesses, adenitis, tubercular arthritis, &c. Baths and irrigations were used locally, and experience of their benefit corroborated by other observers. Sea water, diluted, injected under the skin, favours the organic functions better than chloride of sodium solution. In children showing signs of hypothermia, feeble respiration, suction, and deglutition, and marked torpor, and in two cases green diarrhœa, all exhibited a rapid renewal of vitality and increase of weight from such injections. The first investigation of chloride of sodium retention and elimination was

Widal, of Paris. He undertook a series of researches with other observers. Suppression of alimentary salt has been found valuable in Bright's disease, cardiopathic conditions, ascites, phlebitis, and exudative dermatitis. The sole ingestion of sodium chloride makes the œdema reappear, and meats and albuminoids give the same results as milk if NaCl is entirely excluded. Care is of course needed in testing the urine for chloride retention and hydration, as there is such a state as chloride equilibrium, and this has to be ascertained. Chloride retention probably plays an important *rôle* in the pathogenesis of Bright's disease. Allied to the foregoing conclusions is the effect of dechlorisation of diet in epilepsy, and the reputed greater effect of bromides when salt is eliminated from the diet. Dr. Sauer, of Breslau (homœopathist), adduces the following conclusions: (1) Absolute abstinence from salt in the healthy individual produces albuminuria; (2) excess of salt in the food brings about the same results; (3) the total suppression of salt in a nephritic patient notably lowers the quantity of albumin in the urine.

The above researches allow the inference that chloride of sodium, when absorbed in excess of the normal requirements, causes many digestive, cardio-vascular and respiratory phenomena, indicative of destructive metabolism and great impairment of blood life. And it is just in these states that natrum muriaticum in the potentised form is of use as a remedy.—(*Hahnemannian Monthly*, February, p. 116.)

Radium Therapy up to Date.—Dr. W. Dieffenbach has contributed a paper on the subject of radium therapy to the National Society of Physical Therapeutics. The following is a summary of his chief conclusions. The higher the activity the more potent the action on the tissues. Through the efforts of Mr. Leider, of New York, in mixing radium with gelatine, a better absorption has been obtained than formerly. An activity of 25,000 shows superior electroscopic strength to the so-called one-millionth activity. In a case of adenocarcinoma of the uterus, the author suggested the introduction of radium-gelatine saturated in gauze into the cavity. After six months no symptoms of disease were discoverable. A practical test of the action of radium on cancer was made by Dr. Robert Abbé in the case of a patient suffering from scirrhous mammæ. The tube containing the radium was introduced through an incision into the diseased tissue and left *in situ* for two days. It was then inserted in two other places for a like period. Amputation was then resorted to, and a pathologist's

report on the part treated by radium showed that the cancer cells had lost their nuclei, and vacuoles were left. In others evidences of scar tissue were visible. Normal cells seemed to be but slightly affected by the rays. The following are the classes of lesion and results where radium appears indicated: *Warts and moles*: The gelatine painted over warts and moles causes them to shrink, and after repeated application to disappear, leaving a smooth skin. *Urethral caruncle:* In two cases disappearance was obtained by inserting the tube into the urethra for an exposure of eighteen hours, in divided doses. *Lupus vulgaris:* In small lesions Dr. Dieffenbach reports no failures. In larger lesions, where much hypertrophy, results were negative. *Epithelioma:* Useful in preference to Röntgen rays in small lesions about the mucous membrane. *Psoriasis:* Small patches have yielded to radium plaques. *Eczema:* In chronic cases itching relieved and localised lesions cured. *Sarcoma and Carcinoma:* Results must be reported with reserve until two years or more have elapsed. In the meantime, cases have been symptomatically cured, some have become quiescent, and some show shrinkage of growth. *Trachoma:* Radium rods have been tried with success by Dr. McLeary and Professor Norton. In conclusion, great importance attaches to proper technique.—(*North American Journal of Homœopathy*, December, 1906, p. 766.)

Tabacum.—In an article on tobacco, Dr. Charles Mohr sums up as follows the morbid states in which the drug is likely to prove useful, following Hahnemann and Hurtlaub and Trinks. Neuralgic headache, periodically attended by much sick stomach and sudden pains, as if the head were struck by a hammer. Insomnia with dilated heart, with cold clammy sweat and anxiety. Angina pectoris when pain is down the left arm. Nausea, morning vomiting of pregnancy, especially with much spitting. In gastralgia and enteralgia. In sea-sickness. In cholera infantum, when child is very cold and yet wants abdomen uncovered. Stools watery, sweat on forehead and face. Minor epilepsy without aura. Renal colic on left side, spasms, great sweat, and collapse.—(*North American Journal of Homœopathy*, February, 1907, p. 77.)

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NEW, OLD, AND FORGOTTEN REMEDIES.[1]

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Part II.

This paper is a continuation of my subject of New, Old, and Forgotten Remedies, the first part of which was presented but not read to the Society on April 19, 1906, but was read subsequently at a meeting of the Liverpool Branch, and is printed in the Journal issued in July of that year.

I now proceed to the consideration of six other drugs of varying value in practice, commencing with

VII.—Lactic Acid.

Lactic, or isolactic acid, $HC_3H_5O_3$, is a colourless, syrupy liquid of specific gravity 1210, with an intensely sour taste and acid reaction. It is readily soluble in water, alcohol, and ether. It is produced by the action of the lactic bacillus formed in the souring of milk fermenting the sugar of milk;

[1] Presented to the Section of Materia Medica and Therapeutics, March 7, 1907.

or it may be made with cane sugar in the presence of sour milk, decaying cheese, and chalk. In the latter process lactic acid is set free by the action of sulphuric acid upon the calcium lactate obtained.

The interest of this drug to homœopaths consists :—

(*a*) In the wonderful similarity to rheumatic fever of the provings in four persons recorded by Dr. Foster in 1874. See Sympts. 224, 235-50, 300-309 in Allen.

(*b*) In the lactic acid theories of the origin of acute rheumatism, propounded by the eminent authorities Prout, Latham, and Richardson, the last of whom, by injections of this acid, produced acute rheumatism artificially.

(*c*) By numerous cures of acute arthritic rheumatism recorded in our literature.

(*d*) By the exact analogy of its effects on some provers to the gastro-hepatic form of diabetes mellitus.

I quote the following cases of rheumatism affecting the joints, from a paper by Dr. Tyfel-Ascherslaben in the *Allgemeine Hom. Zeitung* of March 13, 1890 :—

Case 1.—A girl, aged 15, affected with acute arthritic rheumatism, had the pain removed in two weeks by acid lacticum 2x.

Case 2.—B., a miner, had been afflicted with acute arthritic rheumatism for more than six weeks. The first dose of lactic acid 2x gave relief, and the second dose cured him.

Case 3.—In a patient whose joints were swollen and very painful, one dose of lactic acid 2x sufficed to overcome the pain and swelling.

Case 4.—A patient who had suffered for four weeks from acute rheumatism of the joints, accompanied by copious sweats, was entirely cured within two weeks by lactic acid 2.

Case 5.—A case of chronic arthritis, with inflammation and swelling of the epiphyses of the metacarpal bones and consequent partial displacement of the fingers, was so much benefited by lactic acid 2 that in two months both the pain and the anchylosis had disappeared.

Case 6.—In a form of diabetes, characterised by much acidity of the stomach, accompanied by sour eructations and burning in the œsophagus (Sympts. 117, 118, 129), Dr. Laming, of the Hahnemann Medical College, Chicago, found lactic acid very useful. Moreover, Sympts. 52, 56, 57, of the Eyes in Allen,

were verified by Dr. Laming: "An intermittent marked protrusion of the eyeballs, and dilatation of the pupils."

Lactic acid produces a great flow of urine by day and night, sometimes pale, sometimes straw-coloured, sometimes high-coloured, but clear, &c., &c. See Sympts. 177 to 183 in Allen.

A patient suffering under this type of diabetes has a tongue dry and sticky, with intense thirst, worse at night. He craves for food and digests it apparently well, but a reaction state follows, when the food creates distress, nausea, retching, pyrosis. The bowels are constipated, the stools dry, hard, and dark; the body is chilly, with cold legs and feet; the urine voided in the afternoon and evening is richer in sugar than that passed in the morning.

Lactic acid should also be thought of in treating some forms of acid dyspepsia and gastric irritation, notably that kind in which there are eructations of hot acrid fluid, or of burning hot gas from the stomach to the throat, causing a profuse secretion of *tenacious mucus which must be constantly hawked* up, both symptoms *aggravated by smoking*, viz., Sympts. 129 and 130 in Allen. It seems to me that these are characteristic of lactic acid. The chemical, vital, or microbial theories of the causation of rheumatism it is not my province to discuss in this paper, but it may be remarked that if we grant that lactic acid generates the subjective and objective phenomena of some forms of acute rheumatism, and find that it cures similar cases, it must act rather as an *isopathic* than as a homœopathic remedy.

In the type of diabetes mellitus above described, I should give phosphoric acid; but if this failed to relieve, would certainly try lactic acid, or lactate of soda.

I should be pleased to hear from members what clinical experience they have had in the use of lactic acid in rheumatism, dyspepsia, and diabetes mellitus or insipidus.

VIII.—Lemna Minor.

Lemna minor or the common duckweed, of the natural order *Lemnaceæ*, is the lowest form of phanerogamous vegetation. It forms the green scum found on stagnant ponds,

which consists of lenticular floating fronds, composed of leaf and stem together, bearing the flowers in slits in the edge of the minute leaf.

The fresh plant is pounded into a pulp, and macerated in two parts by weight of alcohol.

This plant, as yet unproved by Hahnemann's method, is certainly beneficial in nasal disease. We owe its introduction into homœopathic medicine to our late colleague, Dr. R. S. Cooper. Our friend had a wonderful instinct for the special effects on particular organs or tissues of plants, tinctures of which he prepared after a fashion of his own, which he asserted preserved their "arborivital" powers. Although we smile at his crude idea of founding a system of therapeutics, superior to homœopathy, on arborivitalism, yet we should be grateful to him for enlarging our materia medica by such remedies as lemna, agraphis, and arbutus, and for teaching the value of the "unit dose."

I suppose that few homœopathic practitioners would deny that strictly *medicinal* treatment of nasal polypi is unsatisfactory, although we have several cases of cure recorded in our literature. I believe that calcarea carbonica, teucrium, mercurius protiodatus, thuja, kali bichromicum, sum up our actually effective remedies in this disease, though we have many efficacious in nasal catarrh. Now we have the recorded testimony of Drs. Cooper, Burnett and Clarke, that this little plant, lemna minor, exercises a powerful influence upon the Schneiderian mucous membrane when modified by disease or by morbid growths.

Twelve cases of cure or great relief in diseases of the nose had been recorded up to 1895 by Cooper, Clarke and Burnett, and it is with a view of inciting my colleagues to use this drug more commonly that I bring it before them on this occasion.

I select the following cases as most illustrative of the action of lemna minor.

Case 1.—A boy, aged 14, whose nose was broadened and completely blocked up for two years before coming to Dr. Cooper, November 26, 1892, never remembered possessing the power of smell. The nostrils had been cleared of polypi by operation one year before, at St. Bartholomew's Hospital, but when he

consulted Dr. Cooper, they had grown up again and were plainly visible. From November 15, 1892, to March 4, 1893, four doses of lemna ϕA were given without much change. Then up to April 8 he had calcara carb. 200; this was followed by mercurius sol. 3x for face-ache. Lemna was then resumed, one dose every fourteen days, with pronounced relief. By March 14, 1894, his nose was clear, with none but very small polypi visible; he could breathe freely; and his olfactory sense had completely returned.

Case 2.—A married lady, aged 26, suffered from catarrhal pharyngitis, due to post-nasal ulceration high up; a constant dryness of the throat; the right nostril blocked, but without any visible polypus; the heart was easily disturbed, flatulence and colicky pains in the abdomen came on towards evening. Every morning she awakes with her throat dry, and the tongue coated. She is subject to diarrhœa, colic, and sickness at the menstrual period. On November 12, 1892, Dr. Cooper gave a unit dose of lemna ϕA, with relief to all symptoms except that diarrhœa set in three days afterwards. As this symptom, diarrhœa, has been noticed in other patients, Dr. Cooper considers it pathogenetic of lemna. A second dose having been given on December 9, 1892, on the 23rd the lady came and reported herself much better in all respects. Nose not perfectly clear, but there was no unpleasant taste or smell; throat not dry, as before; mouth clear and taste pure in the morning; tongue cleaner; indigestion and diarrhœa ceased; heart tranquil.

Case 3. — Captain B., aged 44, consulted Dr. Clarke on February 28, 1894, for violent neuralgia, with local tenderness on the right side of the neck.

He has had cold and cough for a month with great amounts of yellow coryza. I gave him bell. 12 for the neuralgia, to be followed by lemna 3x thrice daily. On March 9 he reported that the bell. speedily took away the neuralgia, and that then the lemna cleared off the catarrh in the most astonishing fashion.

Case 4 (Burnett).—A gentleman, aged 60, with nasal polypus of many years' duration, yet only of moderate size, was much troubled by the chronic nasal obstruction, which was much worse in wet weather. Lemna 3x, ℿv. *mane, et nocte* for one month benefited him so much that he told Dr. Burnett at his next visit "I have never taken any medicine that has done me so much good. I feel quite comfortable in my nose, and can breathe through it quite well."

Case 5 (Burnett).—A lady, aged 45, whom I had formerly cured of a uterine tumour, was troubled with nasal polypi, which hung

out of the nostrils and kept her confined to her house. Often had she been operated upon, but they always grew again. Dr. Burnett had temporarily improved them by treatment, but the first rainy weather that came brought them back. Lemna 3x, five drops morning and night, was now ordered, "with the result that the polypi very greatly diminished in size, and the patient could again take her place in society."

Dr. Burnett adds to these two cases the remark: "Clearly the lemna does not either kill, cure, or otherwise get rid of, the polypi, but it rids them of much of their succulence and thus reduces their volume; it also diminishes the bad influence of wet weather to which such patients are so prone."

Case 6 (Cooper). — A woman, aged 26, had crusts continually forming in the right nostril, and pain like a string extended from this nostril to the right ear, which was deaf. All these symptoms were greatly relieved by lemna.

Case 7 (Cooper).—A lady, aged 58, suffering from pains flitting about her head and legs, with pains in her eyes during heavy rain; drowsiness by day and restless sleep at night; had all these symptoms removed by a single dose of lemna; and the pallid, dullish, sickly look in her face changed to a complexion that was natural and healthy.

Dr. T. L. Shearer, homœopathic aurist in the United States, suggests the use of lemna in cases of atrophic rhinitis, where the crusts and muco-purulent discharge are abundant and fœtid.

To sum up: the indications for lemna *ex usu in morbis* thus far seem to be: A putrid smell in the nose, or anosmia; a putrid taste with general foulness of the mouth, especially on rising in the morning; discharge from the nostrils of crusts or of mucopus, or both; nasal polypi; swollen turbinates; pain like a string from nostril to ear, all symptoms being aggravated in wet weather.

Dr. Cooper tabulates the modalities of four leading coryza remedies, thus: Lemna, worse in heavy rains; calendula, when heavy clouds are about; rhododendron, in thunderstorms; dulcamara, in foggy weather and damp surroundings.

Inviting the attention of our aurists and nasal specialists to lemna minor, I now pass on to

IX.—Lathyrus Sativus.

This poisonous plant, the vetchling, wild vetch, chick-pea, or everlasting pea, belongs to the sub-order *Viciæ*, of the natural order *Leguminosæ*. A poison resides in the seeds of *L. sativus*, *cicera*, and *clymenum*, which has not yet been isolated satisfactorily, though Mons. L. Astier obtained from *L. cicera* a gluey volatile substance with a strong taste and weak alkaline reaction, insoluble in water, soluble in chloroform. The toxine is certainly not rendered inactive by drying, baking or boiling the flour made by grinding up the seeds. When this lathyrus bean-flour is substituted for ordinary flour, or is mixed with the latter, a definite series of paralytic effects followed, called "Lathyrism," which affects persons aged from 17 to 35, males more often than females. A district in India suffered a failure of wheat crops from 1829 to 1831. For three years subsequently the natives subsisted upon lathyrus bean-flour. In 1833 the young men and women began to lose the use of their legs, the palsy coming on suddenly, painlessly, and often during sleep.

From 1859 to 1885 "Lathyrism," as it came to be termed, was observed in Allahabad, India, by Irving; at Rome and in other parts of Italy by Cantani, Brunelli, and Georgieri; by Proust, in Algeria; by Professor Koshevnikoff, in Saratof, Russia, in 1891; and in horses by veterinary surgeons in Glasgow and elsewhere. Condensing the pathogeneses admirably set forth in the "Cyclopœdia of Drug Pathogenesy," vol. iii., p. 115 f.f., I may thus describe the leading symptoms of this disease, the intensity of which varied according to the proportion of lathyrus flour mixed with the wheat or maize flour, and the length of time it was used as food. Lathyrism was most frequent in marshy districts. Males of ages between 17 and 35 were more often attacked than females.

(1) Sudden loss of power in the legs, from the waist down, usually coming on at the first rainy weather after a course of lathyrus flour, and always aggravated by damp.

(2) Stiffness and lameness of the ankles and knees.

(3) Excessive rigidity of the legs, flexion being difficult; and

(4) The adductor muscles of the thighs being contracted, the legs could neither be crossed nor extended.

(5) The gait is tremulous, tottering; walking is difficult, often impossible.

(6) The gait of a sufferer from lathyrus palsy is thus graphically described by Professor Koshevnikoff: "He walks leaning on two sticks, with the upper part of his body bent forwards, while he waddles from side to side like a duck; the front part of the sole never leaves the ground, while the heel never touches it; the knees are bent, and never move while the patient is walking." Most sufferers were obliged to keep looking at the ground to guide their feet, but closing the eyes made no difference in this respect (unlike locomotor ataxy).

(7) In trying to walk, the legs of some patients become interlocked.

(8) The tendon-reflexes were always exaggerated.

(9) The tactile, thermic, dolorific, and electrical sensibility was perfect.

(10) Emaciation of the glutei, but not of the leg-muscles, was observed in advanced cases.

(11) The sphincters were unaffected.

(12) In a few instances the arms and hands were tremulous.

(13) When lying on his back a man cannot rise without help.

(14) The mind and special senses always remained normal.

Guided by our rule of similia, we have no difficulty in recognising the exact homœopathicity of lathyrus to cases of spastic paraplegia, or primary lateral sclerosis; and its lesser suitability to infantile spinal paralysis, acute transverse myelitis with degeneration of the cord, and to locomotor ataxia.

In searching our clinical records of cases treated by lathyrus I find ten cases reported as cured or much improved by lathyrus sativus. In 1896 Dr. Léon Brasol, of St. Petersburg, sent a clever study of lathyrism to this Society's journal; and his colleague, Dr. Bojanus, of Samara, Russia, in June, 1897, contributed the most complete paper on the

subject within the scope of my researches. Of the ten paralytic cases treated by lathyrus, I select the following five, all different in kind, as illustrative of the efficacy of this little-known drug.

Case 1.—Reported by Dr. Edward Blake, in *Monthly Homœopathic Review* for May, 1888. Dr. Blake calls the case "Reflex Cutaneous Leg-palsy." November 7, 1867. Henry G., aged 52, has been unable to walk for six years. In 1861, after working in the wet, he had "pains all over," followed by "a stroke"; he lost consciousness for two hours, and the attack left him with trembling of the limbs. . . . He is prone to a pain over his right eye, is stiff in the loins, and feels worse before rain. Three months of ignatia 3 improved him in general health, and by January 30, 1868, he could hobble about, but was still very lame.

He now took lathyrus 3x trit. for two weeks, then lathyrus 1c., without marked benefit. Then I ordered lathyrus 3 cent. trit. for four months. At the end of that time the record was: June 25: Can certainly walk better. ℞ Lathyrus 1x trit. July 16, 1868: Is cured so far that he can walk four miles. Dismissed.

Case 2 (Dr. Clarke).—Dora S., aged 3, was admitted to the London Homœopathic Hospital, September 3, 1884, suffering from paralysis of all the limbs, the lower more severely affected than the upper. All the joints were supple and lax; the foot could be laid back on the legs, and the hand laid back on the fore-arm. Though not absolutely powerless, the legs were thrown about in every direction when the child was held up to walk, as if there was no power of co-ordination. The reflexes were all exaggerated—knee, elbow, ankle, and wrist; when laid prostrate, the muscles of the spine were seen to contract and move the trunk when the finger was run along the spine. On September 18 lathyrus sat. 3, ♏ i, every two hours was given. Rapid improvement set in, so that on October 3 she could almost stand with help. She continued improving, lathyrus being the only medicine taken, until she left the hospital on October 22, able to walk quite well.

Case 3 (Dr. Clarke).—Rheumatic paraplegia in a man, aged 58, a boat builder, of Sheerness. "September 10, 1884, he consulted me. He complained chiefly of his knees and hips, which are stiff, weak, and have a soreness in them. Walking is very difficult, and going up or down steps he finds almost impossible. He is so stiff that for two or three minutes he cannot take a step.

The stiffness is worse after sleeping; if he sleeps for only fifteen minutes his knees become exceedingly stiff. Sometimes he cannot lie on left hip from soreness. . . . The muscles of the limbs were well developed and nourished; there was no obvious affection of the joints.

"I gave lathyrus sat. 3 four times a day. He came back in a month and reported that there had been no improvement until the last three days, during which he had more strength, and could step up and down with more ease and comfort. In another month the improvement was more marked and the legs both much stronger and freer in motion.

"December 10: He can now walk a good distance without discomfort, and can go upstairs easily; though it is still difficult to go downstairs. I gave him a supply of lathyrus, and have not seen him since."

Case 4.—Reported by Dr. W. A. Dewey, professor in the University of Michigan, Ann. Arbour, United States, in the *Medical Century* for January, 1900. "A man, aged 28, deformed by antero-posterior spinal curvature, came into the Homœopathic Hospital of the University on December 1, 1898. Six months previously his legs became heavy, causing difficulty in walking, so that he had to use a cane, then crutches, and in about three weeks he completely lost the power of locomotion. After four months' fruitless allopathic treatment he came to us. On his admission he was absolutely unable to move voluntarily any part of the legs, not even a toe. The adductor muscles were in a state of irritable contraction, so that the thighs were constantly crossed. All the reflexes were exaggerated: the patellar reflex was excessively pronounced; the ankle clonus was the most marked that I had ever seen; and a mere touch on the soles of the feet caused violent spasms of the toes. He had no pain, nor was the spine tender. His general health, including his sleep, was normal; but he complained of a girdle sensation as of 'a cold wet cloth round his waist.' The diagnosis of spastic paraplegia was made, and lathyrus sat. 3x, followed by 6x, was given with manifest improvement after three weeks. By April 5 he could voluntarily raise his legs and move his toes. Shortly after this he could stand alone, and the use of his limbs gradually returned, so that upon his discharge, July 2, 1899, seven months after his admission, he was able to walk out of the hospital, and no contracture or special irritability of the muscles remained. Lathyrus alone was given from first to last, the only other remedial agent employed was a mild galvanic current for a short time, which rather aggravated

the trouble, as has been my experience *where the reflexes are exaggerated.*" From this well-described case of cure we can all learn something—the chief feature being the exact correspondence of lathyrus to spastic paraplegia even in a patient having a spinal curvature.

Case 5.—In the case of a clerk who suffered from loss of power in the legs, his walking being difficult and unsteady, with exaggerated reflexes, Dr. T. Simpson gave lathyrus 3x with most satisfactory results. Eventually the patient could walk a mile without assistance. This was probably a case of transverse myelitis.

Out of the five other lathyrus cases reported in our journals, all except one were greatly improved.

X.—Œnanthe Crocata.

Œnanthe crocata, the "water-dropwort-hemlock, of the natural order *Umbelliferæ*, is next on my list. As its leaves resemble those of celery, and its roots are like parsnips, children are often poisoned by eating it by mistake. Its effect is quickly fatal. Out of eight lads who ate the tuberous roots, gathered in a meadow, five died in a few hours, without having spoken a word. An English country name for it is "dead-tongue," from this latter symptom. Out of 124 persons poisoned since 1556, fifty-five died. Horses and oxen eat the leaves with impunity, but are convulsed or paralysed by the roots. The milky juice of both root and stem becomes yellow when exposed to the air (compare Euphorbium) and yields an acrid emetic alkaloid. The Swedes call œnanthe "horse-bane," from the frequency with which grazing horses are poisoned by it. In Ireland the roots are crushed to make poultices for boils and inflamed glands, often with toxic results. Our tincture is made from the fresh root. The 349 symptoms recorded by Allen may be thus summarised: Head—vertigo, delirium as if drunk, or stupefaction. Cerebro-spinal system: epileptiform convulsions always severe, at first tonic, then clonic, with pale or livid swollen face; frothing at the mouth; eyeballs turned upwards; pupils dilated or irregular; locked jaws; rapid twitchings of facial muscles; coldness of ex-

tremities; weak pulse; the attack ending in coma or fatal syncope; often speech is paralysed. In non-fatal cases great heat in throat and stomach; desire to vomit; distressing hiccough; cardialgia; desire for stool; pain, tenderness, and swelling of abdomen. Red patches, like ecchymoses, on face, chest and arms. A number of patients who recovered, lost their hair and nails.

In the *Homœopathic World* for June, 1900, two very typical cases of œnanthe poisoning, one proving fatal, are accurately narrated; they are worthy of study. The analogy to epilepsy is so very evident, that this drug has often been used with success in that disease. I find thirty-three cases recorded as cured or greatly relieved by œnanthe, given in the tincture and the dilutions up to 3x. Among others, Professor Dewey, of Ann.-Arbour, United States, has used this remedy very frequently, and with much success, in epilepsy. He recommends the dilutions from 3 to 12 as best in ordinary cases, but the higher potencies in chronic cases.

In searching out cases for this paper, I am again (as in Part I.) compelled to complain of the carelessness of some of our colleagues in the United States, in omitting details of dose, frequency, and the dilution used.

One important feature of œnanthe as a remedy is this: Violent headache is caused by too strong doses. If a case of epilepsy presenting œnanthe-like features came before me fresh from allopathic treatment by the bromides, I should begin with a dose of sulph. 30; wait a few days, then commence with œnanthe 1x for a week, going further up the scale to the third centesimal, as symptoms and the progress made indicated.

Dr. Selden H. Talcott, in his unique position as Director of the Middletown Asylum—the largest in the world wherein the homœopathic system is exclusively employed—reports in 1893[1] that œnanthe (from 1 to 6 drops per day of ϕ) has the following beneficial effects:—

(1) The fits decrease in number by 40 to 50 per cent.

(2) The mental state improves; the epileptic lunatic is

[1] Quoted from Dr. Talcott's report by Dr. R. Hughes in the JOURNAL OF THE BRITISH HOMŒOPATHIC SOCIETY, July, 1893.

less suspicious, less fault-finding, less irritable, and is more easily cared for.

(3) The convulsions are less severe.

(4) There is less maniacal excitement before, and less stupor apathy and sleepiness after the fits.

(5) The debilitating effects of the seizure are more quickly got over.

I have selected the following cases, illustrative of different types of this disease, which I consider to be a minor form of insanity.

Case 1.—Dr. J. S. Cooper, of Chillicothe, Ohio, reports in the *Homœopathic Envoy* a cure of epilepsy of twenty-five years' duration with œnanthe crocata 4x, five drops for a dose, every four hours. No further particulars given.

Case 2.—Dr. F. H. Fisk, in the *Chicago Medical Times*, 1892, details a remarkable case, that of Miss H. E. G., which I give here in a condensed form. Miss G., aged 16, of sanguine temperament, robust, well grown, but dyspeptic, had shown signs of *petit mal* at the age of 8. At 12 years of age menstruation began, without any relief to the fits. At 14, the *grand mal* came on so frequently that in twenty-four hours she had six to ten fits, unless she took large doses of bromide of potassium, 60 to 100 grs. per day. After two years of allopathy, her friends tried homœopathy. Œnanthe ϕ was prescribed ♏v. in ʒvi., one teaspoonful every three hours, until headache was complained of; then every four or six hours as required. From that time there was no return of the convulsions.

After three months the medicine was stopped: mental excitement brought on a fit, and œnanthe was resumed for three months longer, during which period no convulsion occurred, and even the brief "absent-minded turns" of the *petit mal* had disappeared. Miss G., now gay, cheerful, and active in mind, entered society. But, as excess of excitement or mental fatigue still brought on an attack, the same medicine was continued for two years, gradually reducing the dose. Then it was stopped, and for more than a year, up to the time of report, there has been no return of the attacks, nor are there any sequelæ. Dr. Fisk adds that five other cases have been cured by œnanthe.

Case 3.—Dr. von Rappaz, of Brazil, reports the case of a girl, aged 10, who had suffered from epilepsy for three years, the fits increasing in frequency, despite the best allopathic treatment. On

April 18, 1894, she received œnanthe 6 cent. There were no attacks until May 12, when a slight fit occurred. Continue œnanthe 6. On June 3 she had a mild seizure of vertigo, without losing consciousness. Œnanthe 12 was then given, and no further fits appeared. She entirely regained her health.

Case 4.—Dr. Garrison, of Easton, Pennsylvania, described in 1896 (*Southern Journal of Homœopathy*), a case of hystero-epilepsy in a married lady, where the convulsions began during her pregnancy. Œnanthe 2x cured the fits in a short time.

Case 5.—Dr. Dewey treated a chronic epileptic, a man, aged 30, who had the *grand mal*, the *petit mal*, and the epileptic vertigo, with œnanthe (dil. not stated). This remedy removed both the *grand mal* and the *petit mal*, leaving only the vertigo, and that in a mild degree. It also greatly improved the mental condition of the patient.

Case 6.—Dr. W. B. Carpenter, Columbia, Ohio, reports the case of F. M., aged 29, a mechanic, with no family or constitutional tendency to fits. In 1894 he was accidentally struck on the lower part of the os frontalis, just above the nose, with a sledge hammer. In October, 1896, his first epileptic convulsion occurred during sleep. These fits increased in severity, and after two years, occurred by day as well as by night. A distinct "aura" preceded the fits, "a ringing sound of bells," then "a buzzing as of bees," increasing in force till he fell unconscious, the coma lasting from ten minutes to an hour. The bromides relieved the patient for seven months, but after that period the fits returned. Œnanthe 4x and 6x arrested the seizures for several months. It has energised the body and brightened the mind. We are warranted in expecting a continuation of the improvement.

A comparison between œnanthe and cicuta may be of use in selecting a remedy for epilepsy.

Œnanthe crocata.	*Cicuta virosa.*
As a rule, no aura, sudden and complete unconsciousness, without a cry, sometimes speechless until coma or death. Swollen livid face, with twitching of facial muscles; eyes turn upwards; pupils at first dilated, afterwards contracted; locked jaws; cold feet and hands; loss of reflex excitability. Red spots or patches on the skin.	Usually an aura: a shriek or cry is uttered; then violent convulsions of body and legs. Opisthotonos always, violent cramps of neck and scapular muscles, pupils dilated, eyes set in a fixed stare. Delirium, singing, dancing. Reflexes exaggerated. Pustular eruptions on skin.

Just now it is worth noting that a study of cicuta virosa shows its homœopathicity to *epidemic cerebro-spinal meningitis*, with which some of our towns are being plagued, the mortality being about 60 to 65 per cent. As a remedy for epilepsy, œnanthe should be compared with cicuta, kali bromatum, hydrocyanic acid, and belladonna. It is also homœopathic to puerperal eclampsia, to hydrophobia, and to uræmic convulsions.

XI.—Passiflora Incarnata.

Passiflora incarnata is the passion flower, giving its name to the natural order *Passifloraceæ*.

This is a tropical plant, the fruit of which is edible, and known as a "granadilla." In Britain passifloræ are hothouse plants, except the *cærulea*, which grows in the open air in the South of England.

The tincture is made either (*a*) from the expressed juice of the fresh leaves, or (*b*) from the fresh leaves and flowers gathered in May.

Passiflora incarnata is as yet unproved; but from the time (1887) Dr. Lindsay, of Louisiana, U.S., where the plant grows wild, gave his experience of it to Dr. E. M. Hale for his "New Remedies," down to the present year, 1907, there has grown up a mass of evidence of its therapeutic value which justifies me in bringing it to the notice of this Society.

In the first place, I commend this plant to the notice of the Research Department of the British Homœopathic Association for a thorough systematic proving. In the second place, whereas some of our members when hard pressed to give sleep to their patients allow them to take the veronal, sulphonal or chloral-hydrate of the unenlightened system, I here bring forward a safe and effective vegetable hypnotic, which neither weakens the heart nor produces skin eruptions, nor, in fact, any after-effects, so far as present experience of it teaches. My audience will agree with me that sleeplessness and imperfect sleep are the curses of our time, and that we homœopaths are constantly reproached by patients with the lack of something to send

them to sleep. As a sleep-producer, passiflora has to be given in material doses, of from 10 to 60 drops, but it does not lose its effect by repetition, nor does the exact dose found to suit each individual patient best need to be increased. Its use at night does not seem to impair or alter the effect of the indicated homœopathic remedy used during the day—this being a great advantage.

The only pathological symptom noticed as the pure effect of passiflora, occasionally, is "darker colour of the urine."

The limitation of its action, laid down by Dr. A. J. Harvey, namely, that "where the inability to sleep is due to bodily pain passiflora does not act," is contradicted, as I shall show by the experience of other observers. Nor do I admit, in view of its excellent effect in delirium tremens and its terrible prodroma of sleepless nights, that assertion of Professor Scudder that "the one great indication for passiflora in all cases is a clean tongue; when the tongue is foul, the remedy will do no good."

A writer in the *American Physician* in 1905 states that this drug "produces a sound, refreshing sleep, from which the patient may be awakened at any time; but, if allowed, he will fall asleep again."

Seventeen cases cured by passiflora are recorded in our journals, between 1888 and 1905, of the following morbid conditions: Insomnia from alcoholism, the morphine habit, valvular heart disease, nervous erethism, and extreme exhaustion; chorea (Troy, of Delaware, U.S.); tetanus, both traumatic and idiopathic, in man and in horses (Drs. L. and J. H. Phares, Newtonia, U.S.); convulsions in children and in adults (Walters, Brooklyn); irregular and rapid breathing due to medullary irritation. Various neuralgias and headaches; Dysmenorrhœa, enlarged prostate, gleet and gonorrhœa in females, nervous cough; angina pectoris (Adolphus); sciatica (C. N. Ray, Calcutta); erysipelas (Troy, Phares, U.S.); spinal meningitis (Ed. *Cal. Med. Journal*); neurasthenic spinal hyperæsthesia, and coccygodynia, with pain in rectum (Adolphus); delirium tremens (D. C. B. Dunlevy, Walters, U.S.). The following six cases are of special interest, but I will read only three of them, in a condensed form:—

Case 1.—Erysipelas of the face and scalp, reported by Dr. W. D. Troy, of Delaware. A man, aged 50, was in bed with high fever, erysipelas of the flaming, rampant sort, developed all over forehead and eyelids, sharp stinging pains in the inflamed skin; he could not rest, and was in great anxiety. Instead of apis, I gave him passiflora ϕ, ♏ii., every two hours, with a lotion of the tincture applied warm with flannel and oiled silk. After three doses the patient fell asleep; next morning the erysipelas was much reduced. I now changed the remedy to hamamelis, but at my next visit found the patient worse, the erysipelas having spread over the scalp and covered the remaining part of the face. I returned to passiflora and kept to it with the most happy results.

Case 2.—A girl, aged 14, had suffered from chorea for three years, the right side alone being affected. Menstruation had not yet occurred. Allopathic treatment had failed. Passiflora 1x, ♏x., every three hours reduced the choreic twitches, and in a few days, when the dose was increased by ♏x. of the ϕ, the catamenia came on slightly. After the next menstrual period, the chorea disappeared (Troy).

Case 3.—In April, 1888, I was called in to an infant, aged 14 months, suffering from convulsions caused by dentition. Bell. 1x was given every fifteen minutes, and the fits ceased in one hour. The next day the child appeared to be perfectly well, the bell. now being given only twice a day. But thirty-six hours afterwards the convulsions returned. I now gave passiflora ϕ (five drops every fifteen minutes), with the result that it never had another spasm from that day to this, June, 1890. The infant slept soundly all that night, and awoke next morning in its usual health.

Since then I have prescribed passiflora in material doses (5 to 10 drops) for the sleeplessness of the teething period without a failure. I give it only at bedtime, never during the day. For the insomnia of adults, from whatsoever cause, I give 60 drops at bedtime, repeated in half an hour if the patient is not asleep.

Case 4 (J. Adolphus, U.S.).—A lady had for several months suffered intensely from pains in head, neck, and spine, described "as if a very heavy weight was lying on her brain; fearful pressure and tearing inside her skull; head felt as if enveloped in ice; the pains ran down the neck and along the spine to the sacrum, where the slightest touch of the coccyx caused agony.

All other remedies tried failed to relieve the pains for more than a few hours, when I gave passiflora in teaspoonful doses every two hours. That same night she slept well, awaking in the morning much refreshed and nearly free from pain. Continuing passiflora for several days more, a rapid and complete recovery resulted.

Case 5 (J. Adolphus).—A man consulted me for breast-pang, a constant pain in his heart, causing a sense of immediate dissolution and fear of death. Heart-sounds were normal, but sharp and accentuated; pulse intermittent occasionally, but always irregular in rhythm, now rapid, now slower. Passiflora (dose and frequency not stated) cured him.

Case 6 (Dr. C. Buell Dunlevy, of Port Chester, U.S.).—Mr. D., aged 52, sent for me in May, 1890. Intense sufferings from chronic hæmorrhoids had induced him to seek relief during the day in alcoholic liquors, and in morphia at night. Finding him on the verge of delirium tremens, I ordered him to bed, knocked off all stimulants and the narcotic, and gave him cannabis indica and nux. His delirium lasted seven days, and as soon as improvement set in his cravings for liquor and morphia returned. Night after night he lay sleepless, calling for morphia. I gave passiflora tincture in teaspoonful doses, with immediate good effect. For eight weeks it has given him refreshing sleep; his mind remains clear in the morning, and he has quite lost his cravings both for alcohol and for morphia.

It seems to me that here we may have a remedy for inebriety much safer and less costly than the much-exploited "Gold cure."

That wearisome habit that some infants have of crying during the night without any ascertainable physical cause, but possibly from pure nervousness, or because they find it dark when they awake, or because they have had too long spells of sleep during the daylight hours, finds an effectual remedy in *Passiflora incarnata.*

The cases hitherto recorded by our American colleagues are thus summarised alphabetically: Angina pectoris, one; cerebro-spinal hyperæsthesia, one; chorea, one; convulsions, three; delirium tremens, with insomnia, three; erysipelas, one; insomnia, with suicidal mania, one; insomnia from valvular heart disease, one; insomnia from dentition, with

diarrhœa, in an infant, one; insomnia in infant, with dysentery and opisthotonos, one; nervous cough, one; spinal irritation, coccygodynia and ulceration of os uteri, one; traumatic tetanus, one—total, seventeen. Enumeration of other cases stated to have been cured by passiflora is impossible, owing to the vague terms used; but these seventeen instances of its success constitute, in my opinion, a solid reason for advocating further investigation into its properties, and, if practicable, proving it upon healthy men and women.

I regret to say that the one case of insomnia from nervous excitability, caused by over-smoking in a man of 50 to whom I gave passiflora, was not benefited. I shall be glad to hear the experience of any members present who have tried it.

XII.—Spiritus Glandium Quercus.

This old and forgotten remedy is the *spirit distilled from a tincture* prepared by macerating the acorns of the *Quercus robur*, or English oak, of the natural order *Cupuliferæ*, in five times their weight of dilute alcohol.

It is to Dr. Burnett that we owe the introduction of the simple homely acorn into homœopathic practice. When translating Rademacher's works, Burnett was impressed with the striking cure of a brandy drunkard, who suffered from an enlarged and inflamed spleen, from ascites, and from œdema of the legs. Accordingly, he used it with much success in splenic enlargements with or without dropsy, as some of the cases in his "Diseases of the Spleen," 1887, prove. In addition, Burnett brought this acorn spirit forward as a cure for alcoholism, particularly when it has produced acute gout in the patient.

He shrewdly judged spiritus glandium quercus to be homœopathic to the effects of alcohol from this observation of Rademacher: "A few, but not many, of those who take it immediately feel a peculiar sensation in the head, which they say is like what they feel when they are drunk—the sensation lasting only a minute or two." This is a pure pathogenetic symptom.

Another pathogenetic symptom observed by Rademacher is this: "With a few people, particularly those who have suffered from old spleen engorgements, diarrhœa sets in after using it for two or three weeks, that makes them feel better. It seldom lasts more than a day, and is not weakening, but moderate."

Having found that a former patient of his, a joiner of Crefeld, had been cured of a severe and chronic abdominal pain radiating from the spleen by a roughly-made acorn brandy, Rademacher prepared a tincture of the acorn in the usual way with alcohol, and administered it in doses of a teaspoonful in water five times a day to an old man, almost moribund, suffering under dropsy and inflammation of the spleen. The patient began at once to pass more urine; the dropsy cleared off; the splenalgia disappeared, and this moderate brandy drinker got well to the amazement of everyone, including Dr. Rademacher himself.

This man complained that after every dose he had a feeling of constriction of the chest. "I ascribed this," wrote Dr. Rademacher, "to the astringent matter of the acorns, and I caused the tincture to be distilled. This acorn spirit caused no further constriction, and the urinary secretion was still more markedly increased. I went further, and used it by degrees in all sorts of spleen affections, in both painful and painless cases, in the evident and in those of a more problematical kind. Gradually I became convinced that it is a remedy, the place of which no other can take; more particularly is it of inestimable value in spleen-dropsy."

Now, Rademacher regarded spiritus glandium only as a splenic remedy, but Burnett further developed its usefulness in acute and chronic gout, and as a cure for tippling or hard drinking. His cases illustrating his little book, "Gout and its Cure," published in 1895, to which I refer you, are brilliant and convincing proofs that we have a notable homœopathic anti-alcoholic remedy in our common acorns. "It should be given in ten- to fifteen-drop doses, in water or in milk, three times a day," wrote Dr. Carl Schultz, of Columbus, Ohio, in 1900. "If dropsy and liver trouble be present, it will be all the more sure to help your patient

Tabular Summary of Twelve Remédies.

No.	Name.	Diseases cured or relieved.	Total No. of cases recorded.	Dilutions.	Recommended also in
I.	*Latrodectus mactans:* Poisonous spider of Virginia	Angina pectoris vaso-motoria	2	3	
II.	*Ceanothus Americanus*	Splenic disease	5	φ, 1x, 1	Deep-seated pain in left hypochondrium.
III.	*Cratægus oxyacantha:* English white hawthorn	Aortic or mitral disease; angina pectoris	46	φ	
IV.	*Iberis amara:* Bitter candy-tuft	Cardiac hypertrophy; rheumatic endocarditis	2	φ, 1x, 30	Functional cardiac irregularity; the effects of oversmoking on the heart.
V.	*Stellaria media:* Chickweed ..	Rheumatism of joints; rheumatic sciatica	6	φ, 2x	Stitching pains; rheumatoid pains which move from one joint to another
VI.	*Thlaspis bursa-pastoris:* Shepherd's purse	Menorrhagia; hæmaturia; uric acid, sand and gravel; dysentery; ascites, &c.	19	φ, 1, 1x, 6	Dysuria in the aged; albuminuria in pregnancy; uræmia in pregnancy; uterine hæmorrhage.
VII.	Lactic acid	Acute arthritic rheumatism; chronic arthritic rheumatism; diabetes mellitus, with excessively acid dyspepsia	6	2x, 2	Hyperchlorhydria of stomach; flatulent acid dyspepsia.
VIII.	*Lemna minor:* Duckweed ..	Post-nasal ulceration; nasal polypus; anosmia	12	φ, 3x	Acute and chronic coryza.
IX.	*Lathyrus sativus:* Chick-pea ..	Primary lateral sclerosis; acute transverse myelitis; infantile spinal paralysis	10	1x, 1, 3x, 3	Locomotor ataxia.
X.	*Œnanthe crocata:* Water-dropwort hemlock	Epilepsy	33	φ, 4x, 6x, 6	Puerperal eclampsia; hydrophobia; uræmic convulsions.
XI.	*Passiflora incarnata*	Insomnia; chorea; tetanus; sciatica; spinal hyperæsthesia; coccygodynia; &c.	17	φ, ♏ 10 to 60	Alcoholism; nervous erethism; intolerable but vague pain; suicidal mania, &c.
XII.	*Spiritus Glandium quercus* ..	Splenic dropsy; splenalgia; alcoholism; gout	Several cases.	φ, 10 to 15 drops.	

The treatment must be kept up for three or four months. I have cured a number of patients with this remedy."

And in addition, arguing from the symptoms of acorn poisoning which have occurred among young calves and foals in some years remarkable for the large yield of acorns, Dr. W. T. Fernie suggests that acorn flour, tincture, or vegetable extract, would prove a specific medicine for the marasmus of scrofulous children ("Herbal Simples," First Edition, p. 14).

I have now concluded my task of presenting "Twelve New, Old, and Forgotten Remedies" to the notice of this Society. The tabular summary which I have prepared may be "taken as read" this evening, as there is a second paper on our programme.

I trust that my labour of twelve months to present interesting facts which may prove useful in actual homœopathic practice has not been fruitless.

By death we have lost some excellent clinicians during the last decade—men possessed of keen observation, bold and original minds, and, above all, of that grand, unselfish "medical spirit," as Drysdale called it, which seems to me to be that phase of the "enthusiasm of humanity" most valuable to the human race at the present day, when therapeusis is based upon theory, and theory upon scientific observations. If we cannot surpass these eminent men, let us at least emulate their achievements in building up an irrefragable scientific therapeusis, associated with the name of our founder.

Dr. CLARKE (in the chair) said they had all been deeply interested in this eminently practical paper. It appeared to him they were discussing not one, but six papers. Six medicines had been brought before them, and it occurred to him that these were not particularly related to one another, so that they had six distinct subjects to go over. He was much interested on hearing of some old and forgotten cases of his own that had passed out of his recollection until this paper brought them back. The first remedy Dr. Moore brought to their notice, lactic acid, was a remedy of a good deal more importance than would appear at the outset. It was somewhat closely related to the nosodes. As it was itself to

a certain extent the product of disease, in studying it they were studying something akin to the nosodes. Used in the potencies it was a very powerful remedy. He had under his care at present an old lady about 80, who was diabetic, and also rheumatic. He gave her lactic acid 5 for her rheumatism. She said that medicine did her rheumatism more good than any other. It did not do much else besides relieve the rheumatism, which affected the feet principally. It did not affect the diabetes, but she always took it when the rheumatism was particularly troublesome. He also mentioned a case of diarrhœa in a delicate boy of 9, who was treated by Dr. Bernard Arnulphy, of Nice. The patient had had very severe fever and dysentery in Brazil two years before. The diarrhœa was urgent, was worse at night, and the stools were very offensive. Dr. Arnulphy cured the case with lactic acid 12. With regard to lemna minor, he might say he was in at the birth of that remedy. He remembered when Dr. Cooper produced a specimen of the plant floating in a tumbler of water, showing the bladder-like arrangement that sustained the leaf and the little tendril roots running from it. He thought it was the habitat of the plant—its flourishing in stagnant ponds—that gave Dr. Cooper the cue to its being related to aggravations from wet weather. Also the bladder-like arrangement suggested a polypus to him. At any rate, however he got at it, it was a very true indication. Dr. Cooper worked out his remedies very considerably on the aggravations that the medicines produced. Having got one strong definite indication, as he thought, he would give the remedy in the single dose, and see what happened. It generally relieved what he gave it for, but it also generally produced some other symptoms. These symptoms Dr. Cooper noted, and used as indications for further prescriptions of the remedy; and he often found that these aggravations were keynotes for the remedy. That was one way in which it was possible to build up a remedy clinically. Dr. Cooper generally tried these remedies on himself, but he was so stable that they produced no symptoms on him, and he came to the conclusion that for a good prover they required someone who was, though healthy, in a somewhat unstable state. The desperately healthy person was not much good as a prover. Dr. Moore referred to spiritus *Glandium quercus*, which was a very important remedy indeed. He had used it largely, not only for the conditions that Dr. Murray Moore had mentioned. Quercus acted very well in trituration of the acorn, and the third decimal was a potency he had used fairly frequently in splenic cases, in cases of flatulence,

old malarial cases, and also in cases where there was an alcoholic history. It was well to remember that the oak was allied to the willow, and there they got its relation to the salicylates which were directly related to the marsh-malarial conditions.

Dr. GOLDSBROUGH had listened to Dr. Moore's paper with very great interest. A good many points had been brought out which would have taken much time for them to look up separately for themselves. On lathyrus he had not forgotten Dr. Clarke's cases. They had impressed him (the speaker) a good deal. He thought they would have a good remedy in lathyrus, especially for the fairly well-known type of spastic paraplegia. The latter was a common disease, and was presented to them as a chronic condition. Anticipating the pathogenesis of lathyrus, one would expect that benefit would be got by the use of it. But he (Dr. Goldsbrough) had tried it in perhaps twenty cases in which the disease was well established, and he was not able to say he had got any benefit from its use in that particular type, for the reason, of course, that the cases which came under notice had undergone considerable degeneration of the motor tracts of the lateral columns, and were therefore in practically an incurable state, though the symptoms might not be very pronounced. That experience bore out his opinion in reference to the drug, that it would be useful where the diagnosis of proliferation of connective tissue elements was not warranted.

Dr. MURRAY MOORE asked whether spastic paraplegia was identical with primary lateral sclerosis?

Dr. GOLDSBROUGH replied that the symptoms of that ailment corresponded to spastic paraplegia, but they might be simulated in other conditions. What was usually recognised as primary lateral sclerosis was a definite type of spinal cord lesion to which lathyrus was scarcely indicated, simply because the pathology of the thing had gone too far. Lathyrus might be indicated in functional states where the diagnosis of sclerosis was not warranted. In myelitis with the symptoms corresponding, lathyrus would be certainly thought of. He had tried it in different dilutions. He had used the third centesimal up to the thirtieth, in single doses, also in repeated doses over some length of time. As to œnanthe, he considered it a promising remedy in cases of epilepsy. From observation and experience he considered that as a general rule one should think in epilepsy of the constitutional remedy primarily. Having found the constitutional remedy, it should be used at discretion, and then, concurrently with or after the fits another remedy, like belladonna, or œnanthe, or cicuta, for

example. Œnanthe was certainly useful in some cases. He agreed that the absence of aura was an indication, a recurrence of major fits, and the general somnolent and heavy state of the patient. It was not often one was called upon to use cicuta in epilepsy compared with other great remedies. With regard to passiflora, he did not consider that insomnia was a reproach to homœopathists. If they would only settle themselves down to consider the state of the patient, the similar remedy could be found—excepting, perhaps, in certain organic conditions, or in paralysis agitans, or the morphia habit, or some conditions where there was no hope of doing good, then he thought they might be called upon to use drugs which induced sleep directly, of which passiflora was a very good example.

Dr. WATKINS thanked Dr. Murray Moore for his instructive paper, which was the outcome of such laborious work. In 1904 Dr. Watkins had the honour of reading a paper before this Society on the subject of acute rheumatism; and in this paper he discussed the subject of its etiology, and he was compelled to come to the conclusion that lactic acid was not a factor in it. Prout was the first to suggest that this acid was the cause. He brought no direct evidence in favour of it, but he was struck by the analogy of gouty and rheumatic arthritis, and he conjectured that the latter was also due to an acid, and that the most probable one would be lactic. Later on, Richardson experimented on dogs and cats, injecting into them large quantities of lactic acid. He then made autopsies on them, and was able to show the presence of rheumatic endocarditis in many of them. He had beautiful coloured drawings made of them, and they are in the College of Surgeons to this day. Three years later Rahere came along, and made autopsies on dogs and cats without any previous inoculations, and was able to show equally beautiful specimens of rheumatic endocarditis. Later than that, Foster claimed to have obtained much success in treating diabetic patients with lactic acid. Whilst carrying out this treatment, some of the patients developed well-marked arthritis. Others have repeated these experiments, but have failed to get any results. Lactic acid is normally present in the blood, but no one has been able to show that it is in excess in cases of rheumatic fever. It is absent from normal and rheumatic urine, but is found in such diseases as hepatic cirrhosis, leucæmia, osteomalacia, and phosphorus poisoning. Lactic acid is also absent from the perspiration, with the exception of in some patients suffering from puerperal fever. He thought that the only living authority who considered that rheumatic fever was due to

lactic acid is Latham, but even he thinks that it is in conjunction with uric acid. Before writing the above-mentioned paper, he (Dr. Watkins) had injected large quantities of lactic acid into rabbits, but was not able to obtain any rheumatic manifestation, whereas they could be produced fairly readily by the injection of the rheumococcus.

Dr. STONHAM said that out of the six remedies he had only used two, the œnanthe crocata and passiflora—the latter to induce sleep once or twice. He agreed with Dr. Goldsbrough that they had nothing to reproach themselves with in the matter of insomnia. As regards hypnotics, he altogether eschewed them from his practice. He could not say that he had any need of them. With regard to cicuta and the character of the fit, he thought Dr. Moore had said that the convulsion was usually ushered in with a cry. That was the usual statement. In a case of poisoning he observed himself some years ago—a case of two children who had eaten the roots of the cicuta—there was no cry whatever. They had the other characteristics, the staring eyes and the opisthotonos, the prevalence of spasms of the extensors over that of the flexors, and convulsions of considerable violence which tended to go from one side of the body to the other; but there was no cry in those cases, so that the absence of a cry would not be sufficient to contraindicate cicuta in a case of epilepsy. With regard to lathyrus sativus, the symptoms would suggest it in lateral sclerosis. He was sorry Dr. Goldsbrough could not give them any better account of his cases, and asked him whether he observed any arrest of the disease in those cases treated by lathyrus.

Dr. GOLDSBROUGH replied that he had two cases on hand which he had had under observation from seven to ten years, and one he knew had not progressed at all, and had had lathyrus 30 pretty well off and on all the time. On the other hand, he hardly thought Dr. Stonham was quite right in suggesting that the disease was a progressive one. As long as the patient could crawl about, he kept in that state for a great number of years without any real advance in his disease.

Dr. EDWIN A. NEATBY remarked on lathyrus as being a medicine he was very much interested in at one time, because he had had the pleasure of looking out a great many references for Dr. Hughes when he was drawing up "The Cyclopædia of Drug Pathogenesy." He remembered, in his own practice, three cases of what at the time he took to be transverse myelitis—cases which occasionally followed acute diseases, and occasionally followed

accouchement. Two cases followed an ordinary normal confinement, and one followed pneumonia. He gave lathyrus in those cases; but it was very difficult, in cases showing a spontaneous tendency to recover, to say how much was done by the remedy. Neither case lasted as long as one of the cases Dr. Murray Moore had quoted. His (the speaker's) lasted from three to six months before complete restoration to power; whether recovery was really due to the lathyrus or not he could not say. He asked whether the case of chorea cured by the passiflora was really cured by that remedy, or whether it might not be "cured" by the primary change of life, in other words, the onset of menstruation which took place when the passiflora treatment had been begun?

Dr. EADIE said he understood the acid believed to be present in rheumatism was sarcolactic, which was formed in the muscles, and not lactic, which is the result of fermentation of lactose or milk sugar. These two substances were isomeric, but had different physical properties; and it was not unreasonable to assume that their pharmacological action might also be different. Another point was that Dr. Moore did not mention anything about the action of lathyrus on the larynx. He had listened to the lectures of one of the veterinarians who had investigated the outbreak of lathyrus poisoning in horses in Bristol ten years ago. The prominent symptoms were roaring, due to paralysis of the recurrent laryngeal nerve, and paralysis of the hind limbs. These symptoms would come on with great suddenness. While the animal was trotting along apparently well it would begin to roar, show weakness in the hind limbs, fall, and perhaps die in a few minutes.

Dr. MURRAY MOORE, in replying, thanked the Society for the reception given to his paper. He looked upon epilepsy as usually incurable, and he was very glad to see any well-authenticated cases of cure. Unfortunately, in some of their American records, there were cases that seemed plausible; but somehow or other, to a British mind, such as, say, the analytical and somewhat sceptical mind of their secretary, when sifting these cases they would see a number of links in the chain that were not complete. If he attempted to write a treatise on epilepsy, he should feel himself debarred from making use of these cases. There were, however, a few cases in which the chain was complete. Of course he (the speaker) sat down as a student under Dr. Goldsbrough, who was *facile expertus* with these nerve diseases. He quite agreed with him that it was the constitutional remedy they should seek for in epilepsy. At the same time he thought it wise to point out that

both in œnanthe and cicuta they had drugs that distinctly pictured two different forms of epilepsy. On lactic acid he had not made up his mind, but he should like to assure Dr. Watkins that he (the speaker) himself was the proof of a chemical reaction. He was gouty, and he could not help it, as it was hereditary. If he carried litmus paper in his pocket it began to turn pink. Even Dr. Watkins would admit there was a chemical acid arising from the surface of his body, and he certainly was not rheumatic. He would like Dr. Watkins to test the perspiration of every patient he was called to, and give the result.

Dr. WATKINS asked whether carbonic acid would not affect it?

Dr. MURRAY MOORE would not go into minute chemical questions like that, but thought the acid of his sweat was uric acid. He thought he had done some good by including lactic acid in the paper, but the subject was *sub judice*, as it were. In reply to Dr. Neatby as to the case where he thought menstruation came on, he (the speaker) had read his paper rather rapidly, and he was afraid he was not quite distinct on this point. It had *not* come on. He had not overlooked the laryngeal symptom in horses. He did not bring it in because he was concerned only with the ordinary symptoms in the human being.

ADDISON'S DISEASE.[1]

BY A. E. HAWKES, M.D.,[2]

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MR. PRESIDENT AND GENTLEMEN,—Our good friend, the editor of the *Journal of the British Homœopathic Society*, when about to publish the last paper I read to this branch, asked to be allowed to alter the title I had adopted. If, however, he had headed the contribution "Appropriated" he would not have been far wrong, so dependent on others are both tyro and veteran when medical writing—and, indeed, any—has to be done. On this occasion scope for a little more originality offers itself, an aim I hope to some extent to achieve.

[1] See Trousseau's "Clinical Lectures," vol. v., p. 149.
[2] Read at the Liverpool Branch, March 21, 1907.

Only yesterday, through the courtesy of a junior colleague, I saw a lady aged 36. She was in bed, and was not so ill but that she could manifest some amusement at the interest taken in her case. Her hair was dark, and thick as to its growth, and the scalp difficult to see, and her general appearance reminded one of the Iberian type, the small dark folk of Boyd-Dawkins and other writers. But the complexion was more pigmentary than one meets with in the healthy Iberian. Perhaps the discoloration was most noticeable between the lower lip and the chin, but the forehead and the rest of the face were abnormally stained. The staining ceased more or less abruptly at that part of the neck to which the dress usually reaches. The anterior axillary folds, over the pectorales, were dark, but not the axillæ themselves. The mamillæ were not unusually dark, but as the waist was approached, and the parts usually laced more or less tightly, the duskiness was increased. The scapular regions and the back generally were darker than the chest in front. The abdomen and inguinal regions were not markedly dark, but the fronts of the thighs were. The patient had not used garters, so the parts to which they are usually assigned were not pigmented, but the dorsal part of the feet, where the shoes had been laced, were characteristically dark, as were the backs of the hands.

Many very dark moles were scattered over the body varying much in size. The tongue exhibited many pigmented areas, but the oral mucous membrane had no discoloured patches, the parts mentioned exhausting the areas in this particular regard. Objectively the pulse was found to be very small, compressible, and frequent. The heart sounds were not abnormal, but very feeble; there were no unusual chest sounds, no dulness on percussion, and palpation in the renal regions afforded negative results.

The patient and her mother admitted that she had been getting thinner for more than twelve months. She herself traced her indisposition to a cold two years ago. Her father died of cancer of the bowel, but the mother seemed well; her age is 65 years. There are two sisters in good health,

and neither brother nor sister has died. She first noticed the darkness of the skin after the cold already referred to, but it became much more obvious last summer, when she was much exposed to the sun while staying on the island of Anglesea. At that time she is said to have looked almost black. She then went to Essex, and there also spent much time out of doors, and for a long time thereafter the colour was but slightly diminished in intensity. The further statements indicated that she did not feel poorly until three weeks ago, when she had another bad cold, but it is admitted that prior to that she had once or twice complained of temporary shortness of breath. A month ago she exerted herself a good deal during the process of removal, and she has not been well since. She does not vomit, but she had an attack of dysenteric diarrhœa a fortnight since. These diarrhœa attacks have been frequent, but never severe before. While she never actually vomits, the nausea attacks occasionally culminate in retching. There is a little cough, and some suspicion attaches to the left apex, but as has been stated physical signs are not convincing. The skin is dry, the patient thin, but progressive emaciation is not admitted. There is considerable dyspnœa now on exertion, and movement is apt to cause retching. There is no sugar and no albumen in the urine.

Such, gentlemen, are the salient feature of this interesting case. After narrating two others we may betake ourselves to systematic treatises, in order to complete the picture at present so imperfect.

Some few weeks ago I was sent for to see an old patient, concerning whom the following particulars were elicited.

His wife, the second to claim that distinction, had been ill herself with influenza—she thought—since Monday, January 28, 1907, and her husband had come home from work ailing on the Wednesday, January 30, 1907.

He stated that he had been working in an unusually cold place—he was a joiner. He would not allow her to send for any professional assistance, as "he did not want to be kept in bed," he said.

He, however, allowed his wife to send on Friday, February

1, 1907, and he was promptly seen by the secretary of this branch, and a little later by myself. His pulse was poor and irregular, he seemed dazed, and complained very much of frontal headache. There was some abdominal pain, and he had at least one attack of diarrhœa, the evacuation being copious as well as loose, and he was only partly conscious of it. He could take but little food; he was very restless and could not easily be controlled; moreover, he often tried to get out of bed. Gels., bry., dig., arsen. alb., and stimulants were tried, but to no purpose, and he died about thirty hours after our first visit.

What was the explanation of this sudden and melancholy result?—for although a well-known practitioner, who to his honour lived and worked in one of our poorer districts, earning the esteem of all who knew him, and a noble lord, equally honoured in his own sphere and out of it, have died of influenza just lately, deaths from this disease are not readily admitted, as such results seem to reflect somewhat on the practitioner's ability, or at any rate on the value of his remedies.

I will first briefly refer to the *post-mortem* examination, and then to the long medical history. We obtained the consent for a *post mortem* with much difficulty, and we had to give our word that as little as possible should be done.

Whether the promise, or its extraction, was the more puerile under these circumstances I must leave you to say. I once got an able colleague to do a *post mortem* for me in a case of laryngeal diphtheria. He was as keen as he was able, and in his zeal he removed the larynx and tongue on my behoof, and they found their way to my house.

His dexterity did not satisfy the father of the child, and I shall not readily forget my chagrin at having to disgorge our ill-gotten prize.

This incident has spoiled many a subsequent *post mortem*, and possibly the promise made on the occasion under consideration was too faithfully kept. We examined only the abdominal cavity, whence we removed nothing which we did not return.

Some of us lately have had to treat cases of influenza

showing symptoms of mild peritonitis. In this case the intestines were all glued together as if by some invisible cement, easily yielding to pressure, and showing none of the ordinary signs so familiar in cases of peritonitis, due, say, to the escape of gastric or intestinal contents.

The left suprarenal capsule was healthy, and the kidney also—there had been no albuminuria. The right suprarenal body was large and practically consisted of a caseating mass, such as you are all familiar with.

What was the previous history of this interesting, if anxious, case? Eighteen or twenty years ago this man, a tall, powerful fellow, had pleurisy. Dr. Drysdale, who was then in active practice, saw him with me, and I remember very well the kali carb. he ordered. Empyema developed, and before any surgical measures could be adopted they were held to be unnecessary, by reason of the empyema copiously discharging itself through the bronchi. He recovered sufficiently, after a long illness, to be passed by Dr. Wallace, who was then in general practice, for life insurance.

Some time after his colour began to change, pigmentation manifested itself, nausea, vomiting, and attacks of utter prostration occurred, and he had at times in consequence to stay from work. I remember one attack about the time of the Maybrick trial. One or two fly-papers were lying on moist dishes near some food, and the attack was so like arsenical poisoning, that I half suspected that some of the fluid had got into the food. Of course this was not the case, for a more careful attendant than the first wife could not be conceived of, unless it were the second.

With arsen. and chel. for his liver symptoms, he was kept in fair health and at work. Some time afterwards Dr. Gibbs Blake was in Liverpool, and he kindly saw him, and ordered him adrenalin tablets with much advantage. He took them for a long time, and with these and other remedies, chiefly bry., merc., and chel., he kept in very good health, seldom being away from work.

He must have suffered from Addison's disease for at least fifteen years, and thus have established something of a record.

He died at the age of 59. His liver was congested, and the urine was bilious in character, but free from sugar and albumen. He treated himself a good deal, and amongst his effects a large quantity of chelidonium ϕ tincture was found.

We have had several cases in the hospital, but the most marked one was that of a woman, past middle life, who came from one of the large neighbouring towns. I got her to go to the hospital, where I opened an abscess in the left hypochondriac region.

She suffered much from asthenia and vomiting, and the skin was much discoloured. The diagnosis was disputed, but, on her dying, my son and I journeyed to the town in question, made a *post mortem* in the presence of the nurses, and secured the specimens, which have, happily, not been reclaimed, so we can see them to-night. Both suprarenal capsules were the seat of abscesses. The contents were much more purulent than caseous, thus differing from the other case. But perhaps the most interesting feature was the disease of the rib, which was extensive, and the site of which can be readily seen.

At an earlier stage a much more radical operation, as sanctioned by Treves for these chronic cases of caries and necrosis of the ribs, so often due to tubercle, might have been carried out, but the patient's condition hardly warranted so radical a measure, although the more conservative policy was not a very promising one.

I remember two other cases of my own in the hospital, but beyond marked asthenia and rather rapid fatality, there was nothing to call special attention to them. One was a very sad case, a young Edinburgh stableman, whose parents were unaware of his serious illness until summoned to Liverpool to see him.

If I mention an elderly lady whom Dr. Proctor saw for me long ago, and whose persistent vomiting led to the diagnosis, I think I have called up most of the authentic cases I have seen, and in these instances honours are equal as to the sexes, which as regards the disease in question is most unusual. On referring to my books, however, I recall a case of a young man, speedily fatal, which disturbs this equality.

I am compelled to refer you to authorities for the function of the suprarenal bodies, which are only 1¼ to 2 inches long, rather less in width, and about two or three lines in thickness (Gray).

Brown-Séquard showed that they are necessary to life, and that when they are removed the animal dies.

Abelous and Langlois have shown that animals deprived of their suprarenals die with symptoms resembling curare poisoning—auto-intoxication.

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Embolic atrophy has caused it; carcinoma may attack the bodies, and Addison's disease not result. It is suggested that Addison's disease may not have had time to develop.

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Sir Samuel Wilks's view that the spread of the inflammation from the tuberculous bodies to the semilunar ganglia, and the other branches of sympathetic, gives rise to the phenomena of the disease, is of much importance. Hence, it is suggested, the vomiting and debility.

Against their view is brought forward the idea of suprarenal inadequacy already referred to. The onset is very insidious. The pigmentation may precede the gastro-intestinal irritability. Severe shock may be the exciting cause of the disease.

Bronzing may be merely a dirty, sallow tint, or, as I have said, it may be very marked.

Hilton Fagge wonders if it would occur if the patient were kept in the dark. Others ask how an albino with the disease would look. The pigmentation closely resembles that of the dark races, but the nails of the negro are not so white as those of the Addison patient.

The sclerotics show pigmentation in some cases, but this may need differentiating from the normal states of deep choroid pigmentation. In one of my patients, a Spanish gentleman who died of phthisis, there was much pigmentation of the mucous membrane of the mouth. I wonder if he had Addison's disease. We must remember that beneath a truss, or on the site of a blister, pigmentation may be exaggerated. So, as to pock marks (Bramwell).

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"Emaciation is not a feature." Vomiting may cause death from exhaustion (Greenhow). The mind is clear, but sight and hearing are impaired. The urine suffers but little change, but the highly-coloured sample I show is not unusual. Seven to ten years seem an extreme duration for the disease to last. Eighteen months is the mean duration (Wilks). Death may be due to syncope, vomiting, diarrhœa, or delirium.

Slight cases may recover perhaps; but of 800 cases five only were recorded as cured, and twenty-eight as having improved (Lewin). Its analogy to myxœdema may be referred to, as it has some bearing on the treatment. According to Rolleston, differentiations from the following conditions may be required. Diabetes, hepatic disease, pancreatic disease, pregnancy and uterine disease, granular kidney, chronic phthisis, malarial melanæmia, melanotic sarcoma, exophthalmic goitre, chronic rheumatoid diseases (pigment). Argyria is permanent; in dirty poor people try soap for the bronzing and food for the "sinking" (Greenhow); syphilis may be excluded by a course of potassium iodide; tinea versicolor; typhus; splenic anæmia. Sunburnt patients, or men exposed to the heat of furnaces, may seem like Addison cases. In acanthosis nigricans the skin is thickened. Diagnosis is difficult in the negro.

During the discussion of Dr. Hawkes's paper, Dr. Proctor related how in his early days London was ransacked, so to speak, for cases of Addison's disease. His reminiscences added much to the interest of the evening. Dr. James L. Hawkes expressed the opinion that the long continuance of one of the cases was due to the fact that only one suprarenal body was affected.

SHALL WE BE GUIDED IN OUR TREATMENT OF UTERINE FIBROIDS BY THE EXISTING STATE OF THE PATIENT AND THE TUMOUR, OR BY THE NATURAL HISTORY OF THESE GROWTHS?[1]

BY EDWIN A. NEATBY, M.D.

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LET me begin by making clear the nature of the question I am asking you to consider with me to-night for a few moments.

In our treatment shall what the French call the *état actuel* or the probable progress of a case of "fibroids" guide us in treatment? By way of example: Suppose a patient with a small raised nodule on the cervix uteri near the os. It is a somewhat wart-like growth, which bleeds slightly when touched. The patient is ruddy, well-nourished, able bodied, and suffers no pain. The microscope shows that the nodule is an epithelioma. It is apparently causing no suffering, no injury, no inconvenience, but in spite of that you decide at once to remove not only the tumour but the whole organ. Here the decision is based, not on the present condition of the patient but on the known progress or natural history of the disease. The case is 'malignant'; if left alone the result will be death, and you do not hesitate to operate. Or, if you do not operate, it is because you believe there is something behind the nodule which the knife cannot reach—not because the condition is so unimportant as not to warrant surgical measures.

But it will be pointed out that fibroids are non-malignant growths, and must not be compared with cancer. Take, then, an ovarian cyst. When its presence is determined it is regarded as proper treatment to remove it, whether it be the size of a tennis-ball or a football, irrespective of any symptoms present or absent at the time of its discovery.

[1] Presented to the Section of Surgery and Gynæcology, April 4, 1907.

Here, again, the treatment is based upon what will be, rather than on what is. Though the tumour is non-malignant, and is doing no obvious harm, you remove it because you know it will do harm if left to itself. There is little or no tendency to spontaneous recovery in such a case. At the best it will remain stationary, and perhaps cause peritonitis or dystocia. In the ordinary course if left alone it will go on growing indefinitely, till the patient dies from mechanical embarrassment of the heart and lungs.

There are no two opinions as to the propriety of operation in such cases, for there is no prospect of an involution of the growth at a certain stage in sexual life. With fibroids it is different. There is at least a tendency towards recovery in some cases, when the activity of the sexual glands ceases. Is this tendency sufficient to make us say: "Yes, the tumour will probably go away by itself if you leave it long enough, and we will let it alone and give nature a chance, unless it is really endangering life or seriously impairing the health." We can only answer the question by considering some of the facts. Let us tackle them at once, and take examples of some of the favourable ones first.

Some years ago I was asked to see my coachman's wife, suffering, I was told, from bronchitis. She was sixty years of age. When examining her I discovered she had a solid uterine tumour extending to a point about three inches above the umbilicus. She had never known of its existence. She always had a "high stomach," but was never, as far as she knew, either better or worse for its presence.

Miss W. was a lady, aged 43, who had carried about an abdominal tumour for many years, ignorant of its presence, able to walk, dance and skate.

Mrs. M. was a lady I treated for many years for menorrhagia due to a fibroid. She was 44 years of age when my observation of her case began—fourteen years ago. She had also tachycardia and proptosis, probably not connected with the growth, as she had had them since girlhood. I watched the tumour grow for two years, when it reached the height of one inch above the umbilicus. During the next six months with menstruation gradually lessening in quantity and fre-

quency, the tumour diminished to half inch below the umbilicus. When I last saw her, two or three years ago, the tumour had practically disappeared.

Almost the same series of events as in the last-named case, has, in a recent hospital patient, unfolded itself before my eyes and ended equally favourably. These are four cases which spring into my mind as I sit down to write this short paper, and they are but examples of others of my own, and of facts familiar to every practitioner.

Though presenting slightly differing features, they are brought forward as examples ready to hand of the widespread belief that uterine fibroids are usually very innocuous; that they can often exist unknown to the unsuspecting host, or if recognised, may generally be patiently put up with until the friendly menopause steps in to starve out the intruder.

But there is growing evidence to show that the innocence of these growths has been over-estimated. Even in my cases, *selected* as instances of their benign character during a prolonged period, there are flaws; for I believe the tumour in the first case embarrassed breathing so much as to turn the scale against the patient: she died. In the second case, after a long peaceful existence, the tumour took to severe bleeding. In the other two, one may think, "all is well that ends well;" but, unfortunately, we cannot be sure that the last has been heard of them.

Miss F. L., sent to me in November, 1902, had passed the menopause for a much longer time than have these two cases. She was 59, and had ceased to menstruate for nine years. Under Dr. Moir's care for her general health, she told him of a watery vaginal discharge, offensive and occasionally brown, and of several attacks of loss of bright red blood. The lady was sallow and losing flesh. Strange to say she had previously been under the care of a well-known non-homœopathic gynæcologist for many years, and he had deprecated any interference on the ground of this discharge, stating that it was of no importance, and might be due to a mucous polypus. (This is a hearsay report, but was made to a medical relative of the patient's, who communicated it to me). She had a fibroid filling the pelvis. With Dr.

Moir's concurrence a preliminary curetting was done, and the diagnosis of adeno-carcinoma of the body of the uterus established. This was followed by total hysterectomy. In November, 1905, a little "bouton" was observed at the right extremity of the vaginal scar, which caused me anxiety. Upon excision it proved to be only granulation tissue around a silk ligature, of which I show the slide here. She recovered her nerve tone after considerable treatment, and is now, more than four years after the operation, well and giving no anxiety.

A. M., a married lady, aged 44, who had had one child and one miscarriage. She came under my care in August, 1899. At the beginning of that year she was alarmed by the onset of a continuous, watery, offensive discharge, together with a dull aching in the lower abdomen, much aggravated on exertion. There were also pain at the period, and before and after defæcation and micturition. She had a large abdominal fibroid, and the cervix was the seat of cancerous ulceration. In the hope of alleviating the pain and removing the discharge, panhysterectomy was at once performed. The patient made a good recovery from the operation, but an early recurrence took place. Though this lady was under medical care, the gravity of the early symptoms was overlooked, and the life of a highly intellectual member of society was thrown away.

Mrs. M., aged 55, sent to me by Dr. Epps, had had a fibroid uterine tumour for many years, and had menstruated regularly until 54 years of age. From January to September, 1906, menstruation was absent, but after that, until I saw her, a reddish discharge was present, amounting occasionally almost to a "flooding." Thus, after waiting patiently many years for the menopause, she was mocked by a delusive nine months of amenorrhœa. During this time the fibroid did not disappear. Indeed, even while bleeding was suspended, nature was preparing a terrible awakening from her false security. The history led Dr. Epps to suspect a malignant development, and I could only confirm his worst fears. The fibroid extended half way to the umbilicus, and as regards its abdominal portion was fairly

freely movable. The cervix was lacerated and enormously hypertrophied by cancerous growth. No ulceration of the vaginal surface was present, but the left fornix was involved. It was not a favourable case for operation, nevertheless as complete as possible a removal of the growth by dissecting it out from the left broad ligament was carried out in February of this year. It is too early to speak as to recurrence. The patient is placed on cacodylate of soda and will continue under observation.

J. M. is a lady with a very similar history to the last named. She had waited many years in the hope that the menopause would remove the uterine fibroid, the bleeding from which kept her in a perpetually anæmic and exhausted condition. Until her fifty-sixth year she had regular periods, and for six months previous to 1904 they lasted from seven to fourteen days. Then came a respite: the intervals lengthened, the quantity lessened, and the tumour diminished in size. Menopausic flushings, &c., were very distressing. The last definite period took place in the autumn of 1904. After an interval of eighteen months, offensive discharge set in. By this time the uterus had shrunk to the size of a largish tangerine orange and occupied the junction of the cervix and body, the corporeal mass being no longer felt. The diagnosis of cancer was made on the clinical history, and abdominal panhysterectomy performed in October, 1906. It was felt that even if the diagnosis were not upheld after operation, it was time to be rid of an organ so constantly causing trouble. A good immediate result followed.[1]

Both this patient and the last had borne children, one four, and the other six, the last child being about 20 years of age in each case.

Miss U., a hospital patient, aged 66 years, had passed the menopause fifteen years when she began to have foul discharge and then to bleed. For a year the hæmorrhage continued uninterruptedly, until her operation five weeks ago. A very nodular fibroid was found—some nodules being simple

[1] In July, 1907, the infiltration in the left broad ligament at and after operation has nearly cleared up. The patient has steadily taken neoformans vaccine by the mouth once a fortnight, with occasional weeks of ars. iod.

myomata, some having undergone calcareous degeneration, and one large nodule being carcinomatous.

That these are not isolated instances is shown by cases referred to by a number of speakers at the Berlin Gynæcological Society, quoted in a recent issue of the *Zeitschrift f. Gebürtshulfe und Gynäkologie* (Bd. lviii., Hft. ii., 1906). At p. 343 Flaischlen relates the case of a woman, aged 56, eight years past the menopause. The patient had had hæmorrhage for fourteen days, otherwise she felt very well. The mucous membrane covering the surface of the myoma had almost entirely undergone carcinomatous degeneration, and also the adjoining portion of the opposite uterine wall pressed upon by the tumour.

Herr Babb related a most interesting and rare case of cancer of the cervix, associated with an adeno-myoma of the body, itself undergoing malignant changes. The former was an epithelioma, and the latter an adeno-carcinoma.

Winter referred to no less than thirty-six cases of myoma and carcinoma, of which twenty-three were corporeal.

Koblank quoted the case of a woman, aged 52, who had had hæmorrhage for one year, beginning four years after the cessation of menstruation.

Amos recounts a similar case of irregular hæmorrhage for one year, two years after the menopause. The intramural myoma was the size of a fist, and a small malignant polypus was found in the cavity.

I will not weary you with a recital of more cases bearing on this point. Enough has been said to show beyond a doubt that when a myoma patient has weathered the storm and arrived at the menopausic haven her dangers are not over; she may still make shipwreck. The obvious reply is that the rock on which she later comes to grief is not that near which she so long steered a perilous course—that sailing safely past Scylla does not lessen the danger of colliding with Charybdis. In short, to quit the not very comfortable figure of speech, it may reasonably be argued that the sequence of myoma and carcinoma is merely a coincidence; that cancer comes in women both before and after the menopause, whether they have previously had a fibroid or not,

and that no one has ever contended that the sufferings a patient goes through (or does not go through) with a myoma, protect her against carcinoma. If this is all the facts warrant us in saying, it is still worth while to have our beliefs thus supported by evidence. But do facts and theories lead us to the conclusion that we have been right all along, and that we have only to go on believing as we have believed, and doing as we have done, to secure the greatest good of the greatest number?

If I were arguing, instead of trying to let facts argue for us, I should say the contention is that *a uterine myoma, so far from protecting from cancer of that organ, predisposes to it.* Speaking theoretically first, it seems a reasonable enough assumption that the presence of a new growth in this organ would alter unfavourably its nutrition, and so lessen its resisting power. This argument would hold good, whether cancer is held to be of microbic origin or not.

The next item of evidence is, that supposing the theory to be correct that a myoma influences nutrition unfavourably, as corporeal myomata are more common than cervical, cancer of the body (in corporeal myomatous cases) should be more common than cancer of the cervix.

Now, taking the figures for non-myomatous cancer patients, Noble, of Philadelphia, shows that cervical cancer is ten times more common than corporeal, whereas in a series of 2,274 myoma cases there were more than two and a half times as many body cancers as cervical ones.

There were 43 corporeal myomatous to 16 cervical cases. The usual non-myomatous ratio for 16 cervical cases would have given 1·6 body cases instead of 43.

In 4,880 fibroid cases 2·8 per cent. of cancer occurred. In smaller consecutive series of 337 and 100 by Noble, the percentage was 4 and 8 respectively.

In a series of 4,267 gynæcological cases of all sorts under my own care, 96 had cancer and 281 fibroids: That is, 2·24 per cent. of non-myomatous patients had cancer; of the fibroids, 14 had malignant disease, giving a percentage of 4·98 of cancer—rather more than double the percentage in non-myomatous patients.

These figures are probably well below the truth, for it often happens that when a uterus is removed for cancer, a fibroid is found and no note taken of it, because the myoma is regarded as of no importance compared with the cancer.

In Noble's collected cases (2,274), with other intrinsic complications, *e.g.*, sarcoma, chorio-epithelioma, necrosis, cystic degeneration, and twisted pedicle, the mortality of fibroids, if left to nature, is shown to be 12 per cent. When it is remembered that a 5 per cent. mortality in cases operated upon is an unnecessarily high one, a strong argument is advanced in favour even of excision in all cases.

Taking into consideration the extrinsic complications of myomata, a larger percentage of naturally fatal cases is obtained, and a still larger number of patients lead a life of chronic invalidism until the menopause or after.

A very large proportion of my own patients, who had associated cancer and fibroids, had borne children.

In endeavouring to answer my own question, I should say that if we were obliged to operate on all our cases or on none, it would be better to operate on all; that if we operate on all we should operate needlessly on some; that in deciding as to operation, the natural tendency to complications and degeneration should be allowed much more weight than formerly, but that we are not justified in being guided by that alone.

In deciding upon operation I would adopt a different standard for young women, say up to 36 or 38 years, and for those of 44 years or more. In the case of the former, I should say that a reason should be required for retaining a fibroid. In the case of the latter, with a symptomless tumour of equal size a reason for removing it should be required.

* * *

And now, gentlemen, permit me to say a few supplementary words as to the recognition of cases of cancer. In the first of my above-narrated cancer-fibroid cases there had been offensive discharge and bleeding for months before it was recognised; a well-known non-homœopathic gynæcologist had said "watch; probably it is a polypus."

In another of the cases which I have related, the same thing happened under the care of a homœopathic practitioner. Nearly a year ago a post-menopausic patient came to this hospital with similar symptoms, and the verdict was "you must be watched," and she was watched until far advanced cancer had declared itself.

A few weeks ago a colleague in the provinces asked me to see an elderly lady who had discharge and bleeding. She had been to a London gynæcologist (not a homœopath), who assured her "there was nothing there." Only a few months after this pronouncement, not content with the *ex cathedra* verdict, my friend asked me to see her, and I found a large corporeal cancer, verified by operation.

Why do I take up your time by referring to these cases? You all know that post-menopausic discharge and bleeding usually means cancer. The same was true of all the medical men who saw the patients I have just referred to. Yes, we all know: and yet such cases are constantly coming to the surgeon and the gynæcologist. In theory and in an examination paper—yes, we all know.

How long will it take to burn it deeply enough into the brain of us that these symptoms are vital, perhaps mortal; that they mean not watch, but act; that the diagnosis, at the earliest possible moment, must be removed from the realm of probability to that of certainty? How long will it take us to learn, so as to act upon the knowledge, that irregular hæmorrhage is not to be calmly accepted as one of the incidents of the "change of life"?

There are, alas, all too many cases quite undiagnosable without an examination, and having no signals to make us examine; where there are danger signals let us heed them, and save the lives of some who are ready to perish, but who may be saved by a policy of promptitude.

Dr. Dyce Brown, in opening a discussion, said they would all agree that the paper was an exceedingly interesting and important one, but it struck him that one would hardly be justified in advising operations on account of the possible future where there was no indication besides the existing fibroid. The operation of re-

moving the uterus was not a trifling matter, and it seemed to him that if there was no definite indication of anything suspicious, or other valid reasons for operation, it would be hardly justifiable. As Dr. Neatby had pointed out, cases of fibroid got well under treatment, and some even without treatment. They knew that cancer might develop in the uterus and in other organs, without any previous fibroid. One ought to be practically certain before advocating an operative measure, as the fibroid might possibly be cured and would never recur.

Dr. STONHAM said that he was sure that they must have all listened with great profit to Dr. Neatby's paper, and to his summarising of the dangers which were before them in cases of fibroid tumour. As far as he could gather, fibroids were quite innocent at the beginning; but after the climacteric they, perhaps, took on a malignant form and eventually caused trouble. That being so, it occurred to him that it might be possible to employ some of the new methods of treatment, such as the injection of cancerous culture, or the giving a cancer nosode by the mouth. It might be possible thus to prevent the development of cancer in the tumour.

Dr. WATKINS wished to ask whether, in the cases of cancerous fibroid, the hæmorrhages were regular or irregular?

Dr. NANKIVELL could not exactly see where Dr. Neatby would draw the line for or against operation. If cancerous tumours so frequently followed myomata, it would almost seem necessary that every myomatous case should be treated by hysterectomy in order to obtain the safest and best results. If this was the case, they would be landing themselves in a very critical position indeed as regards prognosis and treatment. He should certainly shrink from saying that every myomatous patient he saw should be operated upon because the chances of developing cancer at a certain time of life were very great, and that the sooner the patient got rid not only of the fibroid, but of the whole of the uterus, the better for her in after years. He should not feel justified in taking up such a position as this. He thought that the statistics which had been laid before them in the paper failed in one respect. He was sure that there were hundreds and thousands of women who went through life with myomata which were not even detected by medical men. Small myomata were very often undetected. Even in the cases which Dr. Neatby brought forward, there were many who had not the faintest idea they had tumours at all. Possibly the woman who died of the attack of bronchitis would otherwise have lived for many years,

and never suffered from the presence of the tumour. For a general practitioner he had seen a good many cases of fibroid, and only one of these developed carcinoma afterwards. That case was a very curious one. The patient got better for a considerable time under his care, but the recurrence of acute symptoms led him to put her in the hands of a surgeon. The uterus was removed, and there were found not only myomata, but a considerable abscess in the walls of the uterus as well. The wound suppurated; the patient had a very rough time; but she apparently got quite well. About eighteen months after that she developed pleurisy, and they were obliged to consider the probability of a malignant origin. A few weeks later it was found that malignant growths were forming in and about the old cicatrix of the abdominal operation, and of course she died. Dr. Neatby's treatment was here thoroughly carried out, and carried out before there was any development of carcinoma at all; and yet the patient died of carcinoma within eighteen months of the operation.

Dr. SPEIRS ALEXANDER agreed that they were indebted to Dr. Neatby for drawing their attention to the ultimate dangers which might result from uterine fibroid. He supposed that most of them had a general idea that if they could tide the patient over the menopause all danger would be over. He had always understood that the indications for operation previously to that time were pain, hæmorrhage, and pressure; that is to say, severe pain, excessive hæmorrhage, and pressure on the rectum and bladder. If these were present, the tumour should be removed. However, in addition to these indications, they had now to consider the ultimate possibilities, and, in view of these, the question would naturally arise whether it might not be wiser to operate in the majority of cases. In these days of antiseptic surgery, the possibility that serious operations could be carried out with a minimum of danger to the patient was an important factor to be taken into consideration. In a case which he had under his care some years ago, in a lady of over forty, he discovered the presence of a fibroid tumour. There was no excessive hæmorrhage, excessive pain or pressure symptoms, and no operation was performed. When the lady was over fifty, symptoms of carcinoma developed, and before long the patient died. The lady came of a long-lived stock, and had a good family history; and in looking back he had often thought that if she had been operated upon her life would have been prolonged.

Dr. NEILD said that Dr. Neatby had given them a very clear and practical paper which contained much food for reflection.

As he went on in medical practice he dreaded operations more than ever before; but he had seen several cases in which fibroids had degenerated into cancer, and in which he had felt that, if an operation had been performed, such a result would have been prevented. He had at the present time a case in which he was very much afraid that a fibroid was degenerating in that way. A sister of the same patient had small fibroids some years ago, and when the change came it took place in the regular way without much trouble. But subsequently cancerous degeneration began. The case was curetted, and it was not considered desirable to have a further operation. He had found this so in many cases. It was a question whether the fibroid condition was part of the general degeneration, or whether the fibroid condition had not something to do with bringing about the kidney degeneration, and the other degenerations which followed. Of course, every case must be treated on its own conditions, but nowadays they ought not to be afraid of operations if they appeared to be necessary. The question arose whether they ought to wait until signs of degeneration were present.

Dr. GRANVILLE HEY asked Dr. Neatby whether he would operate in all cases of myomatous uteri which showed no tendency to diminish after the menopause? If he would not follow that course, perhaps he would tell them what symptoms would decide him in operating in cases of myomatous uteri. In cases of post-menopausic hæmorrhage it was possible that the hæmorrhage might be from some degenerating fibroid polypus. If that was so, would it not be better to do a diagnostic curetting first before deciding on the major operation? He would also like to know whether anything had been done for testing, or if anything was known of any method of testing, the patient as to the likelihood of the growth being cancer? He thought that Dr. Stonham had referred to that subject. He meant testing on the lines of the opsonic test of a patient for tubercle.

Dr. JAGIELSKI wished to know something about the causation of fibroids, and particularly of those in younger and unmarried women. He himself attributed the occurrence of a fibroid to inordinate sexual excitement, which frequently took place between young people. Such things led to irregularities and congestion, not only in the uterine sphere, but also all round within the abdomen. Frequently nobody called attention to the danger. Medical men had not only to consider remedial treatment, but also to warn patients that they should be on their guard against such excitement.

Dr. BLACKLEY said that one of the very first cases which he had in his practice in London was that of a lady of about sixty years of age, who sent to him for something quite different from fibroid; he believed that it was gout. After a short time she informed him that she had had an abdominal fibroid tumour from about the age of forty. The presence of the tumour was very evident. It was of about the size of a child's head. The lady was married, but had had no children; she was a woman of intense activity, both mental and bodily, had had a singularly healthy life, and there had been no hæmorrhages. She had been advised that the tumour was not doing the slightest harm, and that when the menopause was reached it would diminish in size. Her experience, however, was, that it did not sensibly diminish. His acquaintance with the lady extended over twenty years, but the tumour did not give the slightest trouble until she was within a few months of her death. Having moved into a suburb of London, she got into the hands of an allopathic practitioner, remaining under his care for about three months, but finally, not liking the change of therapeutics, she sent for him (Dr. Blackley). She was then 84 years of age, and she had shrunk tremendously. She died within three or four months of malignant degeneration of the fibroid tumour. It was very easy to be wise after the event, but he took it that if in this case the tumour had been removed when the menopause was reached the lady might possibly have been spared to a still more advanced age.

Dr. CLARKE (in the chair) said that he could only re-echo the praises which had been bestowed on Dr. Neatby's paper. The paper did not pretend to deal with the therapeutic side of the question, but it merely raised the question whether in the treatment of uterine fibroids we should be guided by the natural history of these growths? This question he (Dr. Neatby) had answered in the affirmative.

Dr. NEATBY (interposing) said that he did not mean the paper to be an affirmative upon that question.

Dr. CLARKE (continuing) said there was one weak point in the statistics contained in the paper, they were allopathic statistics. It was natural that that should be the case, because homœopaths had not collected statistics in the same wholesale way. The question of the degeneration of fibroid tumours was an important one; but he was inclined to agree with the statement of a writer, Dr. Clayton Greene (*Medical Press*, May 23, 1906), that tumours of any kind must be regarded as, in a certain sense, showing a malignant tendency. Malignancy was "instability of

tissue," and all tumour growths showed an "instability of tissue." This was confirmed in his own experience by the fact that almost all tumour cases were benefited by an occasional course of one or other of the cancer nosodes. He did not wait to find out whether a case was cancer or not before he gave cancerous treatment; and he found that a very large number of patients who had neither tumour nor cancer, benefited by cancer nosodes given on the indication of a cancerous temperament. It struck him on that hypothesis they ought to begin this treatment of fibroid tumours rather early. If they did this, they would find that in many cases the tumours would diminish and possibly disappear. They had in this line of treatment an element which might modify their decision as to operative measures. In homœopathy they had the means of preventing cancerous developments as well as of curing them when they occurred. Turning to another aspect of the subject, that of etiology, he might mention that he had seen at least two cases of fibroid tumour which had developed in patients who were the children of syphilitic fathers. Whether this had anything to do with the origin of the disease he did not undertake to say. He had had under his care for some years a lady now aged 77, who came to him with a quite small, but very painful, growth, apparently fibroid, of the body of the uterus, palpable in the suprapubic region. A year or two ago he found in the lower half of the right breast a hard nodule which he had not the smallest doubt was scirrhus. The patient had asked him with reference both to the original tumour and the nodule in the breast whether he could advise an operation, and he had said that he should not. She came of an intensely cancerous family, most of her relations having died of cancer. He believed that she was the only survivor of the family. Since he took her in hand she had improved in health, and neither of the tumours had increased in the smallest degree. The breast tumour had diminished by half, and gave her no trouble whatever, and the glands of the axilla had not increased at all in size. One of the chief remedies which he had given in her case was scirrhinum 100, and another had been muriate of hydrastinin. In his opinion there was not the least necessity to bother the old lady with any kind of operation. Dr. Neatby had given them a very valuable general rule, but that must be subject to modification in any case which was undertaken. He thought that Dr. Jagielski had brought before them a quite important point in the etiology of tumours. He believed that unsatisfied sexual desire had a good deal to do with the development of tumours, especially in the female sexual

sphere. He thought there was some confirmation of this in the action of conium. This was a most important remedy in all cases of ill-heath arising from the cause which Dr. Jagielski had mentioned, and it was also one of their most brilliant remedies in cases of tumour.

Dr. NEATBY, in reply, expressed his gratification by the reception which they had given to his paper and by the thoughtful and friendly criticisms that had been made. He did not wonder that Dr. Dyce Brown and Dr. Clarke had not quite grasped the answer which he intended to give to the question raised at the head of the paper, for the answer was not very clearly set forth. He certainly had not arrived at the conclusion that all cases must be operated upon. They were not justified in being guided by the natural history alone ; but, in deciding as to operation, the natural tendency to complications and degenerations should be allowed to have greater weight than formerly. There were a good many cases on the borderland which might very fitly have the benefit of the doubt and be operated upon. Sometimes when an operation had been delayed it was found that very valuable time had been spent in vain, although at first the symptoms were not definite enough to enable them to say that operation was absolutely essential. Dr. Dyce Brown spoke as if he (Dr. Neatby) had referred to cancer alone; but he mentioned many other complications, both in the tumour itself and in the appendages and the pelvis generally. If they got a fairly uncomplicated myoma in the case of a patient, for instance, who came to the doctor because she did not like her figure, or because there was excessive hæmorrhage, they would almost invariably get an excellent result; whereas, if they delayed operation, it might take the patient two or three years to recover and lead a useful life again. Dr. Watkins had asked whether the post-menopausic hæmorrhage in these cases was regular or irregular. In his (Dr. Neatby's) experience it was usually quite irregular. It would be a big matter to go into the etiology of these growths. Dr. Nield's opinion was one of the greatest weight. He was extremely comforted by what Dr. Nield had said, on account of his thorough knowledge of the materia medica. Dr. Nield, who is a careful clinical observer, had come to the conclusion that myomas were not such innocent things as some people seemed to think. That was the conclusion which he (Dr. Neatby) wanted drawn, and not that they should operate in all cases. Of course, his rough-and-ready rule about young patients and old patients requiring a different standard had to be taken with modifications. He thought that in the first place size was

an element which should guide them. There were very few fibroids which disappeared spontaneously if they reached a height above the umbilicus. He had recorded some such cases which went away, but they must be regarded as exceptional. But largeness of size was a distinctly important item in deciding whether there should be an operation or not. In the next place, age was another and even more important item. Thirdly, rate of growth was still more important. They would, he thought, all recognise that, as a rule, rapidly-grown tumours were the more serious, and especially if they occurred in comparatively young women. Rapid growth of a tumour in a young woman might be taken as a sufficient sign for removal by operation. He thought that Dr. Dyce Brown would agree with him in that. Dr. Dyce Brown and he saw a case of the kind in the hospital the other day. The young woman had practically no symptoms, and she was in good health, but she was operated upon on the ground of rapid growth, and they found an extensive commencing cystic degeneration of the tumour, and an extensive mucoid degeneration of the capsule area—the area between the uterine walls and the actual tumour itself.

JOTTINGS OF OPHTHALMIC WORK IN THE LONDON HOMŒOPATHIC HOSPITAL.[1]

BY A. SPEIRS ALEXANDER, M.D., C.M.

Consulting Physician, and late Physician for Diseases of the Eye, Ear, Nose and Throat to the Devon and Cornwall Homœopathic Hospital; Assistant Ophthalmic Surgeon to the London Homœopathic Hospital.

A LARGE part of the work done in the ophthalmic department of the London Homœopathic Hospital consists in the correction of errors of refraction. This work, though arduous, is a necessary adjunct to the treatment of diseases of the eye, and without the one we should perhaps not obtain the others. That the help given is appreciated by the hospital-resorting public is evidenced by the numbers of patients who constantly flock to this department. Last year the number of attendances was 3,142, of which 959 were new patients.

[1] Presented to the Section of Surgery and Gynæcology, April 4, 1907.

Amid the sustained mental stress involved by the refraction work, it is often a relief to turn to the purely medical cases, and it is to these latter that I wish to direct your attention to-night. The only justification for the existence of the ophthalmic department is that which also applies to the hospital as a whole, namely, the demand of the public for homœopathic treatment, this, in turn, resting on the known success which generally attends on our treatment.

The majority of acute diseases of the eye do unquestionably lend themselves in a remarkable way to our system of therapeutics, and even the more chronic forms, up to a certain point, compare favourably in result with the treatment adopted at ordinary ophthalmic hospitals. The limitation just referred to is where serious structural lesions have occurred, and this more especially in the *fundus oculi*. Even here, however, as I hope to show, favourable results may be looked for in certain cases.

A percentage of failure in the treatment of all disease is inevitable, and in this hospital there is one unfavourable circumstance that must not be overlooked in the consideration of our statistics, which makes the results one obtains all the more noteworthy. What I allude to is that numbers of patients afflicted with chronic disease, after going the round of the other hospitals for months, or even years, without obtaining relief, at length drift round our way, as a kind of *dernier ressort*. Some of these are naturally beyond help, but others are substantially relieved or cured. In what has just been said, there is no thought of detracting from the work done elsewhere, for that is often excellent, and if we think our own results are often better, the reason is simply that in homœopathy we have resources which other hospitals do not possess, or of which they do not choose to avail themselves.

Were ophthalmic disease purely local, it is probable that the methods usually adopted would be all sufficient. Some of the simpler forms are no doubt of this character, and yield readily to local measures. As an example, ordinary recent cases of conjunctivitis may be mentioned, these quickly clearing up after a few applications of dilute solution of zinc sulphate to the conjunctival sac.

The chief underlying cause of eye diseases generally recognised by the profession at large is of course syphilis, and here the results obtained, in tertiary forms, from the iodide of potassium treatment, often leave nothing to be desired.

On the other hand, in cases resulting from congenital syphilis and tuberculosis, we believe that our methods are attended by much more favourable effects than can be obtained otherwise.

There can be no doubt that for the successful handling of chronic ocular maladies, the recognition of the diathetic or predisposing factor is of prime importance, and often leads to cure, where a superficial or empirical view of the case might only result in failure. It has already been stated that the most frequently observed of such diathetic conditions are the strumous or tuberculous, and the syphilitic. Where the characteristic appearances of these dyscrasiæ present themselves, a valuable indication for treatment is supplied, and in such cases substantial help is obtained from the corresponding nosodes, tuberculinum and syphilinum, given in high dilution and at infrequent intervals, in addition to any drug that may be indicated by the general symptomatology.

Here it may be mentioned that not a few eye diseases, especially among young children, are the outcome of bad hygienic environment, with lack of intelligent care on the part of parents or relatives. It not infrequently happens that cases are seen in the out-patient department which might be more efficiently treated were it possible to admit them at once as in-patients, and for this purpose an ophthalmic ward in this hospital is a consummation devoutly to be wished, and one that may perhaps be realised at no distant date.

With these preliminary remarks, I may now ask your attention to a few cases illustrative of the work accomplished from week to week in the out-patient department of the hospital where we are now met, in the hope that the discussion to follow may elicit experiences or suggestions that may be helpful to us all.

The first class of cases I will allude to are affections of the conjunctiva. Of these the mildest form is simple conjunctivitis catarrhalis, often recurring after exposure to cold winds. Patients so affected frequently complain that dust or some foreign body has been blown into the eye, and ask the surgeon to remove it. But examination of the eye-ball and conjunctival sac fails to reveal the presence of any such body, the inflammation not being due to the supposed cause at all, but to hyperæmia of the conjunctiva, which is probably a secondary effect, resulting from an initial contraction of the vessels after exposure to cold wind. Such cases are frequently seen, and yield readily to aconite, and if a local remedy be used, the astringent effect of a one grain to the ounce solution of zinc sulphate may be locally beneficial. Of the legitimacy of such a proceeding from the homœopathic standpoint more anon.

A common practice among homœopaths is to prescribe euphrasia in a kind of routine way for all such cases. This is quite incorrect, as it is not indicated in the simpler forms of conjunctivitis, where there is little local reaction beyond hyperæmia and lachrymation. The euphrasia case is characterised by redness and swelling of the lids, and an acrid, muco-purulent discharge, which may excoriate the parts over which it flows. In these respects this drug resembles arsenicum, but with the latter there is more burning sensation in the eyes, there may be a certain amount of œdema of the lids, and the discharge, though excoriating, is more watery than muco-purulent.

A graver form of conjunctivitis is the purulent, which is often seen in young children of the unhealthy and strumous type, and, for the most part, dwellers in slums. Such cases are often severe, and call for prompt measures for their relief. Where this is not obtained, ulceration of the cornea, and even perforation, with ultimate loss of sight, may take place.

The child is generally carried in in its mother's arms, with eyes firmly closed, and head turned away from the light, which is intolerable, while thick purulent secretion may be seen exuding from the œdematous eyelids. There

is so much photophobia, or dread of light, that blepharospasm results, and it is often difficult to open the eyes sufficiently to obtain a clear view of the eyeball.

CASE 1.—An infant, W. B., aged $1\frac{8}{12}$, presenting all the features just described, was brought for advice on May 14, 1906. The treatment prescribed was that employed with favourable effect in the majority of such cases, and consisted in the internal administration of argent. nit. 6 t.d.s., and the mother was directed to cleanse the eyes thoroughly night and morning with warm water, and thereafter to drop into each a 2 per cent. solution of argyrol. This, as you know, is an organic silver compound, generally considered to be strongly antiseptic, though this opinion, as I shall show presently, is open to doubt. I am rather inclined to believe that in the 2 per cent. solution at least its action is locally homœopathic.

The treatment was carried out efficiently for a fortnight, the child being brought daily to the hospital for that purpose, and by that time the attack, which at first threatened destruction to both eyes, was entirely overcome.

The treatment just described suggests an important question, and one which, on the principle of *agitatione purgatur*, will bear discussion here to-night. The subject in question is as to the use of local applications in ophthalmic and other diseases.

It may be pertinently argued that if the homœopathic simillimum be all-sufficient for the cure of disease, any local measures are uncalled for, as the local manifestations will disappear *pari passu* with the cure of the constitutional state giving rise to the outward signs and symptoms. Such an argument assumes that all disease is constitutional only, and not local, a hypothesis, the full discussion of which is beyond the scope of this paper. The practical question for us is, whether we are to trust to the internal remedy alone, with only the use of such external measures as shall ensure cleanliness, or, regarding a given case as local in so far as bacteria are present in the discharges, to resort to the use of bactericides? The only justification for the employment of the latter would seem to be for the extermination, or to expedite the extermination, of bacteria, which some hold to be the cause of the discharge. Admitting for the moment that this may be the

case—which of course is open to question—do the so-called germicides really exterminate such organisms? In relation to this question, I will quote some apposite remarks by a well-known oculist, Dr. Freeland Fergus, in a recent number of the *Glasgow Medical Journal*:—

"The agar-agar or serum-agar tubes, with the cultivations of the various micro-organisms, afford a tolerably reliable test as to the value of certain remedies. Again and again the colonies growing in these tubes have been for considerable periods immersed in a 15 per cent. solution of protargol, and that without doing them the slightest harm. Mr. Harman points out, and probably truly, that as protargol is a colloid, its powers of penetration are likely to be very small. Quite recently Dr. Fortescue Brickdale wrote an interesting letter to the *British Medical Journal*, in which he said: 'As to argyrol, I cannot speak definitely; but some years ago I investigated the bactericidal properties of collargol, and published the results in the *British Medico-Chirurgical Journal* for 1903. My laboratory experiments led to the same conclusion as those of Dr. Marshall and Dr. Macleod Neave—namely, that the bactericidal action of collargol is practically *nil*. I therefore investigated the clinical literature and was able to collect accounts of forty-four cases. From a critical review of these cases I came to the conclusion that in cases proved to be septicæmia and pyæmia in man collargol had no effect, and that in toxæmic cases the effect was mainly seen in a fall of temperature very similar to that produced by hydrotherapy and certain antipyretic drugs.'

"My own clinical experience has by no means given me the favourable results of which other men speak. I confess I have found the drugs of little service, and they have had a thorough and extensive trial in my hands. Here, for example, is a striking case. A gentleman came with senile cataract in each eye, and also with an inflamed conjunctiva. It was quite impossible to operate on the eyes in the condition which they presented at his first consultation. The matter was delayed for a month, and meantime he was seen every day by his own doctor, who applied a solution of prot-

argol regularly and systematically. By the end of the month the conjunctiva had become considerably more inflamed, and the parasite to which the inflammation was due was much more abundant than it had been at his previous visit. The condition was certainly worse instead of better. What really put that man right was to give up all so-called astringent remedies and to irrigate him thoroughly three or four times a day with a pint of tepid normal saline. A tolerably extensive experience has shown that the best method by which to overcome a pure inflammation of the conjunctiva is saline irrigation.

"Other surgeons have also had disappointing results. Scarcely a week passes but patients come with notes from medical men giving details of the treatment of conjunctivitis, both with the older remedies and with those now so much in vogue. Generally such communications wind up with an expression of great disappointment at the result. Recently a case came under notice in which collargal drops had been used for a period of six months. In such circumstances, one does not know whether to admire the more the faith of the physician or the patience of the sufferer. So competent an authority as Mr. Harman has little to say in favour of the new remedies. Within the last year I have seen a large number of cases in connection with the Workmen's Compensation Act, and in a considerable proportion of these one of the eyes had, in consequence of injury, been removed. Not infrequently the socket was found in a state of chronic suppuration, and that many months after the enucleation. It seems to me that if these drugs really had the value which some of their advocates claim for them, such a state of matters should have been put right within a few days; for in the histories of most of them mention was made of the extensive use either of protargol or of argyrol."

What Dr. Fergus regrets has not been carried out in the case of argyrol has been accomplished for us by Dr. F. Watkins. He has very kindly tested the effect of this preparation, in a 20 per cent. solution, on various bacteria, and reports as follows:—

I find that exposure for half an hour to the 20 per

cent. argyrol completely sterilises the following organisms: *Staphylococcus pyogenes albus, Staphylococcus pyogenes citreus, Bacillus typhosus, Micrococcus neoformans.*

In marked contrast to the unfavourable results recorded by observers of the other school with argyrol are those obtained by ourselves. It is used here in cases of purulent ophthalmia, but always in conjunction with the indicated internal remedy, the effects being then quite favourable. We may therefore conclude, first, that the latter is the potent factor in the cures effected; and, secondly, this being the case, we might probably obtain as good results from the local use of sterilised water or normal saline solution, or any such agent as might secure local cleanliness.

Indeed, saline solution is now being employed in some cases in this hospital, and with favourable results. If local remedies are to be used, they should be either solutions of the same drug that is being given internally, or some simple agent, such as those just mentioned, for the promotion of cleanliness.

By such means only can we be sure of obtaining a pure drug effect; for if we give, for example, arsenicum internally and zinc sulphate locally, and the patient recovers, to which can we attribute the cure? Such a practice seems to me to be as unscientific as it is unhomœopathic.

But to return to the subject of conjunctivitis. Another variety frequently met with in the out-patient department is the phlyctenular. Here again the patients present many of the usual features of the strumous or tuberculous diathesis, which should always be considered in the treatment. It is easy enough, as a rule, to get rid of a given attack, but our measures have likewise to be directed to the correction of the predisposing condition, by which alone can recurrences be guarded against. One great advantage that the patient thus derives from his attendance is that, not only is the ocular manifestation of his tendency overcome, but his general health is substantially improved and fortified against dyscrasic outbreaks in other organs. In a word, the patient, and not his disease alone, is treated.

The symptomatology of phlyctenular conjunctivitis is, of

course, familiar to you. Together with the appearances of the catarrhal type, little pustules, about the size of a pin's head and smaller, are to be seen here and there on the ocular conjunctiva. Sometimes one or more may be situated just at the edge of the cornea, and may even encroach on their structure, and eventually, breaking down, form an ulcer. In other cases, the pustules may assume a miliary character, and may then form a ring round the cornea.

A considerable degree of photophobia and lachrymation usually accompanies all these varieties.

As in all diseases, the appropriate drug treatment must depend on individual indications, but in a general way, the remedy that will prove most usually curative is antim. tart., or, in some cases, antim. crudum. The drugs both possess many eye symptoms of the inflammatory type, but what led to its employment in phlyctenular cases was the analogy presented by its action in skin cases, characterised by pustular eruptions, such as chicken-pox and small-pox. On account of its apparently favourable action in modifying the course of these diseases, it was thought that it might possibly be useful in this similarly pustular affection of the eye. It was accordingly given in a number of cases, and with the happiest results. By way of example, the following cases may here be cited :—

Case 2.—Rose S., aged 15, applied for treatment on May 14, 1906, on account of pain, inflammation, watering of right eye, and dread of light. The conjunctiva was found to be much infected, while, situated on its surface, and near the outer border of the cornea, were three large phlyctenulæ.

Antim. tart. 3x per die was prescribed, and the eye to be bathed night and morning with boracic acid lotion. On the 28th the patient returned, with only traces of the attack remaining. The medicine was continued for a little longer, and then followed up by sulphur 30, which completed the cure.

Case 3.—Was one of the miliary variety in a girl, L. B., aged 12. Here the cornea was surrounded by a zone of minute phlyctenulæ, with the usual accompaniments of inflammation, &c., strongly marked.

The same treatment was adopted as in the preceding case, with prompt and decided relief, so that on June 11 the only remark in the notes is " quite well."

Yet another form of conjunctivitis, but less frequent than the former, is the membranous or croupous. There, in addition to the usual appearances of purulent conjunctivitis, a fibrinous membrane may be found adhering to the palpebral conjunctiva, and the ocular may also be affected, though to a less extent. It closely resembles the exudate of diphtheria, but is distinguished from that membrane by the absence of the Klebs-Lœffler bacillus.

Case 4.—A typical example of this disease was brought to the hospital on April 19, 1906. The patient was an infant of 3 months, with a history of acute inflammation of right eye, with purulent discharge of a week's duration. On examination, nearly the whole of the palpebral conjunctiva of the lower lid was found to be covered with an opaque greyish membrane, and there was also a small patch on the upper lid. The cornea was clear. A small patch was also found on the left upper lid. A swabbing from the lid was sent to Dr. Watkins for investigation, and he reported as follows: "Cultivations made and incubated for fourteen hours show only a very scanty growth, consisting of short bacilli, usually arranged as diplococci, and some of which are surrounded by a halo. The bacilli have rounded ends, and are thickest in the middle. No clubbed forms are seen; they all stain uniformly and deeply—no polar staining.

"These are not true diphtheria bacilli, but are probably xerosis bacilli, or possibly the pseudo-diphtheria bacilli. The only reason for supposing that it is possible that they are not xerosis bacilli is the fact that their growth is rather rapid for this form of organism."

The result of treatment in this case was rapid and decided. Argent nit. 3 was prescribed internally, and argyrol 20 per cent. was applied once a day for two days to the conjunctiva. Thereafter, lot. hydrarg. perchlor. 1-5,000 was used locally every four hours. On the 23rd the membrane had disappeared entirely, the discharge was lessening, and both eyes were very much better. Three days later the statement in the notes is that the condition is now practically well, only a little injection of the palpebral conjunctiva remaining.

Cases of the different forms of conjunctivitis might be multiplied *ad libitum*, but the foregoing will suffice to illustrate the types generally met with.

There is a different form of ailment in which the con-

junctiva is involved, and which somewhat resembles phlyctenular conjunctivitis, but which properly belongs to the underlying structure, and is known as episcleritis. It is characterised by the occurrence of inflamed nodules of a somewhat dusky hue, for the most part situated over the insertion of the recti muscles, more particularly over that of the external rectus. These swellings are distinguished from phlyctenulæ by the circumstance that the conjunctival vessels run over their surface, while in the latter the vessels lead up to and are merged with them. The usual symptoms of vascular injection and lachrymation are present, though often to a less extent than in conjunctivitis, and there is much less photophobia. The ailment is one of adult rather than of child life, though children also suffer from it.

Case 5.—G. R., aged 14, was seen on September 29, 1906, on account of an attack of this character. In addition to the symptoms mentioned, she complained of pain in the eyes, which was referred to the spots in each eye where the nodules occurred. This is a feature very generally noticeable in such cases. Antim. tart. was at first prescribed for this patient, but without much apparent effect, except that the pain was somewhat lessened. On October 11 the prescription was altered to thuja 3x, this medicine being thereafter continued at intervals till January 24, 1907. Under its influence steady but rather slow improvement took place, the nodules with their attendant pain and inflammation gradually disappearing, till, on the last date mentioned, all were gone, and the patient was thereafter put on sulphur 30 and dismissed, cured.

One of the maladies most frequently claiming attention at all ophthalmic clinics is keratitis, or inflammation of the cornea. Of this affection there are several varieties, some overlapping each other more or less; but perhaps the commonest is interstitial or parenchymatous keratitis, and it is of this that I wish now to speak shortly. Like many other ophthalmic conditions, it appears for the most part in the subjects of congenital syphilis, and of the tuberculous diathesis, as well as in persons of weak constitution generally.

The disease is marked by inflammatory infiltration of a larger or smaller area of the corneal lamellæ, sometimes near the periphery, sometimes in the central portion. The surface of the cornea loses its translucent appearance, be-

coming steamy and opaque, with a yellowish discolouration in the spots where the infiltration is thickest. With some cases there is marked pericorneal injection of the ciliary vessels, intense photophobia and lachrymation, and supra-orbital or ciliary pain. In others, however, these concomitant symptoms may be almost absent. Where the deep layers of the cornea are affected, the iris and ciliary body are also liable to be involved.

The disease is apt to run a slow and tedious course, lasting in some cases for several months, and the patient is prone to relapses from time to time. In the end, however, full recovery and restoration of vision may be looked for in a large proportion of cases.

The all-important question of treatment depends partly on the individual factors of each case, and partly on the etiology. Where there is a family history and the usual manifestations of specific disease, such as Hutchinsonian teeth, the nosode syphilinum, in infrequent doses of the 200 c. dilution, is of the greatest possible value, and often leads to the clearing up of old-standing and obstinate cases, which have long resisted the more usual methods of treatment. If the diathesis seems to be of the strumous type, tuberculinum, given in the same way, is an important adjunct to other medication.

Cases of both these types, as already mentioned, are often tedious, and present various fluctuating symptoms, becoming sometimes better and sometimes worse, and necessitating modification of treatment according to the condition at each visit.

Case 6.—Such a case was that of F. F., aged $9\frac{6}{12}$ years, who applied for advice on February 6, 1905. The eyes, more especially the right, had been inflamed since Christmas. The cornea presented the usual steamy appearance, with ciliary infection and watery discharge. There was but little pain, but some dread of light, so that it was difficult to open the eyes.

The treatment at first adopted was the internal administration of merc. sol. 3x, with atropine grs. ii. ad. ʒi locally. At the next visit, on February 20, the left eye had cleared up, but the right was much worse. In addition to the foregoing measures, ung. hydrarg. oxid flav., grs. ii. ad. ʒi, was ordered for application to the

right eye. By this means both the internal and local effect of mercury was invoked. Treatment on these lines, with sulph. 6 and calc. carb. 6 given intercurrently, was maintained till September 14, when the case is reported to have come to a standstill, and the prescription was altered to syphilinum 200 once a week, with sac. lac. night and morning. On October 12 a marked change for the better had set in, and seemed to follow promptly after the above change of treatment. This improvement was maintained, and on November 9 a very decided advance was recorded, the cornea being found to be clearing up, and the patient beginning to read again. On January 22, 1906, the eye was still clearer, only a slight nebula showing in the cornea.

The patient was seen again later in the year—in the month of August—on account of another acute attack of a similar nature, with ciliary injection and haziness of the cornea. It was much less severe, however, and soon cleared up under merc. corr. 3x, followed by aur. iod. 3, and on September 6 the eye had entirely recovered.

The chief point of interest in this case then is that, after the usual mercurial treatment had failed to give relief, rapid improvement and ultimate recovery took place after the exhibition of syphilinum.

The next three cases to be briefly described are examples of ulcus corneæ, and are cited chiefly to demonstrate the action of different remedies in this as in other conditions, selected in accordance with the individual characteristics of each case. There is no one remedy for a given disease. The remedies may be as diverse as the symptoms, and the true simillimum must be chosen before real benefit can be expected. Corneal ulcer results, as you are aware, from a circumscribed inflammation of a given area of that structure. The affected part becomes infiltrated with leucocytes, and the epithelium, underlying lamellæ and Bowman's membrane breaking down, an ulcer is formed. Healing is affected by epithelial cell proliferation, and the formation of new connective tissue at the base of the ulcer. The newly-formed tissue, however, is never so transparent as the original, and hence, where the affected area is central, vision may be permanently impaired.

The usual accompaniments of pain, pericorneal inflam-

mation, photophobia and lachrymation are often present to a greater or less degree, but in some cases may be almost absent. The concomitant symptoms are those which give valuable help in the selection of the appropriate remedy.

Case 7.—K. B., aged 2. First seen March 22, 1906. In this case there was a small ulcer, and in addition to the usual symptoms, a good deal of muco-purulent discharge. The prescription was merc. cor. 3x t.d., and the eye to be irrigated with lot. hydrarg. perchlor. 1-6,000. The following week a decided improvement had set in, and the treatment was continued. On April 2, however, the patient had become much worse again, there was much purulent secretion and intense blepharospasm. The treatment was now changed to argent nit. 6 t.d. and argyrol 2 per cent. locally, and with a very favourable result, so that a week later the child was so much better in every respect that no further attendance was necessary.

It has been stated that corneal ulcer may occur with only very slight inflammatory reaction, so that the patient suffers but little inconvenience. In cases of this kind, the remedy most generally indicated is kali bichrom.

An example of its action was afforded by

Case 8.—B. P., aged 22, seen on August 2, 1906, on account of two small ulcers on the left cornea, which she had had for a year, with some ciliary injection, but no photophobia, and but little watering. The patient received the drug mentioned in the 3x dilution, with lot. ac. borac. locally, and continued taking it till October 25, when the eye is reported to be better than it had been for twelve months. Sulphur 3 was now prescribed, and this improvement continued till December 20. On that date merc. corr. 3x was given on account of vascularisation of the ulcer, and under its influence healing was completed, so that, on February 14, 1907, only a nebula remained.

In contrast to such cases, others may be seen in which, with a minute ulcer, the photophobia is out of all proportion to the local appearances, being intense in character, with pain, lachrymation and blepharospasm. Here conium mac. is often of great value, and was the remedy given in

Case 9.—J. M., aged 16, who came on January 6, 1906, suffering from a small ulcer on the left cornea, with the severe concomitant symptoms just described. In this case the effect was very

striking, for in a week the inflammatory symptoms had disappeared, and the ulcer was found to be healing. By the 26th recovery was practically complete, and the patient ceased to attend.

Case 10 is one of rheumatic iritis in a man, E. G., aged 37, and seen on February 22, 1906. He had been under treatment on account of it at an ophthalmic hospital for four months without any benefit.

He complained of pain in the right eye, the iris of which was turbid, and slight posterior synechiæ were present. There was the usual conjunctival and ciliary injection, and a small phlyctenule at the inferior border of cornea. Atropine had been used as a mydriatic, and had caused a local eczema. On this account duboisia gr. 1 ad. ʒi. was given locally, and rhus tox. 12 t.d. internally.

The effect of treatment was soon manifest, as on March 8, but little inflammation remained, the phlyctenule had disappeared, and the whole condition was much better.

By April 5 the right eye had practically cleared up, but now a slight similar attack had occurred in the left eye. The same treatment was pursued as for the other, and with a like result.

From time to time marvellous accounts are to be met with in homœopathic literature of the radical cures of cataract by medicinal means. Such reports may no doubt sometimes be authentic, but should be received with a due amount of reserve, for such results are, like angel's visits, few and far between. And it must be borne in mind that certain forms of cataract do sometimes clear up spontaneously, with full restoration of sight. I once saw a patient with well-advanced cataract in both eyes, and after a long course of calc. carb. one eye cleared completely, though no impression was made on the other. I never could satisfy myself that this case was not an example of spontaneous cure.

The drug that has been credited with most activity in this direction is causticum, though I have not met with any record of it having produced an actual opacity of the lens. Such an action, however, would not be a necessary condition to the cure of that condition by the drug, provided it can be shown that it has set up any degree of lenticular obscuration, which, if continued, might eventually lead to opacity. Symp-

toms highly suggestive of this action are recorded in the "Chronic Diseases," vol. iii., p. 92, where "obscuration of sight, as if a gauze were drawn over eyes," is mentioned, and also "dim-sightedness, as if a thick fog were before the eyes."

The drug has been prescribed in a good many cases here, but though some patients taking it have remained *in statu quo*, so that it may have arrested the growth of the cataract, yet I am not aware that any case of actual cure has been recorded as a result of its action.

Case 11, that of W. M., aged 24, may be of interest as one example of the effect of medical treatment on traumatic cataract. This variety is generally regarded as incurable, and unsuitable for operation, but the present case seems rather to redeem it from that hopeless category. The patient was seen on February 5, 1906, having already been treated by a private doctor for about seven years, but without any improvement. The cataract had developed eleven years previously, as the result of a blow on the right eye. No fundus reflex was present, but he could discern objects dimly.

The first prescription given was based on the etiology of the case, and was arnica mont. 30 t.d. This was continued till April 30 following, when, no change being apparent, it was altered to silica 30. On May 28 the patient stated he could see a little better, especially in fine weather.

July 2. On this date the cataract is reported to be looking decidedly thinner at the edges, especially on the nasal side, and the patient was now able to make out fingers at six inches.

August 13. There is now a little light reflex perceptible at the upper border of cataract, and fingers can be counted, especially toward the nasal side, at about six inches distant.

September 17. Fingers can now be counted at about nine inches, and in any direction. The fundus reflex is clearer at the upper border, and there is also a slight reflex at nasal side.

Silica was continued steadily, and on November 17 clear patches were found to be appearing at intervals round the pupil, in the shape of little apertures in the opaque lens, through which the fundus reflex was clearly perceptible.

On February 18, 1907, the patient was able to see all the fingers and the whole hand at about eight inches quite clearly, and better inwards and upwards. He is still under treatment,

and his progress so far gives ground for the hope of eventual full recovery of sight.

The next two cases to be recorded are of retinitis hæmorrhagica, so called, though it might be more correct to speak of them as retinal hæmorrhage.

Case 12.—J. C., aged 60, came for advice on account of severe pain in the right eye, with dimness of vision. There was also much pain extending from the nape of the neck, and over the occiput toward forehead and eyes. The conjunctiva and ciliary region were inflamed, and the pupil too contracted for satisfactory ophthalmoscopic observation. Under homatropin, the vitreous appeared hazy, so that no clear view of the fundus could be obtained, and a large opacity was seen to be floating in it. Vision with glasses which had formerly corrected the patient's hyperopia, was now reduced to $\frac{6}{24}$.

In the prescription given to this patient, no account was taken of the pathological condition of the eye, the treatment being based on the characteristic subjective symptoms, which indicated actæa. rac., which was accordingly given in the sixth dilution thrice daily.

A fortnight later the patient reported that the pain was entirely gone, but also said the medicine has caused dysuria. On leaving it off the latter had subsided. He then mixed two drops only in a tumbler of water, taking a dessert-spoonful thrice daily, without any return of dysuria. The haziness of the vitreous was now found to have cleared up, and the floating opacity was no longer present. The fundus oculi being now visible, numerous small hæmorrhages were observed in the upper hemisphere, their flame-like shape and distribution suggesting the nerve-fibre layer of the retina as their probable site. The medicine was continued, and on February 15 the eye looked and felt well, and not only so, but vision had now increased to $\frac{6}{6}$, or the normal standard, with the aid of the glasses that had been previously worn.

Case 13.—A. S., aged 50. Seen June 11, 1906. This patient complained of constant and severe headache, worse on attempting to use the eyes, with much dimness of vision, especially of the left eye, with which the distance test types gave only $\frac{6}{60}$. Under homatropin a diffuse hæmorrhage was seen in the upper part of retina, and spreading over towards the macular region. Lachesis 6 t.d. was prescribed.

On June 24 no improvement of sight had taken place, and there had been much pain in the affected eye. The urine was tested for albumen, but was found to be free from it.

In the absence of very characteristic subjective symptoms, and in contrast to the preceding case, the probable pathological condition, namely, arterio-sclerosis, as the most likely cause of the hæmorrhage, formed the basis of the prescription now given, which was merc. cor. 3x t.d.

The effect was favourable, for on July 9 the hæmorrhage was seen to be clearing away, the pain in the eye was no longer felt while indoors, but only in the open air. The sight had improved, being now $\frac{6}{12}$.

July 30.—There is constant aching in the upper part of both orbits. Sight remained as on previous visit. Sulph. 6 t.d. was now given and continued till August 29, but without any perceptible effect. The pain over the eyes persisted, and was constant. Ruta. grav. 3x t.d. was accordingly ordered, and with rapid and marked effect. On October 8 the patient said she felt much better, and that hardly any pain remained. There was also a very striking improvement in sight, which had now advanced to $\frac{6}{6}$ letters. Sulph. 30 n. and m. was prescribed, and on November 5 the report is: Quite well, fundus normal.

Case 14, the last with which I shall trouble you, cannot be claimed as a triumph for homœopathy, but exemplifies the importance of the etiological factor in the treatment of disease.

The patient, W. M., aged 43, had attended an ophthalmic hospital for seven months, on account of dimness of vision of the right eye and diplopia. All that appeared to have been done for him was that he had received drops for the eye, and the pupil being dilated, these were presumably atropine.

On examination, on November 29, 1906, no change was discoverable in the media or fundus, but it was noticed that while convergence was normal, there was no power of abduction beyond the middle position of the eye. Paralysis of the external rectus muscle was therefore diagnosed, and the patient admitting an attack of syphilis twenty years previously, it seemed probable that the former was due to a gumma somewhere in the track of the sixth cranial nerve. Kali iod. grs. v. t.d. was therefore ordered, and eserine gr. i. ad. ʒi., to be dropped into the eye to antidote the mydriatic effect of the atropine that had probably been used.

On January 3, 1907, a very distinct improvement was observed. The eye could now be abducted beyond the middle line, and there was no diplopia.

On January 24 recovery seemed almost complete, the power of abduction being practically restored, and the pupil again responding to light.

In conclusion, I have only to say that in these jottings, in addition to the cases for which I am personally responsible, I have drawn freely from the notes of former workers in the ophthalmic department, and in particular Mr. Knox Shaw was good enough to place his records at my disposal.

Dr. JAGIELSKI said that they were all very grateful to Dr. Alexander for showing that homœopathy was capable of producing excellent results in the treatment of eye diseases. What had interested him particularly was Dr. Alexander's point in connection with cataract. They knew that Dr. Burnett had produced a very valuable book on cataract which had not been surpassed, and he was sorry Dr. Burnett did not get all the credit that was due to him. There was a lack of recognition of the cataract disposition in patients, who also were gouty and rheumatic subjects, in consequence of which cataract afterwards came on. He (Dr. Jagielski) had himself published several cases which he had seen. One case was that of his own father. He took his father from Poland to Berlin for treatment for cataract, and it was said that the patient must wait until the cataract had matured. It was a very poor consolation to a patient to wait—it might be a year or two longer—till he got quite blind. His father, however, underwent homœopathic treatment, and the cataract got well. Excellent results could be obtained from homœopathic treatment if the case was taken in time.

Dr. GOLDSBROUGH said that the paper was full of points worth considering. He had used nitrate of silver in ophthalmia neonatorum, and nearly always found it successful. He gave it internally, and used a lotion of one in ten thousand. Dr. Alexander had remarked that there was a question of whether silver nitrate acted as a homœopathic remedy, or simply as a remedy in the way of cleanliness. He had always regarded it as homœopathic. Of course, the solution was made with distilled water. The cases cleared up without leaving behind any serious trouble. With regard to phlyctenular conjunctivitis, he had found mercurius biniod. successful, without any local application at all. He had also one case of the membranous form of conjunctivitis, which yielded quickly to kali bichromicum. Last year he had a case of episclerotitis, where cinnabar did no good. The patient simply used fomentations of hot water. She was 60 years of age, had had bulbar hæmorrhage, and recovered under baryta; but baryta had

no effect in the eye inflammation. As to keratitis, especially when it was strumous, he had treated it very successfully with calcarea and arsenicum given in alternation. When he began out-patient work at the hospital, there was a case of very severe inflammation which had been under Dr. Clarke, and which came back to him (Dr. Goldsbrough), and which yielded very quickly to these remedies. In all forms of inflammation of the eyes, homœopathic treatment was eminently successful; and, if they wanted to demonstrate that fact to men who were sceptical, they could not do better than bring them to the ophthalmic department of the hospital and allow them to watch the cases going on. Of course the greatest care was needed in diagnosis, and also in guarding against complications such as were met with in iritis and hæmorrhages or glaucoma. A case came to the hospital that afternoon in which the diagnosis, as far as eye trouble was concerned, had been quite neglected. The patient came to him with neuralgia of the left eyebrow. It was his practice to examine the eyes in every case of neuralgia or nerve trouble which came to the out-patient department; and, in this case, he found on the right side that there was no image reflected from the fundus at all. Some time ago the patient's doctor had treated her for neuralgia, without taking any notice of the condition of the eye at all. There had been vitreous hæmorrhage, which had completely destroyed the patient's sight on the affected side.

Dr. GRANVILLE HEY joined with previous speakers in saying that, if there was one part of the hospital which showed what homœopathy could do, it was the ophthalmic department. Dr. Alexander had referred to a constitutional condition, such as syphilitic keratitis. Of this disease two cases had come under his (Dr. Hey's) notice recently. One, a young man, had been coming to the hospital for a considerable time—years, he believed—without any marked benefit until he was put under syphilinum, when he began to improve at once. The other was the case of a girl, the youngest of a large family, and the only one of the family affected with congenital syphilis. She had been attending the surgical out-patient department, and Dr. Beale sent her in to the ophthalmic department because of some inflammation about the eyes. He had been treating her for syphilitic disease of the left femur. She was almost blind. There was perforation of the palate, no bridge to the nose, and very marked syphilitic keratitis. He (Dr. Hey) found that syphilinum had not been tried. She was put on that remedy, and the case went on splendidly. In strumous cases also, *e.g.*, cases of tubercular conjunctivitis, the

success of homœopathic treatment was seen. He had been interested in what Dr. Alexander had said about collargol and protargol. It was interesting to hear that strong solutions of these silver salts did not do any good in the cases referred to; and yet, in early gonorrhœa, injections of 2 per cent. protargol would cause all the symptoms to disappear rapidly. It would be interesting to know how, in one case, they got results, and in the other they did not. With regard to collargol, he found in Vienna that in cases of septicæmia, they injected 10 cc. into the blood vessels, and got excellent results.

Dr. SPEIRS ALEXANDER thanked the meeting for the reception which had been given to his paper. The object which he had in preparing it was to show that the work done in the Homœopathic Hospital was a good example of what homœopathy could do in ophthalmic cases, and to contrast that practice with what was done in other hospitals. As he had pointed out incidentally, some of the patients who came to the Homœopathic Hospital had for months been going the round of other hospitals; and that although the same local applications might be employed here as in other hospitals, for the purpose of asepsis and so on, yet, directly the patients got the indicated homœopathic remedy, a good result was obtained. The investigation that Dr. Watkins had made for them was, he thought, very valuable in that way. If protargol and collargol were powerless, yet argyrol had the power of sterilising the various organisms which one met with; and it followed that if the Homœopathic Hospital got results, and the other hospitals did not get results with the same local agents, those of the former must be attributed to the homœopathic treatment used in conjunction with it.

ON LATENT GOUT AND ITS IMPORTANCE IN RELATION TO PROGNOSIS AND TREATMENT.[1]

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GENTLEMEN,—In choosing the title of my paper for this evening I use the term "latent gout" in preference to the much misused one of "suppressed gout" for two reasons.

[1] Presented to the Section of General Medicine and Pathology, May 2, 1907.

First and foremost, for the reason that one is constantly appealed to by patients with gouty family history, who have nevertheless at no time had an attack of arthritic gout, who may indeed live to the end of a long life without such an attack. Here, manifestly, there is no question of *suppression*. Secondly, for the reason that these patients, in common with those who may have had very occasional attacks of unmistakeable arthritis, are, during the intervals, prone to certain ailments rather than to others, and that one's prognosis and treatment must be influenced accordingly. The prognosis—because I, for one, hold it as practically established that gout, when it comes, comes to stay, and what is true of gout itself is equally true of a large proportion of ailments occurring in gouty subjects. They may by treatment be kept within reasonable bounds and even disappear from time to time until something occurs to disturb their repose, and they emerge from their concealment. In such patients many very ordinary ailments will steadily defy treatment by ordinary remedies unless we interpose with one or other of a limited number of drugs which long experience has shown to have the power of lifting the patient out of the rut as it were, and to have, in fact, what used in my student days to be called an *alterative* effect.

The part played by heredity in the perpetuation of gout is so well known that it has become axiomatic, and need not be further insisted upon here. When we speak of the hereditary nature of gout we mean, not that every child of gouty parents is of necessity born gouty, but is predisposed to gout; is in fact *potentially* gouty. Every ailment arising during the life of such an one is not gout, but there are certain maladies which are so frequent in their incidence, to the exclusion of others, that one is driven to the conclusion that here there is a something in the background which "shapes our ends," and nature is not left free to "rough-hew them as she may." Let us sketch rapidly the life-history of a child born of gouty parents and see what these affections are.

In early infancy, although such a child may be in other respects singularly healthy, we are struck with the frequency

with which it suffers either from eczema or its first cousin impetigo. We all know this unfortunate child, with its oozing or bleeding mask, the head never still for a moment, but boring by day into its nurse's arms, and at night during sleep into the pillow. With regard to impetigo it will be objected that it is due to a pathogenic microbe, but microbes require a congenial soil, and this they apparently find in the skin of an arthritic child as certainly as in that of the so-called scrofulous one. During later infancy the same child is prone, on very slight provocation, either to tonsillitis, with very high temperature, or to respiratory catarrh, *i.e.*, chill, coryza and bronchitis, each very acute while it lasts, but soon over. Should eczema still be present, it is apt to alternate with asthma. Urticaria, too, is a common ailment at this period; here, again, one is at once struck with the robust appearance of the children whose lives are often made a burden to themselves and to those about them by this veritable scourge of infancy.

From the twelfth to the fifteenth year acute articular rheumatism is frequent; the micrococcus of rheumatism evidently finds a suitable nidus in the joints of the potentially gouty child. At puberty migraine and epistaxis are very common. If, during early manhood, the patient contracts gonorrhœa, this is apt to be followed by intractable blenorrhœa, which not infrequently lasts a life-time. I have been struck, too, with the frequent occurrence of gonorrhœal rheumatism and infective endocarditis in young men of gouty parentage.

From the twenty-fifth year onwards certain skin affections are apt to declare themselves. Of these the commonest is perhaps eczema of the fingers, mostly symmetrical; at first it is vesicular, then desquamating, and often characterised by deep and painful fissures. Intertrigo in the groins or axillæ is also frequent. The common feature of all these skin affections is that they occur most frequently in the spring and disappear during the summer, and this may go on year by year for long periods.

About the thirtieth year dyspepsia begins to be experienced. It is usually of the type which is accompanied by distension, eructations, constipation, and much flatulence.

Digestion is unusually slow, and I find that such patients are often most comfortable when subsisting on two meals a day. Lithuria is a constant symptom, as is likewise pruritus ani, which often makes life a burden. Bleeding piles, too, are very apt to occur at this age, or glairy discharge from the rectum, which excoriates the skin around the anus.

As an alternative to dyspeptic troubles, the patient may develop a tendency to bronchial catarrh; this is often complicated by asthma, and has a tendency to become chronic. Should he contract influenza, such a patient suffers much more than a non-gouty one. Granular pharyngitis, commonly met with in smokers, but not confined to them; amygdalitis often terminating in quinsy, migraine or congestive headaches, and furunculosis (with its attendant oxaluria) are characteristic of this period of life. Seborrhœa and pityriasis of the scalp, with sweaty head and premature baldness, are also of surprising frequency. After a few years of more or less constant dyspepsia, the latter as a rule tends to become permanent, or at least intermittent, and the patient does not usually give one much help in avoiding such a contingency. In spite of the fact that the tongue is large and dirty, and that he constantly complains of a bitter taste in the mouth, this patient's appetite remains good, or even excessive, at any rate during the earlier part of the day. He is in fact distinctly a large eater. As a natural consequence of this, we are quite prepared to be confronted before long with liver troubles. These are chiefly functional, and consist of severe migraine, with supraorbital neuralgia, anorexia, malaise in the right hypochondrium an hour or two after meals; feeling of bearing down at the anus; slight yellowness of skin; urine rich in reddish-brown pigment, and very easily influenced by food. About this time, too, slight arthritic symptoms are apt to be present, so slight indeed as to be frequently overlooked by both patient and doctor until followed by unmistakeable nodosities and tophi. To this period also belong gall-stones, renal calculus and diabetes, or, more strictly speaking, glycosuria.

At or about the age of sixty, attacks of false angina may

occur; heart changes leading up to asystole, and chronic interstitial nephritis may, one or both, supervene, unless the condition is relieved by an occasional attack of acute gout.

The patient's character, meanwhile, suffers somewhat severely. He becomes irritable and impatient, and loses his power of mental concentration. Vertigo, accompanied by vomiting, sometimes so severe as to resemble "Ménière's disease," and noises in the ears, chiefly of a buzzing or hissing character, serve, in old people, to make them weary of life.

Such is a rather lengthy sketch of the natural history of the demon gout, who is always lurking in the background, seeking to corrupt the morals of the most harmless of ordinary ailments.

Some extracts from my case-books may perhaps serve to bring out some of the points above enumerated.

Case 1.—Chronic catarrh—nasal, bronchial, gastric, and intestinal—neuralgia and eczema.

Mr. M., a retired stockbroker, came to me first in 1899 at the age of 70. He is a strict Jew and of very spare habit, weighing barely ten stone. Has always been very abstemious and careful in his diet. Father had gout. He himself has never had gout, but a few joints are distinctly nodose.

When first seen his chief complaint was supraorbital neuralgia, which, as it was associated with very profuse nasal catarrh I ascribed to blocking of the frontal sinuses. He had, at the same time, a few small patches of dry eczema on the shins. Since 1899 he has suffered in turn from catarrh in one or other form, but most of all with rectal catarrh, accompanied by severe pain in the hypogastrium, and associated with slight fissure and pruritus. The urine has been free from albumen and sugar, but constantly deposits red sand and oxalate of lime crystals. The drugs which have helped him most have been lycop., ignatia, arsen. and opium. Occasionally gastralgia was only to be allayed by salicylate of bismuth.

Repeated visits to Harrogate, Llandrindod, and Eaux Bonnes have resulted in no permanent relief to any of the catarrhal manifestations.

Supraorbital and frontal headache are now always relieved, at least for the time being, by 0·5 gram doses of aspirin. The pain in the hypogastrium is best relieved by small doses of heröin.

Case 2.—Intestinal catarrh.

Miss P., aged 61, comes of a gouty stock, but has never had any pronounced arthritic attacks, although she has deformity of several of the finger joints. She is of very spare habit, weighing barely eight stone, and has always been a total abstainer. Came to me in 1898 complaining of constant looseness of the bowels; stools when formed being of very small calibre. This condition of matters has continued with intermissions until the present, but usually yields slowly to verat. and arsen.

In March, 1904, came to me complaining of much pain and tenderness over the left sacro-iliac articulation and in both knees, which were very stiff in the morning. Sulph. 3 and later ledum were given. In June she spent a month at Aix-la-Chapelle, and came back very much improved in every way.

In 1905 began to complain of pain in left iliac fossa, especially after any little chill, the pain being followed by sickness and diarrhœa, the stools pale and containing mucus. Weight stationary. Digital examination afforded no special information. Hydrast., arsen., lycop., and ac. nit. all failed to give more than very temporary relief. In January last these attacks of relaxation began to alternate with constipation, during which the old pain in the sacro-iliac joint was very much to the fore. Bryon. gave a little relief, but the patient was obliged to walk in a half doubled-up position. I then bethought me of aspirin, giving 0·5 grm. t.d., with the result that the patient presently wrote for a fresh supply and proclaimed herself freer from discomfort, and better in every way than she had been for a long time.

Case 3.—Catarrh of the lower bowel.

Miss W., private secretary, aged 58, one of a large family, two of whom suffered from psoriasis, one from eczema, and one from gall-stones. Mother was distinctly gouty, and had occasional eczema. Patient has never had gout or any skin affection. Is very thin, but not losing flesh.

Came to me in 1898 complaining of constant mucous discharge from rectum, with stools of very small calibre. On rectal examination no obstruction could be made out, and a full-sized rectal bougie passed without difficulty. Hydrastis and arsenicum were given steadily for a week at a time, and afforded much relief, though the catarrh never disappeared entirely. Since 1899 the patient has had several attacks of influenza, which have caused much nervous prostration and serious heart weakness, but during the time that these have lasted the rectal catarrh is always in abeyance.

Case 4.—Bronchial catarrh; mental depression.

Mr. H. S., aged 65, American and a quaker, of no occupation. Has never had gout, but a brother, now dead, was repeatedly under my care with acute gout. Before consulting me this patient had for twelve years suffered much from depression of spirits and inability to concentrate his thoughts, and had been obliged to travel constantly and to lead an idle life. In 1897 he had a very long convalescence under my care from influenza. Many drugs were given at first, but the one which finally became our sheet anchor was lycopodium 3. In 1901 had bronchial catarrh with asthmatic attacks, during which time he was absolutely free from the depression usually present, and was decidedly more capable of sustained mental effort. The only drug he took during the attack was senega ϕ.

Case 5.—Spasmodic asthma.

Miss N., aged 48, first seen in 1900. Mother living, aged 80, very stout, and has occasional attacks of acute gout. Daughter, who has never had gout, is also immensely stout. Has suffered from asthmatic attacks in the winter for several years. I treated this patient during two severe attacks occurring in two successive winters with very satisfactory results, the drugs used being largely emetin. 4x and arsen. 3x, usually given on alternate days.

Since 1901 the patient has paid several visits to the arsenical waters of Mont Dore, with the result that the winter following has usually been fairly free from asthma. This was the case last winter, although she is still increasing in weight; has had an attack of retinal hæmorrhage in one eye and has a fibro-myoma of uterus.

Case 6.—Asthma; neuralgia.

Mr. A., aged 53, solicitor, of Jewish descent and bilious temperament. Father suffered with asthma and mother from gall-stones. Patient has had attacks of spasmodic asthma from the age of puberty, and has in consequence been obliged to live in the heart of London, a night spent at Brighton or St. Leonards being invariably followed by threatenings of an attack. This patient is particularly susceptible to the influenza bacillus, and after an attack has always a long convalescence. On one occasion influenza was followed by severe neuritis of the posterior tibial nerve, which lasted for many months, during which, however, he was free from asthma, although six weeks of the time were spent at Harrogate. This may possibly be explained by the fact that he was taking arsenic most of the time in addition to undergoing

bath-treatment at Harrogate. He now goes every year. Since the commencement of 1903 he has suffered much from left supra-orbital neuralgia with discharge of much thick yellow mucus from left nostril. Sense of smell is gone. Sulphur relieves the neuralgia.

Case 7.—Neuralgia.

Mr. A. W., publisher, aged 52, was treated by me for syphilis about the years 1880-85. Has had several attacks of acute gout. Has been practically a total abstainer for many years past. In May, 1902, came to me complaining of right supraorbital neuralgia, coupled with slight giddy attacks, which appeared to proceed from left parietal region. ℞ Sod. iod. gr. iii. t.d., and gelsem. ϕ night and morning. At the end of a fortnight he began to have some gouty twinges, and the urine was scanty and hyperacid; gelsem. was replaced by lycopod. No arthritic attack ensued, and at the end of six weeks the only symptom left was described as a "swimmy" feeling in the head, especially on stooping. This was promptly relieved by ac. picric, a drug which experience leads me to regard as specially useful in many neuroses in gouty patients. He now has occasional attacks of acute gout, and is fairly free from headache or giddiness.

Case 8.—Lichen circumscriptus.

Mr. A., a Sheffield steel manufacturer, came to me in 1901 for advice for a lichenous rash which had tormented him for some years. The patient was a small man of bilio-sanguine temperament and great mental and physical activity. Family history was gouty, but he personally had never had gout. The legs, buttocks and arms presented numerous circumscribed patches of lichenous rash which were intensely irritable. I advised a sojourn at Ilkley for the sake of its pure water and air, but as the patient had made all arrangements for going to Harrogate for a course of treatment I allowed him to go.

At the end of about a month he again presented himself, the rash being, if anything, more irritable, especially on the arms, which were always at their worst at night. I prescribed phenazone 1x, gr. i. *ter die*, and the local application of a liniment of chloral and camphor. Improvement began at once and proceeded steadily. I have usually found that patients with a gouty strain in them are particularly susceptible to the effects both of large and of small doses of antipyrin.

Case 9.—Psoriasis.

Miss G., aged 40, of nervous temperament, was sent to me by Dr. Byres Moir in 1895 on account of psoriasis. The patient's

family history was distinctly gouty, but she had never had any distinct arthritic attacks herself. Under the treatment suggested by me, chiefly external, she got clear of the rash, but was not so well in general health. In 1898 she showed distinct gouty symptoms, and spent the winter in Bath at Dr. Moir's suggestion. In the following spring, the rash being again troublesome, Dr. Moir sent her to me, and I suggested substantial doses of liq. arsen. In July the patient had an attack of subacute gout in the ball of the foot, and the arsenic was interrupted. In September she went for a course of treatment to Llandrindod, and came back much improved in every way: the rash was no longer troublesome, and Dr. Moir reported that, in spite of this, the general health remained good.

Case 10.—Eczema seborrhœica.

Mr. N., aged 48, wine merchant, a Jew (but not a strict one) was sent to me first in 1898 by Dr. Byres Moir. He was then suffering with severe seborrhœic eczema of scalp, neck, axillæ and groins, for which I prescribed chiefly external remedies, the principal one being a lotion of resorcin, with the result that in a few weeks he was clear of all rash. Two years later, in the early spring, he returned with a similar, though less severe, attack, and acting on my advice, he spent the greater part of the month of April at Aix-la-Chapelle. Whilst undergoing treatment there the rash came out more, and the patient had a slight attack of acute gout in the left great toe. He returned home very much discontented with his stay at Aachen, and when in the following July he had a smart attack of impetiginous eczema on the face, scalp and neck, he was not complimentary in his references to that "beastly hole." Under antim. crud., however, and a very mild lead lotion, the rash rapidly subsided, so that by the end of the month the skin was clear. To the best of my knowledge it has remained so from that time.

Case 11.—Glycosuria.

Mr. D., aged 77, retired merchant, American; is very temperate, but fond of sweets. Father suffered from gout and bronchial catarrh, but lived to the age of 89. Patient first came to me in 1895, on his return from a trip to the States, saying he had been told that he was suffering from diabetes, and was taking pills prescribed by his old homœopathic physician in Brooklyn; these turned out to be of *codeia* in substantial doses. I encouraged the patient by telling him that the ailment was probably not genuine diabetes and would pass off. Since 1895 he has had *intermittent* attacks of glycosuria, the output of sugar ranging from 1 oz. to 3½ oz. in twenty-four hours. The attacks

have usually lasted some months; there is never any loss of weight, and, except in the matter of sweets, the diet has not been restricted. The urine is always freely acid. The patient's only complaint which appeared to me in any way connected with the glycosuria—and I have noticed it in other cases—was of a feeling of discomfort in the œsophagus, especially at its lower end. This was always relieved by oxalic acid. The drugs given during the attacks of glycosuria were usually lycopod., ac. phosph. and jambul, but I cannot say that I found the two latter exercised any decided influence upon the glycosuria. In 1899 the patient again visited the United States, being away three and a half months, eating and drinking just what pleased him. On his return the urine was quite *free* from sugar (!). In 1903 he had an attack of glycosuria, during which the quantity of sugar was fairly constant at about 3 oz. per diem. I gave him aspirin, beginning with a dose of gr. v. t.d., and gradually raising the quantity to gr. xx. t.d. The glycosuria was quite unaffected by it. A course of treatment at Llandrindod during the autumn of the same year was equally ineffective. Last October he returned to London, after spending fourteen months in travelling about the United States, during which time he had eaten moderately of sweets, but had been a total abstainer. The urine was normal in quantity (56 oz.), and there was a bare trace of sugar present. His only complaint was of giddiness on standing up in the morning and on stooping during the day. This was speedily relieved by ac. picric.

Case 12.—Glycosuria and insomnia.

Mr. L., a German merchant, long resident in England, aged 63, weighing 14 st. 5 lbs., who had had occasional attacks of acute gout, came to consult me first in 1903 for persistent insomnia, with slight arthritis in thumbs. The urine was large in quantity (112 oz.—but the patient, like many Germans, was naturally a very "thirsty subject") it deposited urates on standing, contained sugar to the extent of $2\frac{1}{2}$ oz. in the above quantity, and there was a trace of albumen present. The daily output of urea and uric acid were fairly normal, and the relative proportions of the two were as 43 : 1. Except as to quantity of liquid, which was much curtailed, the diet was but little interfered with. Treatment was begun by giving lycopod. and sulph. on alternate days, and this was succeeded by uran. nitric.

Four months later the patient visited Germany for some weeks, and took both wine and beer. On return he was better in every respect but that of sleep. The weight had fallen some pounds, and the daily output of sugar was much diminished in quantity.

By the end of the year, under the influence of lycop. and uran. nitric., the quantity of urine had fallen to 66½ oz.; albumen and sugar were absent, and the weight had fallen to 13 st. 12 lbs. (*in puris naturalibus*). The insomnia remained as before, but was relieved by occasional doses of veronal. I strongly advised a visit to Carlsbad.

As the subject of chronic nephritis was discussed at one of our meetings not so very long ago, I will not trespass upon your time by citing cases. The results of drug treatment in interstitial nephritis can never, in the very nature of things, be expected to be brilliant, for the kidney condition is merely the local expression of a generalised state of more or less complete arterio-sclerosis. I would like, however, to call attention to a drug which bids fair to be a real help in the treatment of arterio-sclerosis with high tension pulse. This is adrenalin. I have prescribed it a good many times of late, usually in the sixth decimal dilution, in various forms of arterio-sclerosis with or without renal complication, with most encouraging results. Needless to remind you that its pathogenesy, which is a striking one, is precisely such as would lead us to expect such results when it is prescribed homœopathically.

Now, gentlemen, as it was my intention that this paper should be suggestive rather than exhaustive, and as there is a very important paper still to be read and discussed this evening, I think it time that mine was brought to a close. What I would, on the strength of the foregoing somewhat sketchy observations venture to suggest is, that in the matter of prognosis we should take the patient or his friends a little more into our confidence, giving him plainly to understand that gouty ailments of all kinds cannot be dismissed as cured once and for all, but will sooner or later return; that they often alternate one with another, and that the best that can be hoped is that they may be only intermittent and not constant. In the matter of treatment, that where there is good reason to suspect the influence of gout in the background, it is useless to confine our treatment to the exhibition of such remedies as we should give to the *ordinary* patient, but that we save time by alternating them

with, or, better still, preceding them by, a course of such drugs as sulphur, arsenic, or lycopodium—all drugs well known to the careful student of "Hahnemann's Chronic Diseases." Also that drugs containing salicylic acid, such as aspirin, have a real specific effect upon the shadowy something which we call gout.

Dr. CLARKE (in the chair) said the subject was one of the greatest interest, and Dr. Blackley had brought forward some valuable clinical material for discussion. In the paper which he (Dr. Clarke) read before the Society last year, he brought forward the case of a lady who had influenza badly. She got over the acute phase of it, but there remained a high temperature, with scarcely any other symptoms. Nothing he gave her made any difference to that temperature, until one day his attention was called to pain and swelling of the foot. He then saw that he had to deal with gout. So he put the patient on urtica urens ϕ, when at once the fever disappeared, and the whole trouble cleared up. He was surprised that Dr. Blackley did not mention that drug, for it was a most valuable remedy, and quite bore out everything which Dr. Burnett wrote about it. With regard to the nature of gout, he thought most members would have been struck when hearing Dr. Blackley's history of the gouty patient from childhood, through the various periods up to old age, with the resemblance to the list of the symptoms of psora, in Hahnemann's "Chronic Diseases." But Burnett contended that gout was more a sycotic than a psoric disease. In confirmation of that, he found that nearly all gouty patients benefited by a course of thuja and other antisycotics. He considered that Dr. Blackley was a little too pessimistic in his views of the powers of the homœopathist to deal with gout. Possibly a gouty patient could not be converted into a non-gouty patient, but many of the manifestations of the disease could be effectively cured. If homœopathists were to go back to Hahnemann's way of dealing with chronic diseases, more good results would be obtained with gouty patients than if they were treated with the more non-chronic remedies, like bryonia, &c. He had been much interested in Dr. Blackley's account of the action of salicylates, but he would be glad to have a few more indications for the use of aspirin. When allopaths gave drugs in minute doses in any condition, that was often an indication for homœopaths to use the drug in high potencies.

Dr. MADDEN said that gout was such an extensive subject that

one felt shy in commencing to discuss it. But it had always occurred to him that we lacked an efficient means of bringing out an attack of acute gout. Failing to bring out such an attack in one lady, she asked why she should not take some port wine. He consented, and when she came a week later she did not report that she had had an acute attack, but that she had felt much better. He advised her to persist with port wine, and she was still improving. He had always looked upon the use of aspirin as a refuge of the destitute for the purpose of relieving pain, and nothing else. But Dr. Blackley had assured members that it had some specific antidotal effect on gout. Dr. Madden would be glad to be convinced of that. He had recently treated a case of obstinate chronic gout, in which the patient was previously taking large doses of aspirin. He was anxious to wean the patient from that, and so he had some imitation tablets made, but consisting of only sugar of milk, and they relieved the pain just as well. He was therefore in doubt as to the efficacy of those much-vaunted remedies. No doubt lycopodium, sulphur, and arsenic did much to reduce the constitutional tendency to repeated attacks of gout, and they to some extent shortened an attack of gout. He could also confirm Dr. Clarke's statement that the use of urtica urens was excellent in the treatment of acute gout.

Dr. GOLDSBROUGH said the paper had interested him very much. There were several medicines to be thought of where there was an alternation of respiratory or gastric symptoms with skin eruptions. For instance, mezereum had rendered him good service in herpetic and vesicular eruptions, especially if the patient was subject to gastric catarrh. Also where constipation was present. He did not take such a gloomy view of the disease as did Dr. Blackley. If members were careful and patient in working out the symptomatology, more benefit, Dr. Goldsbrough thought, would be derived than by relying on the grosser doses of drugs, such as mineral waters and others which had been mentioned, and aspirin. He remembered the case of a man who was suffering badly from nephritic colic, to whom he gave berberin 1x in trituration. He got better of his colic, but he had an acute attack of gout next day. He did not know whether the drug had anything to do with bringing out the attack. The man had had acute colic once or twice before, but on the present occasion his relief was so marked that he thought there might be some connection between the improvement and the administration of the berberin.

Dr. WATKINS said he had listened with great pleasure to Dr.

Blackley's paper, which had been mainly clinical, though he had hoped it would have gone more into etiology than it did. It was a long time since the subject was discussed by the Society. He thought he could explain the reason why Dr. Blackley's patient, whom he sent to Aix-la-Chapelle, had the gout precipitated, and also why the port wine improved the health of Dr. Madden's lady patient. The question of the alkalinity of the blood was at present in a chaotic condition. Until recently everybody thought the blood was alkaline, but latterly it had been contended that the blood was normally acid. The alkaline view was based upon the fact that it turned litmus paper blue. But litmus paper did not constitute a delicate test. If one took a solution of bicarbonate of soda, it would turn litmus paper blue, whereas chemically that salt was an acid salt. There was a point at which a solution would blue red paper, and redden blue paper, yet obviously the same solution could not be acid and alkaline at the same time. Ludwig and Meyer, and others, declared that there was free carbonic acid in the blood, and if that was so, there could be no free alkali, and there could be no neutral carbonates, nor yet any tribasic phosphates. Another reason for supposing it was acid was that there were phosphates of lime and magnesia in the blood in a state of solution, and if the medium were alkaline, they would be precipitated. Therefore Joulie had based upon this assumption a new method of estimating the acidity of the urine, that authority believing that the acidity of the urine indicated the degree of acidity of the blood. This observation had shown that the so-called cases of gout could be divided into two classes: that in which the blood was hyper-acid, and which were followed by a deposit of biurate of soda; and those cases where it was hypo-acid, where the phosphates, lime and magnesia were precipitated. Clinically the theory had been confirmed by showing that some of the deposits—tophi—which were considered uratic, consisted of alternate layers of biurate of soda and phosphate of lime. So he thought the cases which had been mentioned were examples of hypo-acidity. Alkaline waters rendered the blood less acid, and so precipitated phosphates of lime and magnesia. In Dr. Madden's case the administration of port wine increased the acidity of the blood, and perhaps brought it to the normal.

Dr. ALEXANDER asked if Dr. Blackley would give more information about one medicine he referred to, emetin, saying what was its character and the indications for its use?

Dr. CLARKE said, in answer to a question by Dr. Madden, that the best medicine to bring out an attack of acute gout was *the*

simillimum. He had often done it, but he could not say by what remedy. In giving remedies as accurately as he could, according to the symptoms, he had often succeeded in bringing out acute gout in the toe to the great relief of the patient's state generally, but he did not think there was any one remedy which would do it.

Dr. BLACKLEY, in reply, thanked the members for the way in which they had received his paper. He had not intended that it should be pessimistic. All he had suggested was that gout came to stay, and that might mean either a little or a great deal. In his experience it meant that by assiduous and careful treatment one could get the condition quiet for the time being—sometimes for a long time, at others for a very short one. He had known patients who went to Aix-la-Chapelle for gouty skin affections, and came back clear—remained clear for one, two, or three years —but the ailment always returned. He had never seen any gouty condition absolutely cured, and he was never surprised when the trouble returned. The best one could hope for was that the phases of the disease would change as time went on. A moderate amount of eczema, for instance, was preferable to mild spasmodic asthma. Urtica urens had disappointed him very much; he believed it caused the excretion of crystalline uric acid, but had no effect on the gout as such. The object should be not only to get rid of uric acid, but to keep it in a soluble form. Berberin was a very useful drug, but the dosage mentioned by Dr. Goldsbrough was fairly heavy. He had seen it used for gall-stones in gouty people. Dr. Watkins' exposition of present-day opinion concerning the acidity or alkalinity of the blood was very interesting, and was new to him. It was well known that people who went to the sulphur springs were often made worse thereby. He had given picric acid for many years, and he dated his study of that from the time when the "Cyclopædia of Drug Pathogenesy" was coming out, and he translated for that work a great deal of the material which was published. He had used it for the last twenty years, and he had seen aggravation from its use in the third decimal, but never from the fourth decimal. It was particularly useful in acute neurosis, and in the neurosis in fairly aged people. When old people got giddy through stooping to lace up their boots, they were relieved by picric acid. In answer to Dr. Alexander's question regarding emetin, he said that it appeared to produce pure spasmodic contraction of the circular fibres of the finer bronchial tubes.

SOCIETY NEWS.

OBITUARY.

Pemberton Dudley.

The late Dr. Pemberton Dudley, of Philadelphia, was elected a corresponding member of the Society in 1898. He died on March 25 last, from the effects of shock sustained in a fall from a trolley car. He was in his seventieth year. Pemberton Dudley graduated in the year 1861. He took a prominent part in all movements connected with the welfare of homœopathy. He organised his own county Society in 1866; was President of that and the State Medical Society. He was Secretary of the American Institute of Homœopathy for seven years from 1867, and President for the year 1896. From 1880 to 1888 he was Editor of the *Hahnemannian Monthly*. His editorship marked the period when this magazine began to rank among the most influential homœopathic periodicals of the world. He held various honorary society memberships, and at the time of his death was engaged on an important work on the institutes of medicine. The JOURNAL is indebted to the *Hahnemannian Monthly* for the above information.

SUMMARY OF PHARMACODYNAMICS AND THERAPEUTICS.

Extracts from Exchange Journals by the Editor, in collaboration with J. Galley Blackley, M.B.

Baja. *Pathogenesis of the Tincture.*— The following pathogenesis of Baja, a plant indigenous in Bengal, has been furnished to the *Allgemeine Homöopatische Zeitung* by a native practitioner:—

Psychical symptoms.—Anxious and downcast; great feeling of anguish; disturbance of spirits.

Head.—Confusion and emptiness of head; head as heavy as lead; headache; pulsation in temples, which is relieved after a time by pressure.

Eyes.—Vessels injected; tears; seems as if there was mist before the eyes; night-blindness.

Face.—Flushing and waves of heat, with redness of eyes; pallor or slight icteric tinge.

Nose.—Coryza; ozena; catarrhal troubles.

Tongue.—Coated and dry; thirst, with longing for refreshing drink; acute thirst.

Stomach.—Nausea; vomiting of bile and food; vomiting of blood.

Hypochondrium.—Spleen and liver enlarged; stabbing pain in spleen; pain in hepatic region increased on pressure.

Cough.—Persistent tickling, laryngeal cough.

Stool.—Constipation; diarrhœa rarely.

Urine.—Frequent inclination; urine scanty and high-coloured.

Genitals.—Itching of scrotum; pain during menstruation; pain in vagina.

Chest.—Dyspnœa; quickened respiration; asthma.

Fever.—Rigors, with heat and thirst following; chilliness; persistent chill; coldness within and heat without; shivering and coldness of extremities; sweating after the hot stage; malaria and intermittent fever of every kind (? curative); heat and burning of skin, with restlessness.

Skin.—Spots; eruptions; icterus; itching.

Tissues.—Œdema.—(*Allg. Hom. Zeit.*, May 7, 1907, p. 78.) —J. G. B.

Barium Salts in Arterio-Sclerosis.—Dr. Cartier, of Paris, contributes an article on the above subject, which is translated by Professor W. A. Dewey. Dr. Cartier points out that baryta salts do not appear capable of actually producing arterio-sclerosis, but they have a marked action on the blood pressure, causing increased tension, and also on the heart. The effect on the heart is to excite its action, slowing it afterwards and stopping it in systole. There is considerable contraction of the blood vessels. Baryta salts also have produced nephritis with congestion of the glomerules, hæmorrhage in the tubes, and cellular lesions of the labyrinth. Dr. Cartier has used the baryta salts in cerebral arterio-sclerosis and in senile asthma. The headache of baryta is dull, heavy, not paroxysmal, < night on pillow; in addition, the sensorium is not clear, there is loss of speech, headache in persons mentally and physically dwarfed, sensation as if head compressed with a vice, stiffness of neck. The following case of senile asthma is typically illustrative of the use of baryta: The patient, aged 77, presented all the signs of arterial induration, pipestem zigzag arteries, where they could be felt. For seven years he had suffered from asthma, which he could not get rid of. He received baryta carb. 6 and 30. This he took for eighteen months. He was not seen in the interval, but at the end of the time was quite changed. He could go upstairs easily, and had passed a winter which was quite paradise by comparison with previous ones. The condition of the arteries remained unchanged. Baryta must be given for a long time; it is a remedy of long action, which does not tire the stomach, and acts slowly without causing medicinal aggravation. (*Medical Century*, March, p. 65.)—Ed.

Cerebro-Spinal Meningitis.—*Cerebro-spinal Meningitis, with meningococci present—intrarachidian injection of collargol—cure.* —MM. Widal and Louis Ramond report a most interesting case of cerebrospinal meningitis, of which we give the following *résumé*:—

The patient was a woman, and the attack terminated in recovery. The evolution of the temperature curve was seen to comprise three periods: a first of nineteen days, interrupted by chills and characterised by very irregular temperature; a second of ten days' duration with fever *en plateau*, the temperature oscillating between 39° and 40° C.; and a third, seven days long,

following an injection of 5 cc. of 1 per cent. aqueous solution of collargol, during which we see the temperature steadily lowered down to the normal. For twenty-three days this attack, characterised by Kernig's sign, by stiffness of the neck, inequality of the pupils, and by *herpes labialis*, developed after the benign type; headache was the only cerebral symptom noted; neither paralysis, spasms, sensory troubles, nor the slightest approach to delirium were present. The patient answered with the greatest clearness all the questions put to her. From the twenty-third to the twenty-eighth day of the illness grave symptoms set in, characterised by continually increasing delirium, by absolute prostration, and by incontinence of urine. From the twenty-ninth day, when the injection of collargol was made, the temperature fell at once, the delirium became less violent, and the general condition became manifestly better; but the next day but one a rigor and a painful spot in the left side supervened, and auscultation revealed, at the base of the lung on the same side, the existence of a pneumonic *souffle;* the delirium re-appeared, and was quite as bad as on the worst days. Twenty-four hours later there was incontinence both of urine and fæces, and a bedsore appeared over the sacrum. In spite of these unpleasant complications the temperature continued to diminish, so that eight days after the collargol injection (on the thirty-sixth day of the disease) the fever had completely disappeared. The intellect was still slightly obfuscated, but the bedsore had commenced to heal. Twenty days after the fall of the temperature Kernig's sign could only be faintly elicited, and when the patient left the hospital it had entirely disappeared; all that remained was exaggeration of all the reflexes, and this persisted for a long time afterwards. Microscopic examination of the cerebro-spinal fluid, all through the period when the disease was at its height, showed a cytological formula in which the polynuclears predominated, as is the rule in non-tubercular meningitis. A puncture, performed eight days after the defervescence, showed still a predominence of these elements with multilobular nuclei; and it was only eleven days later, *i.e.*, after eighteen days of apyrexia, that the majority were found to be lymphocytes. The number of leucocytes per cubic millimetre fell gradually from 10,200, the earliest figure, to 671 at the moment when the symptoms appeared most grave. The meningococci were easily seen in film preparations, and became more numerous in successive punctures; they were cultivated abundantly on the blood gelose of Bezançon and Griffon. Under the influence of the collargol injection, the number of leucocytes rose to a figure never pre-

viously attained. Four days after this injection 14,000 per cubic millimetre were counted, with 93 per cent. of polynuclears ; on this day numerous meningococci were seen in the films, for the most part intracellular. At the same time, numerous small masses of collargol of different shapes, and of a chocolate-brown colour, were seen both free and in the interior of the cells. The cure certainly appears in this case to have been due to the collargol. A certain number of cases had already been recorded of cures both by inunction of collargol (Netter, Barth, and Manhau), and by intraspinal injection (Papillon and Esbach). (*L'Art Medical*, December, 1906, p. 461.)—J. G. B.

Ilex Paraguaiensis. *Pathogenetic and Therapeutic Effects of Maté.*—Dr. Ernst von Bassewitz gives the following as the symptoms produced in himself by taking, in divided doses, 50 grams of maté of good quality infused in 750 grams of water at about 70° C. :—Sensation of *bien être*, not followed by depression, and certain stimulation of cerebral activity, shown by the easy solution of a given mathematical problem. The pulse rose from 72 to 78, becoming at the same time more vigorous, as was shown by the alterations in the sphygmographic tracing. The axillary temperature rose from 36·5° to 36·9° C., and the skin became slightly moist. Appetite was increased, and the urine was very slightly increased in quantity. (He was not an habitual drinker of maté.) The author gives the following as the symptoms he has met with in others from the abuse of maté : Persistent epigastric pain, diminution of smell and taste, disagreeable sense of dryness in the mouth and pharynx, anorexia, pyrosis, vomiting, gastric attacks and frequent headaches; the pulse becomes small and irregular ; the urine at first augmented, then notably diminished, becoming turbid on standing; severe nervous depression is constantly noted, associated with the many-sided train of symptoms called " neurasthenia."

Another train of morbid phenomena is seen after sudden abstinence, in persons who have for a long time been accustomed to the daily use of this aromatic and stimulating beverage, viz. :— Overpowering somnolence and incapacity for work, whether physical or mental; inappetence, gastro-intestinal disorders; diarrhœic stools in conjunction with very notable diminution of urinary secretion; equally frequent are headaches and general pruritus. All this yields as by enchantment to a renewed ingestion of maté. " As a therapeutic agent infusion of maté acts as a slight astringent owing to its relatively high proportion of tannin ; it therefore constitutes an admirable corrective to

symptomatic polydypsia. We employed infusion of maté in our military clinic during an epidemic of typhoid fever. Owing to failure of our milk supply, we were obliged to make use of beef-tea, meat-juice, &c., which, although well tolerated, increased the tendency to diarrhœa and scanty urine, with aggravation of the *status typhosus*; but from the moment when we began the *ad libitum* administration of infusion of maté these inconveniences disappeared. We have had favourable results in substituting maté for coffee as an analeptic in cases of collapse, using a 10 per cent. infusion. We have used the same strength in many cases of hemicrania, especially in arthritics. To the habitual ingestion of maté by the great majority of the inhabitants of Rio Grande is attributed the great rarity of renal or vesical calculus amongst them. When the occasion arose we have prescribed maté in cases of renal colic followed by voidance of crystals of uric acid or of oxalate of lime. We have noted equally good effects in sundry cases of hæmaturia: even in Bright's disease we have seen sometimes a diminution of the albuminuria without any harmful effects, save in cases of advanced arteriosclerosis complicated by attacks of *angina pectoris*. In these latter we have seen increase in intensity and frequency of the attacks whilst taking maté, and therefore regard it as contra-indicated." "It is of the greatest use as a prophylactic against sunstroke, being a safe stimulant to the circulation, to diaphoresis and diuresis, functions which are all depressed in the above-named morbid condition."—(*Revista Homœopathica do Parana*, March, 1907, p. 54.)—J. G. B.

Kali Chloricum.—*Action on the kidneys.*—Dr. F. W. Wooldridge, of Pittsburg, contributes an article entitled "The Special Action on the Kidneys of Kali Chloricum," in which is detailed some experiments with the drug on guinea-pigs. The following is a brief summary of the results. The drug produces a true nephritis, the glomeruli or malpighian bodies and the uriniferous tubules being most susceptible. The drug appears to attack the active secreting cell itself. The hyaloplasm becomes cloudy and finally granular. The intracellular elements are prone to take the acid rather than the basic stains. Dr. Wooldridge believes the drug to be homœopathic to acute parenchymatous nephritis. He has given it in the first decimal dilution at first, following by higher ones when the kidney shows signs of clearing. (*New England Medical Gazette*, January, 1907, p. 27.)—Ed.

Lapis Albus.—A case is reported by Dr. Karl Greiner, of Sparta, Michigan, in which lapis albus 6x (the silico-fluoride of

calcium) appeared to cause resolution of a subcutaneous swelling the size of a pigeon's egg, hard, tense and threatening suppuration, under the chin of a child 4 years of age, which followed a sharp blow on the spot. The medicine was given in preference to surgical treatment. It was taken for six weeks, when the swelling was reduced to the size of a pill, soft, still red, and fluctuating. The medicine was continued, there was no suppuration, and in two or three weeks longer it had disappeared. The general health continued good all the time. (*Homœopathic Recorder*, May, p. 230.)—Ed.

Mercurius. *Fatal mercurial poisoning after injections of grey oil.*—MM. Œttinger and Fiessinger communicated to the Société Médicale des Hopitaux a case where death followed injections of grey oil. Three intraumacular injections of 1 cubic centimetre of 40 per cent. grey oil were made; the first two were made at intervals of eight days, and the third after a lapse of fifteen days. It was a month after the last injection that stomatitis appeared. This passed off, but diarrhœa and albuminuria set in, and the patient died of uræmic coma sixty-nine days after the last injection. After death small pieces of the liver and kidney were removed and submitted to histological examination. The lesions observed in the liver were very different from those met with by H. Jousset in the rabbit.[1] The lesions were cellular, being situated especially in the centre of the lobule and diminishing gradually towards the periphery. In the portal spaces nothing abnormal was noted; no trace of angiocholitis was detected. In the experiments of H. Jousset, on the other hand, it was in the porto-biliary space that lesions were found, consisting particularly in sclerotic changes, the biliary vessels being altered, and the hepatic cells slightly so. M. Œttinger suggests that it will be advisable, in having recourse to injections of grey oil, to use a strength of 20 or even 10 per cent. (*L'Art Médical*, April, 1907, p. 293.)—J. G. B.

Natrum Muriaticum. *Pathogenesis.*—Dr. Fournias, of Philadelphia, pursues his investigations into the pathogenesis of natrum muriaticum. Results observed under the prolonged use of salt as an article of diet corroborate the symptoms in the pathogenesis. Disorganisation of the blood with impairment of the general nutrition are at the base of the distrophic phe-

[1] "Action of Calomel upon the Liver and Kidneys," H. Jousset. J. B. Baillière, 1907.

nomena displayed by the drug. The hæmolytic effects comprise anæmic, oligomia, hydremia, hypoglobulia, hypoalbuminous chlorosis, effusions, bleeding from the gums. These show themselves in characteristic symptoms. In organs of secretion *dryness* is a characteristic feature. Natrum mur. *excites* the circulation, with fluttering of the heart and irregularities of pulsation, worse on motion, on lying on the left side, and on going to sleep or waking. The respiration is correspondingly affected with the circulation. In the digestive sphere, in addition to *dryness* there is *irritation*. In the *sensory* sphere the head, neck, back limbs, tongue, liver, chest, rectum, share in the disorder. In the *motor* sphere, debility and disinclination for exertion are the dominant notes, particularly with regard to the muscles of the eyes. In the reproductive sphere, relaxation and irritability with discharges are noticed. Much depression attends menstruation. Under *mind* depression and irritability are characteristics. Sympathy aggravates hurriedness, anxiety, ideas of culpability, self-tormenting, weakness of will, indecision. Dr. Fournias gives sections also on characteristics and relationships with other drugs. His presentation of the subject deserves careful study. (*Hahnemannian Monthly*, March, p. 193.)—Ed.

Natrum Muriaticum. *Therapeutics.*—Dr. Fournias' contributions on the therapeutic aspects of natrum mur. are more discursive, and he gives no cases. He considers the drug indicated in the certain diseases of the blood and nutrition next to digestive and circulatory troubles, and finally to nervous and cutaneous disorders. In scurvy, natrum muriaticum is after phos. merc. and carbo. veg. Malarial cachexia, anæmia, malnutrition, enlargement of liver and spleen call for this medicine. In the generative sphere some clear general indications are given; for instance, in amenorrhœa and painful menstruation, preceded by mental depression and attended by beating headache, palpitations, cramps, constipation, and acrid leucorrhœa, especially in studious schoolgirls, or anæmic women who have had malaria, or who have been exhausted by prolonged lactation. In mental derangement it is especially indicated in cases of intellectual and moral hypochondriasis, especially after debilitating diseases. In visual troubles, muscular asthenopia, conjunctivitis from eyestrain, hyperæsthesia, and amblyopia are the chief indications. The headaches of natrum mur. are mostly to be considered in connection with other disorders in which it is indicated. In some constitutional dermatoses it may be called for, where the eruption is vesicular, tettery, crusty or blotchy, with or without rhagades. Moist-

oozing eruptions at the outlets of the body call for it. In eczema, seborrhœa and herpes it may also be thought of. (*Hahnemannian Monthly*, April, 1907, p. 250.)—Ed.

Quinine Sulphate. *A Proving.*—Dr. Fritz C. Askensdedt, of Louisville, Ky., has proved quinine on himself with a view to ascertaining its effect on the blood and excretory organs. Dr. Askensdedt was in good health, except for a tendency in the spring and summer to eczema and prickly heat. Normal pulse 72, T. 98·2°. The proving was begun on July 6, and finished on July 14, ordinary habits and practice being continued meanwhile. Alcohol, tobacco, tea and coffee are not habitually indulged in. The doses of the drug were as follows: July 5, 2.30 p.m., 8 grains; 7.30 p.m., 8 grains. July 6, 8 a.m., 8 grains; 1.30 p.m., ditto; 10 p.m., ditto. July 7, 8 a.m., 8 grains; 2 p.m., 4 grains; 12 night, ditto. July 8, 8 a.m., 4 grains; 2 p.m., ditto; 9.30 p.m., ditto. July 9, 8 a.m., 2 p.m., 7 p.m., and 11 p.m., ditto. July 10, 7.30 a.m., 6 p.m., and 11 p.m., ditto. July 11, 8 a.m., ditto. The following symptoms were produced in the order of their occurrence. First day, 9 p.m., sense of fulness in the ears with tinnitus, resembling the sound of hammering on anvils from a long distance. Sense of exhilaration, excitement noticed by others, impaired reasoning power, conversation required special effort. On second day, except for fulness and ringing of ears, felt well. At noon a hæmoglobin estimate showed a loss of 10 per cent. from previous normal amount. On the third day, 10 p.m., sensation of tremulousness, lack of self-confidence, slight frontal headache, griping in bowels, unusual constipation had to be relieved by enema. Fourth day, woke at 4 a.m. after dream of murder; could not sleep again; 1 p.m., hæmoglobin estimate showed 15 per cent. below normal, a loss of 532,000 cells to cmm.; dull frontal headache and tinnitus all day, at night felt "bum." Fifth day, slept well 12 to 6; felt well on awaking (was now taking the 4 gr. doses); 2 p.m., white coating on tongue; mental powers regained, very little tinnitus, an occasional rather sharp pain in forehead. Sixth, seventh and eighth days, felt well on latter day, red cells and hæmoglobin nearly restored to normal. On ninth and following days, hands broken out with prickly heat and eczema. This was unusually early and proved of exceptional severity. The analysis of blood and urine were made according to accepted methods. They are given in the form of a chart, in comparison with the normal, investigation of which was conducted for five days previous to the proving. During the heavy doses of the drug the effect on the blood and urine was very

marked, and during the lighter doses the return to normal exhibited a rebound which might be described as a reactive or secondary effect. The most marked effects were as follows: 1. *Blood.*—An immediate and rapid decrease in the red blood cells, with even a greater reduction in hæmoglobin. As this action on the blood was attended with a corresponding increase in the elimination of chlorides, it led to the inference that the effect of the drug was directly upon the blood rather than inhibitory on the blood-making organs. The white cells manifested a slight tendency to polyneucleated leucocytosis. 2. *Urine.*—Quantity increased with alkaline reaction, but rapid return to normal. Urea decreased, but rose abruptly on the sixth day; excessive elimination of uric acid, abundance of chlorides, accompanied by subnormal temperature. Phosphoric acid showed a gradual reduction for a few days with abrupt rise on fifth day. "The time of greatest impregnation of the blood with the quinine and the minimum of blood destruction was preceded by the greatest excess of uric acid, so that it would appear that the action of the drug is probably not upon the blood alone. As a summary of this proving, there was found on the one hand destruction of certain of the blood elements and on the other a lessened oxidation, a disturbance of the katabolic function of the liver attended with various nervous phenomena." (*Hahnemannian Monthly*, April, page 241.)—ED.

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CHOREA OF CHILDHOOD.[1]

BY JOHN ROBERSON DAY, M.D.LOND.,
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The term chorea has been used interchangeably with St. Vitus' dance to connote such a number of similar but distinct affections that at the outset it is desirable to define what we mean by chorea.

Sydenham's definition is, "An acute disease of childhood, rarely of adults and of the aged, characterised by irregular involuntary movements, a variable amount of psychical disturbance and associated very often with arthritis and endocarditis."

It is a singular disorder, and has been known since the Middle Ages. St. Vitus' dance was the name first given to the epidemic dancing mania, as it occurred at Strassburg in the fourteenth and fifteenth centuries. This probably differed from chorea as Sydenham defined it, and as we now

[1] Presented to the Section of Medicine and Pathology, May 2, 1907.

regard it. The term St. Vitus' dance is therefore only confusing. More than one hundred years ago Bonteille (d. 1815) wrote of this disease: "Tout est extraordinaire dans cette maladie; son nom est ridicule, son caractère equivoque, sa cause inconnu, son traitement problématique." With our modern methods of investigation this disease has become better known to us, and consequently less extraordinary.

The intimate relationship between rheumatism and chorea has long been known and is well established clinically. Recently the *same* micro-organism, which has been demonstrated beyond doubt to be the cause of rheumatism, has been found in cases suffering from chorea.

The diplococcus of Wassermann has been isolated from the cerebro-spinal fluid of patients who have died from acute rheumatism and chorea. In 1899 Wassermann produced polyarthritis in rabbits with this diplococcus, and in 1900 Poynton and Paine confirmed his observations, and further demonstrated a diplococcus in the pia mater and brain of a fatal case of chorea. They also produced incoordinate movements in a rabbit by injecting this same diplococcus. Later, in 1905, Poynton and Paine found this diplococcus in the pia mater of a fatal case of chorea, cultivated it from the cerebro-spinal fluid, and produced experimental arthritis and carditis.

This *Diplococcus rheumaticus*, or rheumococcus as it is termed, will produce both rheumatism and chorea. The part it plays in acute rheumatism has been well set forth in a paper which Dr. Watkins read before this Society in 1904, and to which I refer you.

In the *Lancet* for October 13, 1906, Drs. Poynton and Holmes show how three cases of chorea were associated with the presence of this *Diplococcus rheumaticus*, and one of these cases was associated with pregnancy.

The reason this diplococcus attacks the nervous system in children is no doubt, as has been here and elsewhere suggested, that the brain and nervous system of children is so very unstable. This point has an important bearing on treatment, as I shall subsequently point out. Over-work at

school, a sudden fright, or any nervous strain, will lower the vitality of the nervous system and so predispose the child to this rheumatic infection.

Similarly in chorea gravidarum, the well-known strain of pregnancy on the nervous system precipitates an attack of chorea in one who inherits the rheumatic tendency. In acute chorea there is a chromatolysis in the cells of the cerebral cortex due to the *toxin* of the rheumococcus. In epilepsy, the disease which bears such a close resemblance to chorea, there is this same change in the cells of the cerebral cortex. The age-incidence of chorea and epilepsy being similar, it is possible that the immaturity of the cells of the cortex may be a causative factor in each case.

Here, then, we have a distinct advance on our knowledge of the nature of this disease, and the old theories of multiple embolism and vacuolation of the brain must be discarded.

The Symptoms of Chorea.

The symptoms of chorea are familiar to us all. When the disease is well developed the case is unmistakable—but the slighter cases may be overlooked. The trouble begins with what the mother describes as "fidgetiness." It is at all times a difficult matter for a healthy child to sit still, now it becomes an *impossibility;* the more the child is noticed, the worse the movements become. The arms and face usually are the first to suffer. The child is awkward and drops things, and is often scolded for what is not carelessness, but commencing chorea. The facial muscles being attacked, the child makes faces; of course involuntarily. I can recall such a case in a boy who could not control his features; his mother told me how he often got into trouble because he would make faces at people in the street! The movements tend to increase in severity, so that the child cannot feed itself or even speak distinctly. The legs are next involved, and walking becomes a difficulty, so that falls are common. All the muscles of the body may be affected. A peculiar "clucking" noise in the throat is very suggestive.

The movements may be more marked in one limb or one side of the body; such cases have been termed *hemichorea.*

Much weakness is often found in the affected parts—the so-called *paralytic chorea*. All these symptoms are made worse by excitement and observation. During sleep they cease. In very severe cases the movements may prevent sleep.

There are certain mental symptoms which show themselves in irritability of temper and outbursts of passion in a child who has usually a placid disposition. The character of the child may completely change. A case is recorded of a girl, aged 21, who would hide away her clothes and wander away alone; once she could not be found for two days.

There may be certain skin eruptions, such as those commonly associated with the rheumatic state, *e.g.*, erythema nodosum and purpura.

The temperature is generally normal, except in those cases which are complicated with arthritis, or very severe maniacal forms. The duration is very variable, and relapses common.

It cannot be too strongly insisted on that chorea is a very serious disease, and this, not because the attack is likely to prove fatal, but because of the frequent association of heart complications.

Osler says, "There is no known disease in which endocarditis is so constantly found *post mortem* as chorea."

Endocarditis may exist even when the bruit has disappeared. This has been demonstrated in two carefully observed cases *post mortem*.

Osler states: (1) endocarditis is a very common complication of chorea minor; (2) endocarditis is independent of, and not associated with, acute arthritis; (3) in a considerable proportion of cases, much larger than has been hitherto supposed, this endocarditis lays the foundation of organic heart disease.

Diagnosis.

In most cases the movements are perfectly characteristic —the excitement of "seeing the doctor" generally brings out the movements in full force. If the arms are stretched out and the fingers separated, it will be found impossible to keep the fingers still. Any delicate muscular action is performed

clumsily or it is impossible, and good tests are threading a needle or picking up a pin from the table. The movements can also be demonstrated by getting the child to write.

Tics are common in children, and must be clearly distinguished from chorea, although both occur in the same type of children, viz., the excitable, nervous, and intellectual. Gowers prefers the name habit spasm, which he defines as "a spasmodic movement, half voluntary in aspect, which the patient is unable to control."

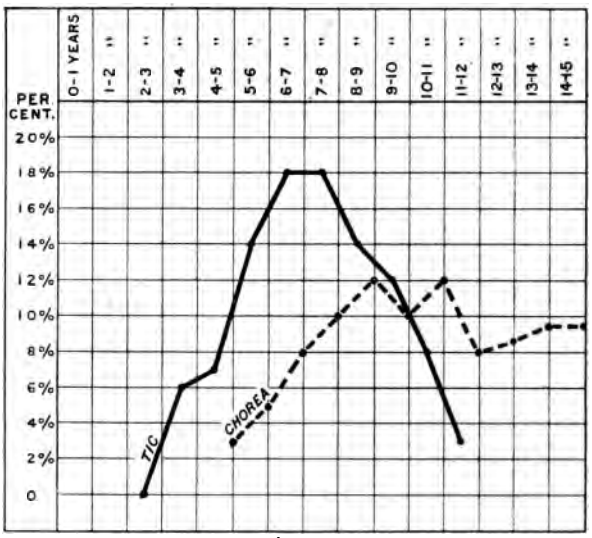


FIG. 1.

Both sexes are about equally affected, and in this it differs from chorea, which has a marked tendency to affect girls.

The commonest instance of a tic is "blinking the eyes."

A boy is now attending my clinic who has a persistent habit of "licking his lips." It has caused an eczematous condition of his lips and the surrounding skin. The quick nodding of the head, seen in girls, is no doubt caused by an effort to adjust the hat in the first instance, and by constant repetition has become confirmed as a habit.

Stammering is probably of this nature, and not a chorea, as described by the late Edward Blake. The prognosis I have already dealt with. Chorea being only one of the many

manifestations of rheumatism, is serious because of the frequency with which the heart is involved.

During the years 1895 to 1905 inclusive there were 171 cases of chorea admitted as in-patients to the London Homœopathic Hospital. These consisted of fifty-one males and 120 females.

There was a rheumatic family history in twenty-four. Fifteen had suffered from rheumatic fever. In no less than forty-five there was valvular disease of the heart—a mitral systolic bruit. Thirty-nine had suffered from previous attacks of chorea. Eight are stated to have had tonsillitis. In only one are rheumatic nodules mentioned; these bodies should always be looked for, because they indicate a serious rheumatic affection, and, if pronounced, are stated by Cheadle to be equivalent to the death warrant of the patient.

The *ages* varied from 3½ (a case of my own) to 27. The boys ceased to be attacked sooner than the girls, and this is no doubt owing to the incidence of puberty, which occasions more distress to girls than boys, and is a common time for them to suffer.

Some appear to be doubtful cases; for example, in a female, aged 25, the chorea was stated to have been caused by worry and cured by fright—the medicine given was ignat. 3x. Only two cases died, the one being complicated with epilepsy, and she died in a fit, aged 12. The other, a boy, aged 13, had suffered from rheumatic fever and chorea several times, and there was also a family history of chorea.

Fright is commonly ascribed as the exciting cause, and the severe thrashing which the boy, aged 9, received at school is readily understood as a sufficient cause in an overworked and rapidly-growing child.

The perusal of the notes of all these cases is most interesting and suggestive. (See table.) I here only give you a very brief epitome of them. The table further shows us what a wealth of material we possess in the hospital case books, and I take this opportunity to thank my colleagues, who have so readily placed them at my disposal for the purposes of this paper.

From these cases I have constructed a graphic repre-

sentation, which demonstrates the remarkable effect of the age of the patient in determining this disease. The greatest number were between 6 and 16; the curve rises rapidly to 7 and 8 years, at 9 it reaches its maximum, and then, after some variation to 15 years, falls very rapidly.

American writers have observed a distinct relation to the season of the year, and Morris J. Lewis has drawn the following conclusions:—

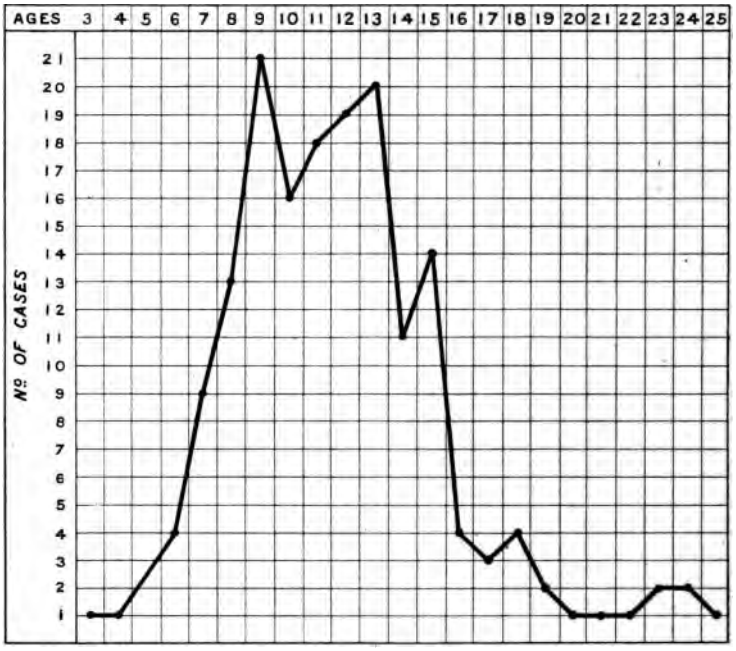


FIG. 2.

(1) The seasonal relationship of chorea and rheumatism is proved.

(2) There is a remarkable resemblance in form between the rheumatism and chorea tracings representing the total amount of sickness per month.

(3) This fluctuation in the curve of rheumatism and chorea is due to the same cause.

(4) While overstudy plays a most important *rôle* in

predisposing children to chorea, the times of greatest study do not coincide with the greatest frequency of the disease.

(5) It is more than probable that *weather* has much to do with the production of chorea.

During fifteen years observations were made to determine this point, and Lewis found the greatest number in March, a fall in April, and a rise again in May, the numbers then falling gradually to their lowest in November. I have con-

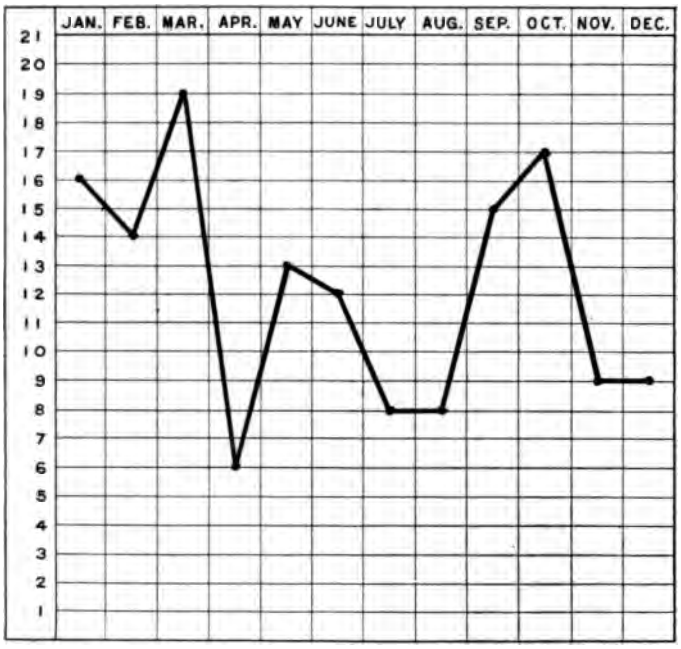


FIG. 3.

structed a scheme from our 171 cases to elucidate this point, and to some extent it bears out Morris Lewis's conclusions.

It is of interest at this point to turn to the vegetable kingdom, and observe the influence of the seasons upon the growth and development of plants.

"All plants require rest, and obtain it in some countries by the rigour of winter; in others by the scorching heat of

summer. Cultivators often fail in their attempts to grow certain plants from want of attention to this essential point. Thus, most alpine plants which enjoy an unbroken rest under the snow for several months, are very difficult of culture in our mild and varying winters."

"The winter of 1850-51 was ushered in by some heavy falls of snow, with which I filled my alpine case, giving the plants a perfect rest for three or four months, and with a most satisfactory result; the *primula marginata*, *linnæa borealis*, and other species, flowering much finer than usual. Many of these beautiful plants would, I am convinced, succeed well if kept for five or six months in an ice house."

Plants in hot countries have their periods of rest in the dry season. In Egypt the blue water lily obtains rest in a curious way. This plant abounds in several of the canals at Alexandria, which at certain seasons become dry, and the beds of these canals, which quickly become burnt as hard as bricks by the action of the sun, are then used as carriage roads. When the water is again admitted, the plant resumes its growth with redoubled vigour."

The seasons have their effect on animals also; a large number hybernate during the long dark days of winter, and only wake up in the spring. Primitive man no doubt rested much in the same way, and at any rate was not subject to the wear and tear of the nervous system which civilisation has brought about.

I have made enquiries of medical friends who have lived in Africa, India, China, and Mauritius, and in no case can they remember that the natives of these countries suffer from chorea, or, indeed, from any nervous disorders, save occasional paralysis.

Griesbach, in Alsace, has recently conducted a series of very interesting experiments, which also have a bearing upon the subject we are considering. He used the æsthesiometer to test the mental condition of a number of school children. When the child was mentally fatigued, the points of the instrument required to be widely separated, so as to be distinguished as two points, and conversely when the child was fresh they could be distinguished as two when much closer together.

This formed a simple and exact way of testing the skin sensibility, and from this a number of facts were obtained which showed there was little variation during the holidays, but during school time there were great variations. "Even in the morning, before school, a large number of the children failed to show as great sensibility as on holidays; probably some of them were night workers, or were overworked the day before. The greatest reduction of sensibility was after mathematics, the least after manual training; thus, close mental work is shown to cause the greatest fatigue, while manual training produces least."

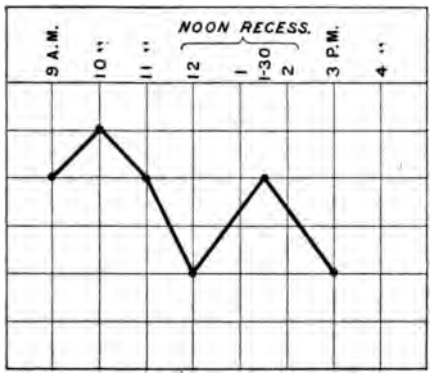


FIG. 4.

The daily variation of mental power is such that the curve of mental energy, beginning at a high level in the morning at 9 o'clock, rises moderately till 10 a.m., falls slowly till 11 a.m., and then very rapidly till the middle of the noon recess; by 1.30 p.m. the curve has risen to the 11 a.m. level, but it soon falls rapidly, and before 3 p.m. is at the 12 o'clock level.

Furthermore, during the spring time there is a peculiar state of nervous irritability throughout the entire animal kingdom,

> "In the spring a livelier iris changes on the burnished dove,
> In the spring a young man's fancy lightly turns to thoughts of love."

From a consideration of such facts as these we see what a

very important part preventive treatment should play in chorea. The children of rheumatic parents are a constant anxiety, and should be most carefully protected from damp and chills. If possible, a dry gravel soil should be selected for the place of abode. The diet should be largely vegetarian, including, of course, milk, eggs, and butter, but excluding butcher's meat. Plenty of fresh air and an open-air life, together with physical exercises, particularly deep breathing exercises. A country life as opposed to a town life. The avoidance of late hours and excitement, and especially overwork at school. These children are for the most part of the bright intellectual type, who learn easily, and need no cramming. This vigilance becomes especially necessary in the case of girls who are entering their teens; the first indication of "fidgets," or restless dreamy sleep, should be taken as a warning to stop all school, and plenty of rest in bed should be enjoined. Several months spent on a farm is often the wisest course to pursue. In treating the attack, the child should be at once put to rest in bed, and perfect quiet is essential. For this purpose in the wards of the hospital we screen off these patients to prevent them playing with the other children. Plenty of nutritious food, especially milk, butter, fats, and cod-liver oil, is needed.

The condition of the organs of excretion is important. Copious draughts of water are beneficial to flush out the kidneys. The skin, which is often dry, should receive special attention, and a vapour bath or pack to encourage diaphoresis, as suggested by Sir Wm. Gowers, I have seen of great value.

As regards remedies, there are many which are homœopathic to the condition, and some are of signal service.

In reviewing the remedies given to the 171 cases, I find eighteen were given in all, and I place them in the order of frequency with which they were employed:—

Agaricus, 1x., 3x., 1 and 3	65 times.
Ignatia, 1x., 3 and 12	53 ,,
Arsen. 2x., and 6	37 ,,
Liq. Arsenicalis	37 ,,
Zincum Metal, 3 and 6	20 ,,
Actæa, 3x.	17 ,,

Stram., 1x.	13 times
Sulph., 12 and 30	13 ,,
Hyoscy., 1x.	12 ,,
Cuprum, 6 and 12	8 ,,
Bryonia, 1x.	5 ,,
Cicuta, 3	3 ,,
Gels., 1x.	3 ,,
Spigelia, 1x.	3 ,,
Bell., 6 and 30	2 ,,
Plumb., 3x.	2 ,,
Argent. N., 3x. and 1	1 ,,
Cantharis, 1x.	1 ,,
Tarentula, 6	1 ,,

Some of the slighter cases received no medicine, and were cured by the rest and feeding during the time they remained in hospital.

I would here refer you to an interesting paper on "Chorea from a Therapeutic Standpoint," by Dr. Goldsbrough,[1] who examined eighty-five cases from the case books of the hospital. The preference for the remedies in his list, which included cases anterior to my list, differs somewhat from those above stated. The most favoured were arsenic, actæa, ignatia, agaricus, and stramonium, &c.

The difficulty is always in differentiating these. *Agaricus* is undoubtedly of the greatest value, and is advocated by Dr. Hughes as the precise simile to the idiopathic form of chorea. These symptoms are twitchings in the eyelids, eyeballs and cheeks, and in the muscles of the chest and abdomen. All symptoms are made worse in cold weather.

Ignatia is exactly suited to the nervous mental state. In some cases there are distinct hysterical symptoms associated with the chorea, and then ignatia is the simillimum.

Arsenic is characterised by great restlessness. It is a right-sided remedy, and should be given in right hemichorea. If the other well-known indications for arsenic, such as great thirst, silvery-white tongue and diarrhœa are present, it may be prescribed with the greatest confidence.

[1] *London Homœopathic Hospital Reports*, 1897.

Zincum is indicated in the most chronic cases.

Actæa has a distinct relationship to rheumatic pains, and where these co-exist it should be very useful. Dr. Goldsbrough cites an interesting case in such a condition. Also in chorea of pregnancy from its action on the uterus.

Gelsemium has an extreme feeling of restlessness. Exertion causes excessive tremor. There is trembling in all the limbs, with an unsteady gait.

Tarentula I have found of great use in some cases where there is intense restlessness.

Mygale does not appear to have been employed at all in the 171 cases. I have, however, found it very helpful. It has not been proved, except clinically. In one case of a man bitten by this spider there were twitchings of the facial muscles, chiefly of the right side, and also of the right side of the body, so violent as to prevent walking.

There is no doubt that chorea is much more frequently met with amongst the poor than amongst the well-to-do population—for the obvious reason that the children of the former are underfed and subjected to unhygienic conditions. Amongst the latter class the children are better cared for. On April 27, 1906, I saw G. M., aged 6. She had twitchings of the face, was restless and nervous. I prescribed rest and a very quiet life, giving agaricus 3x *ter die*. By May 29 she was practically well. On August 1 she returned from a holiday with hysterical crying and twitching of the face. Ignat. 3x, followed by mygale 30, produced a most beneficial effect. As soon as this child shows any of the symptoms of chorea she at once has treatment, and the development of the disease is promptly arrested. Psychical disturbances are common at such times, violent outbursts of passion in which she will attack her mother; these psychical storms are but phases of the disease, and are happily understood by the mother as such.

The following cases, taken from the Children's Department of the London Homœopathic Hospital, illustrate the effects of the different remedies used in treatment. The first six cases are types of the severer forms of the disease, and present points of considerable interest:—

Ada C., aged 9. April 20, 1905. Family history of fits on father's side, and epileptic insanity on mother's side. She was brought to me for enlargement of the tonsils. On September 17, 1906, she had an epileptic fit, and after this chorea developed, movements getting worse. Her case was further complicated by the onset of puberty. Mygale 6 helped her very much. The movements persisting in the legs, gels. 1x was given, and the last note said she was still improving.

October 12. Movements of legs worse after eating potatoes. Gels. 1x, ♏ iii. zi.

February 14. Still improving.

Amelia G., aged 7½, a twin, brought to hospital on June 22, 1905, with fidgets; moves mouth, arms and legs; falls about. A highly nervous, fair and florid child; no definite physical signs beyond the movements. She has attended on and off for some time, and had ignat. 3x, agaricus 3x, tarentula 6, gelsem. 1x, when the feet and legs were attacked chiefly. The notes say she is certainly better when attending the hospital, though she is never long free from the movements. She is very emotional and irritable.

Edith B., aged 7, came on April 21, 1904, with history of weakness since an attack of measles in February, 1903. Her father was rheumatic.

She was very thin and had rheumatic nodules over the external maleolus; *nil* cardiac. The legs were chiefly affected, and she had been falling about. Agaricus 3x, followed by conium 3x, and *admitted* May 5.

January 21, 1907. Another attack of chorea for fourteen days; getting rapidly worse; *admitted.*

Eliz. L., aged 12, attended on April 4, 1907. Has had "rheumatics" one year ago, and not well since; always moving, especially left arm. She is a very bright child, in the seventh standard at school, though the youngest in class.

The heart sounds are normal; she is very hyperæsthetic; movements are constant and irregular in the shoulders, especially left; agaricus 3x given.

April 18. She had an hysterical attack, crying and laughing, when a friend came to see her. There is also leucorrhœa and other signs pointing to puberty, so pulsat. 3x was now given.

Edith J. C., aged 8.—Family history: Father died of phthisis. Mother died in a fit and suffered from chorea when she was pregnant with this child.

Patient is a delicate child with long chest and refined features,

and is very nervous. Heart is normal. In February, 1906, had *erythema nodosum*. The excitement of school always makes her worse, and rest and agaricus 3x, tarentula 12, mygale 12, benefit her.

Severe relapsing chorea, six distinct attacks. Death from heart disease.

Rose R., aged 9.—First seen October 20, 1892, with rheumatic pains in knees and ankles, and a double apex bruit. She had previously had two attacks of chorea.

November 27. A third attack of chorea. Each attack is preceded with an attack of rheumatism. (Ars. a. 3x).

June 8, 1893. Acute rheumatism. Temperature 102°, with severe joint pains. (Acon. 3x, bry. 1x, alt. two hours.)

October 5. After another attack of acute rheumatism, had a fourth attack of chorea.

November 23. Throat was painful and tonsils enlarged. (Acon. 3x, bry. 1x, alt. two hours.)

May 3, 1894. Tonsilitis again.

February 20, 1896. Fifth attack of chorea, and on

October 23, a sixth attack. She finally died of heart disease.

She has a sister who has recently been in the London Homœopathic Hospital with chorea.

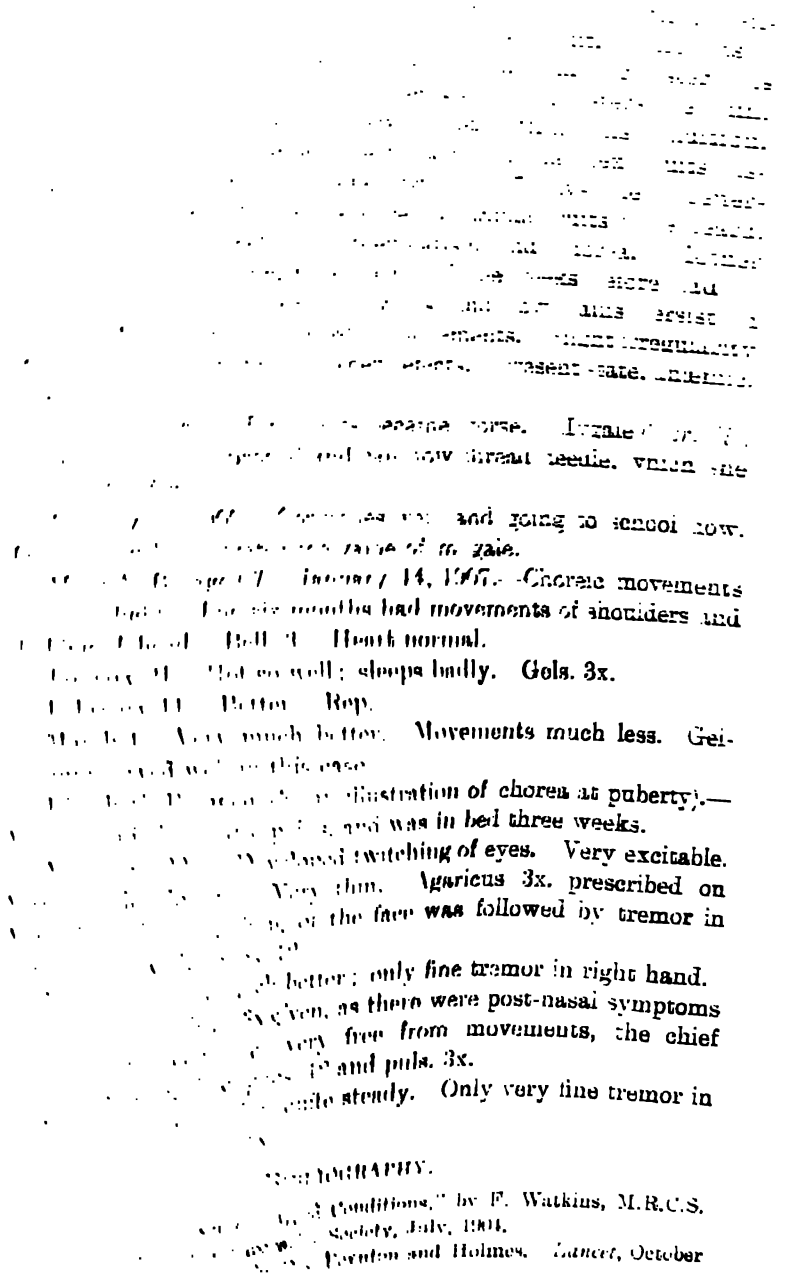
Gertrude D., aged 6, came on June 29, 1905, with constant blinking of the eyes, and was very nervous and excitable. There were no definite physical signs apart from the movements. Ignat. 3x did much for her nervousness, but the twitching of the eyes continued, and for this agaricus 3x was given.

She continued cured until April 3, 1907, when she came to see me again with the same symptoms. Her mother stated that this attack had originated from the excitements of the Christmas holidays! Agaricus 3x was again prescribed, with rapid improvement of all symptoms.

Nellie T., aged 5. February 11, 1905, came with an attack of erythema nodosum of both legs. Temperature 101·4°. This occurred during an attack of whooping cough. Acon. 3x, followed by rhus, was given.

Two years after, March 25, 1907, she came with chorea, which she had had for one week. The right arm and leg were most affected. Mygale 3 and ol. morrhuæ were given, and on April 4 I admitted her, as her speech was now affected.

In the hospital she had no medicine for forty-eight hours, and then was put on agaricus 3x. At once an improvement was noticed which has steadily continued, and she can now walk well, speaks distinctly and no movements are perceptible.



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Dr. J. H. CLARKE (in the chair) expressed the Society's indebtedness to Dr. Roberson Day for his valuable paper. It was a good many years since he (Dr. Clarke) had seen much of chorea, but he remembered that the two remedies which gave him the best results were agaricus and stramonium, the latter being especially useful when the attack was determined by fright. Though tics might not be the same affection as chorea, they were closely allied conditions, and he thought that the "habit spasms" of Gowers formed a small minority of the tics which were encountered. A girl came to him who had had head-nodding for many years, and she was speedily cured by a few doses of lycopodium 200. That patient would not have been cured so expeditiously if the movements had originated in the habit of fixing on the hat, as had been suggested; he believed it was a spasm allied to the grimaces one frequently saw. One such case he cured with thuja. In this case the cause was vaccinosis. Dr. Day did not insist on constitutional treatment in the period between the attacks. This he (the President) thought was very essential. It was one thing to clear up acute chorea, but quite another to so alter the child that it could resist the next attack which threatened.

Dr. SPEIRS ALEXANDER supposed there was no specific remedy for chorea; that each case must be treated on its own merits? If there were a rheumatic basis, such medicines as actæa might be useful; but not only that drug, but any other that might be suggested by the congeries of symptoms. Many years ago he had a boy, aged 13, under his care, whose mother complained of his bad temper, which she described as demoniacal, so that if shut up in a room he would smash the furniture in his rage. Stramonium 12 was prescribed, and some time after the demoniacal temper had been replaced by an angelic one. Dr. Alexander had not heard of any recurrence. One case which had puzzled him was one of severe chorea of long standing in a girl, aged 15. He sent her into the London Homœopathic Hospital, where she

Cases of Chorea [illegible]

No.	Sex.	Age.	Date of admission.	Condition of heart.	[illegible]	[illegible]	[illegible]
1	M.	13	16. 9. 95.	..	Slight case	.	.. 1
2	F.	14	25. 10. 95.	Systolic murm.	Third attack [illegible]	. ..	
3	F.	18	23. 12. 95.	Normal ..	[illegible]	.. ..	..
4	F.	9	...				
5	M.	10	...				,,
6	F.	24	...				,,
7	M.	11	26. 2. 96.	Normal	[illegible]	[illegible] Cupr. m. 3	,,
8	M.	11	12. 3. 96.	Faint systolic murm.		[illegible]	,,
9	F.	18	24. 6. 96.		[illegible]	... ...	Rapid recovery.
10	F.	15	22. 6. 96.		[illegible]	... ...	,, ,,
11	F.	9	16. 5. 96.		Second attack. Left side mostly affected	Stram. 3x. Act. rac. 3x. Ars. 2x	Cured.
12	F.	9	7. 7. 96.	Mitral murmur	[illegible]	Act. 3. Stram. 1x.	,,
13	F.	10	.		Slight case. No treatment	. ...	,,
14	F.	11	2. 9. 96.	No murmur		Ign. 12	,,
15	M.	12	2. 9. 96.		Chorea followed by tonsilitis	Ars. 6	,,
16	F.	7	28. 9. 96.	Mit. murmur.	Chorea with rheumatism	Act. r. 1 and 3x. Ars. 2x. Agar. 1	,,
17	F.	11	5. 9. 96.	Mit. murmur.	Second attack	Ign. 3. Zinc. 6	,,
18	M.	6			... ...	... ...	,,
19	F.	15	5. 1. 97.	Functional cardiac bruit	Fourth attack	Ign. 1x, Cupr. m. 6 and 12. Agar. 1x	Very little improved.
20	F.	14	. ..	... ...	... ...	... ...	Cured.
21	F.	10	28. 11. 96.	... ...	Chorea with follicular tonsilitis	Agar. 3	Steady recovery.
22	M.	12	.. ...	... ...	... ...	... ...	Cured.
23	F.	11	8. 1. 97.	*Nil* cardiac ...	Seventh attack. Inveterate case with tonsilitis	Agar. 3 and 3x, Ign. 1x, Liq. ars. mil. ter.	Unimproved.
24	F.	16	21. 1. 97.	Soft syst. apex bruit	Second attack	Nothing affected this case until val. of zn. 1x was given	Cured.
25	F.	6	8. 3. 97.	... ...	With muscular weakness (paresis)	Agar. 3	,,
26	F.	5½	20. 3. 97.	... ...	First attack. Slight case	Agar. 3	,,
27	F.	25	22. 4. 97.	... ...	Chorea caused by worry; cured by fright ...	Ign. 3	,,
28	F.	10	22. 5. 97.	... ...	Several previous attacks	Agar. 3x	Improved.
29	M.	12	12. 6. 97.	... ...	Neck muscles chiefly affected. Head jerked	Agar. 1x	Cured.

30	F.	12	29. 7. 97.	... ...	Complicated with epilepsy. Died in fit day after discharge. *P.M.*—Small hæmorrhage over right cerebrum	Cupr. 3. Bell. 6 and 30. Cic. Ign.	Died.
31	F.	14	... ...	... ...	... ...	... ...	Cured.
32	M.	12	12. 11. 97.	*Nil* cardiac ...	Second attack	Agar. 3x	,,
33	F.	11	22. 10. 97.	Mitral disease ...	Chorea followed scarlet fever	Agar. 3x	,,
34	F.	23	... ...	... ...	Chorea with neuritis	... ...	Improved.
35	F.	9	12. 10. 97.	Cardiac dilatation, but no bruits	Duration three months	Agar. 3x. Ign. 3. Bell. 1x ...	Cured.
36	M.	12	... ...	*Nil* cardiac ...	Severe second attack. Four months' duration	Agar. 3x. Gels. 1x. Sulph. 12	Improved.
37	F	9	... ...	,, ,, ...	History of rheumatism	Agar. 3x	Cured.
38	M.	12	12. 1. 98.	,, ,, ...	In the hospital for chorea, November, 1897. Relapse one week after discharge. Two sisters had chorea	Gels. 1x. Ars. a. 3x. Agar. 3x	,,
39	F	15	10. 2. 98.	Soft syst. apex bruit	Brought on by fright. No rheumatic history	Agar. 3x	,,
40	M.	15	23. 2. 98.	... ...	Second attack, severe, both sides. Father had rheumatic fever five times. Patient had rheumatic fever at 7 years old and chorea at 10 years	Agar. 3x. Hyoscy. 1x. Ign. 1x	,,
41	F	21	24. 2. 98.	*Nil* cardiac ...	Never had rheumatism. This fourth attack induced by fright, both sides affected	Ign. 1x	,,
42	F	9	3. 3. 98.	,, ,, ...	No previous attack. Slight. Right side only	Ign. 3x	,,
43	F	15	11. 6. 98.	... ...	... ...	Ign. 1x. Zinc. met. 3 ...	Improved.
44	F	17	23. 5. 98.	... ...	... ...	Ign. 1x	Cured.
45	F	1	2. 6. 98.	... .	... ...	Ars. 2x	,,
46	F	15	10. 6. 98.	Endocarditis ...	Second attack. General chorea. Speech especially affected	Sulph. 3x. Ign. 3x. Ars. 2x	,,
47	F	11	28. 7. 98.	... ...	... ...	Act. 1x. Agar. 1x. Cina 1x	,,
48	F	13	26. 9. 98.	Systolic bruit ...	... ...	Ars. a. 3x. Pot. brom. grs. iii. Act. r. 2x. Agar. 1x	,,
49	F	13	16. 11. 98.	... ...	Very slight case	Agar. 3x	,,
50	M	7	... ...	... ...	... ...	... ...	,,
51	M.	9	17. 12. 98.	*Nil* cardiac ...	First attack from severe thrashing, chiefly right side	Ign. Cupr. 3x	,,
52	M.	13	15. 1. 99.	Endocarditis ...	Two years ago, after being caned, had choreic movements. Frequent tonsilitis and arthritis. Sister had rheumatism and endocarditis	Agar. 1x. Zinc. 3. Ign. 1x ...	,,
53	F.	17	16. 1. 99.	Morbus cordis ...	First attack. Chiefly right side	Merc. sol. 3x	,,
54	F	8	21. 1. 99.	... ...	Had attack four months. Chiefly right side	Plumb. 3x. Agar. 1. Ars. a. 2x	,,
55	F	8	23. 2. 99.	Systolic bruit ...	First attack after scolding. No history of rheumatism. Right side chiefly.	Plumb. 3x. Agar. 3x. Ign. 6	,,

Cases of Chorea in the London Homœopathic Hospital (1895-1905)—*continued.*

No.	Sex.	Age.	Date of admission.	Condition of Heart.	Remarks.	Medicines.	Result.
56	M.	9	20. 3. 99.	Apex bruit ...	General chorea followed fright	Ars. a. 2x	Cured.
57	F.	19	21. 3. 99.	... ...	Mental condition such that she was unmanageable	Ign. ϕ	Unimproved.
58	F.	11	20 4. 99.	... ...	First attack. Very emotional. Severe general movements, right side. Several attacks of tonsilitis. No rheumatism	Agar. 3x. Ign. 1x. Ars. a. 2x	Cured.
59	F.	5	21. 3. 99.	Mitral bruit ...	Very bad case, not able to speak or feed herself	Ars. a. 2x. Act. 1x	Much improved.
60	F.	8	25. 5. 99.	... ...	Had fright. No history of chorea or rheumatism. Right side most affected	Agar. 3x. Cupr. 6. Ign. 12.	
61	F.	9½	27. 6. 99.	... ...	Right side chiefly affected. No history of chorea or fright or rheumatism	Ars. a. 2x. Ign. 1x. Agar. 3x.	Unimproved.
62	F.	14	25. 7. 99.	Mitral disease ...	Acute rheumatism. Well-marked chorea ...	Bry. 1x. Ars. 3x. Canth. 1x	Cured.
63	M.	9	1. 9. 99.	Mitral disease ...	Third attack. Family history of rheumatism	Agar. 3x	,,
64	M.	7	24. 8. 99.	Endocarditis ...	Rheumatic pains. Sister had chorea ...	Bry. 1x. Ars. a. 3x. Agar. 1x. Spig. 1x. Hyoscy. 1x	,,
65	F.	14	12. 10. 99.	*Nil* cardiac ...	Second attack. General chorea	Agar. 1x	,,
66	M.	9	26. 9. 99.	Peri- and endo-carditis. Heart (left) permanently damaged. Dilated mitral bruit	First attack began two weeks before admission. General chorea. Family history of rheumatism, mother's side. Readmitted December 20 same year	Ars. 3x. Bry. 1x. Phos. 3. Cactus ϕ. Ars. i. 3x. Naja 3. Stroph. ϕ. Ferr. protox.	,,
67	F.	9	11. 10. 99.	... ...	... ...	Agar. 1x	Improved.
68	M.	5	28. 11. 99.	... ...	... ...	Ars. i. 3x. Ign. 3x. Bry. 3 Cactus ϕ. Liq. ars. ♏ii. to ♏ vi.	Cured.
69	F.	13	23. 12. 99.	... ...	Third attack treated in the hospital ...	Sacch. lact. only	,,
70	F.	13	15. 12. 99.	Systolic apex bruit	No improvement until agaricus was given ...	Stram. 1x. Ign. 1x. Agar. 1x	,,
71	F.	25	28. 9. 99.	*Nil* cardiac ...	Second attack	Agar. 3x. Cupr. a. 6. Hyoscy. 1x Tarent. 6. Hyoscy. 3x	,,
72	F.	15	8. 1. 00.	,, ,, ...	... ...	Ign. 1x. Fers. ars. 3x	,,
73	F.	13	17. 3. 00.	... ...	... ...	Agar. 1x. Ign. 1x. Zinc. met. 3. Zinc. val. 1x	,,

30	F.	12	29. 7. 97.	... ...	Complicated with epilepsy. Died in fit day after discharge. *P.M.*—Small hæmorrhage over right cerebrum	Cupr. 3. Bell. 6 and 30. Cic. Ign.	Died.
31	F.	14	... ...	... ...	... ...	... ...	Cured.
32	M.	12	12. 11. 97.	*Nil* cardiac ...	Second attack	Agar. 3x	,,
33	F.	11	22. 10. 97.	Mitral disease ...	Chorea followed scarlet fever	Agar. 3x	,,
34	F.	23	... ...	... ...	Chorea with neuritis	... ...	Improved.
35	F.	9	12. 10. 97.	Cardiac dilatation, but no bruits	Duration three months	Agar. 3x. Ign. 3. Bell. 1x ...	Cured.
36	M.	12	... ...	*Nil* cardiac ...	Severe second attack. Four months' duration	Agar. 3x. Gels. 1x. Sulph. 12	Improved.
37	F	9	... ...	,, ,, ...	History of rheumatism	Agar. 3x	Cured.
38	M.	12	12. 1. 98.	,, ,, ...	In the hospital for chorea, November, 1897. Relapse one week after discharge. Two sisters had chorea	Gels. 1x. Ars. a. 3x. Agar. 3x	,,
39	F	15	10. 2. 98.	Soft syst. apex bruit	Brought on by fright. No rheumatic history	Agar. 3x	,,
40	M.	15	23. 2. 98.	... ...	Second attack, severe, both sides. Father had rheumatic fever five times. Patient had rheumatic fever at 7 years old and chorea at 10 years	Agar. 3x. Hyoscy. 1x. Ign. 1x	,,
41	F	21	24. 2. 98.	*Nil* cardiac ...	Never had rheumatism. This fourth attack induced by fright, both sides affected	Ign. 1x	,,
42	F	9	3. 3. 98.	,, ,, ...	No previous attack. Slight. Right side only	Ign. 3x	,,
43	F	15	11. 6. 98.	... ...	... ...	Ign. 1x. Zinc. met. 3 ...	Improved.
44	F	17	23. 5. 98.	... ...	... ...	Ign. 1x	Cured.
45	F	1	2. 6. 98.	... .	... ...	Ars. 2x	,,
46	F	15	10. 6. 98.	Endocarditis ...	Second attack. General chorea. Speech especially affected	Sulph. 3x. Ign. 3x. Ars. 2x	,,
47	F	11	28. 7. 98.	... ...	... ...	Act. 1x. Agar. 1x. Cina 1x	,,
48	F	13	26. 9. 98.	Systolic bruit ...	... ...	Ars. a. 3x. Pot. brom. grs. iii. Act. r. 2x. Agar. 1x	,,
49	F	13	16. 11. 98.	... ...	Very slight case	Agar. 3x	,,
50	M.	7	... ...	... ...	... ...	... ...	,,
51	M.	9	17. 12. 98.	*Nil* cardiac ...	First attack from severe thrashing, chiefly right side	Ign. Cupr. 3x	,,
52	M.	13	15. 1. 99.	Endocarditis ...	Two years ago, after being caned, had choreic movements. Frequent tonsilitis and arthritis. Sister had rheumatism and endocarditis	Agar. 1x. Zinc. 3. Ign. 1x ...	,,
53	F	17	16. 1. 99.	Morbus cordis ...	First attack. Chiefly right side	Merc. sol. 3x	,,
54	F	8	21. 1. 99.	... ...	Had attack four months. Chiefly right side	Plumb. 3x. Agar. 1. Ars. a. 2x	,,
	F.	8	23. 2. 99.	Systolic bruit ...	First attack after scolding. No history of rheumatism. Right side chiefly.	Plumb. 3x. Agar. 3x. Ign. 6	,,

Cases of Chorea in the London Homœopathic Hospital (1895-1905)—*continued.*

No.	Sex.	Age.	Date of admission.	Condition of Heart.	Remarks.	Medicines.	Result.
56	M.	9	20. 3. 99.	Apex bruit ...	General chorea followed fright	Ars. a. 2x	Cured.
57	F.	19	21. 3. 99.	... ...	Mental condition such that she was unmanageable	Ign. ϕ	Unimproved.
58	F.	11	20 4. 99.	... ...	First attack. Very emotional. Severe general movements, right side. Several attacks of tonsilitis. No rheumatism	Agar. 3x. Ign. 1x. Ars. a. 2x	Cured.
59	F.	5	21. 3. 99.	Mitral bruit ...	Very bad case, not able to speak or feed herself	Ars. a. 2x. Act. 1x	Much improved.
60	F.	8	25. 5. 99.	... ...	Had fright. No history of chorea or rheumatism. Right side most affected	Agar. 3x. Cupr. 6. Ign. 12.	
61	F.	9½	27. 6. 99.	... ...	Right side chiefly affected. No history of chorea or fright or rheumatism	Ars. a. 2x. Ign. 1x. Agar. 3x.	Unimproved.
62	F.	14	25. 7. 99.	Mitral disease ...	Acute rheumatism. Well-marked chorea ...	Bry. 1x. Ars. 3x. Canth. 1x	Cured.
63	M.	9	1. 9. 99.	Mitral disease ...	Third attack. Family history of rheumatism	Agar. 3x	,,
64	M.	7	24. 8. 99.	Endocarditis ...	Rheumatic pains. Sister had chorea ...	Bry. 1x. Ars. a. 3x. Agar. 1x. Spig. 1x. Hyoscy. 1x	,,
65	F.	14	12. 10. 99.	*Nil* cardiac ...	Second attack. General chorea	Agar. 1x	,,
66	M.	9	26. 9. 99.	Peri- and endo-carditis. Heart (left) permanently damaged. Dilated mitral bruit	First attack began two weeks before admission. General chorea. Family history of rheumatism, mother's side. Readmitted December 20 same year	Ars. 3x. Bry. 1x. Phos. 3. Cactus ϕ. Ars. i. 3x. Naja 3. Stroph. ϕ. Ferr. protox.	,,
67	F.	9	11. 10. 99.	... ...	... ...	Agar. 1x	Improved.
68	M.	5	28. 11. 99.	... ...	... ...	Ars. i. 3x. Ign. 3x. Bry. 3 Cactus ϕ. Liq. ars. ♏ii. to ♏ vi.	Cured.
69	F.	13	23. 12. 99.	... ...	Third attack treated in the hospital ...	Sacch. lact. only	,,
70	F.	13	15. 12. 99.	Systolic apex bruit	No improvement until agaricus was given ...	Stram. 1x. Ign. 1x. Agar. 1x	,,
71	F.	25	28. 9. 99.	*Nil* cardiac ...	Second attack	Agar. 3x. Cupr. a. 6. Hyoscy. 1x Tarent. 6. Hyoscy. 3x	,,
72	F.	15	8. 1. 00.	,, ,, ...	... ...	Ign. 1x. Fers. ars. 3x	,,
73	F.	13	17. 3. 00.	... ...	... ...	Agar. 1x. Ign. 1x. Zinc. met. 3. Zinc. val. 1x	,,

74	M.	15	... ...	Endocarditis, mitral systole	... ...	... ...	Cured
75	M.	12	29. 1. 00.	Apex bruit ? ...	Left hemichorea in highly neurotic boy induced by fright. Pulse intermittent	Ign. 1x	,,
76	F.	12	... ...	... ...	... ...	... ...	,,
77	F.	11	1. 2. 00.	*Nil* cardiac ...	General chorea after fright	Agar. 1x. Ars. a. 3x	,,
78	F.	15	15. 2. 00.	... ...	Chorea. Mentally deficient	Hyoscy. 3x. Ign. 12. Ferr. protox.	,,
79	F.	12	12. 3. 00.	... ...	... ...	Ign. 1x	,,
80	F.	6	5. 4. 00.	... ...	No medicinal treatment	... ...	,,
81	M.	9	... ...	... ...	... ...	... ...	,,
82	F.	$7\frac{1}{2}$	21. 4. 00.	Endocarditis ...	General chorea with rheumatism and pneumonia	Liq. ars. Acon. 1x. Bry. 1x. Ars. Iod. 3. Phos. 3x. Hyoscy.ϕ	Much improved.
83	F.	13	3. 5. 00.	... ...	... ...	Agar. 3x. Ign. 3	Much improved.
84	M.	9	25. 4. 00.	... ...	Chorea and German measles	Acon. 3x. Liq. ars. Agar. 1x. Puls. 1x	Cured.
85	M.	7	... ...	Endocarditis ...	... ...	... ...	,,
86	M.	13	... ...	Endocarditis ..	... ...	... ...	,,
87	M.	19	13. 8. 00.	Mitral systolic bruit	Had acute rheumatism and after recovery chorea developed same year. Mental condition—"silly"	Stram. 3x. Bry. 1x and stram. 6	,,
88	M.	12	... ...	... ...	... ...	... ...	,,
89	M.	16	3. 9. 00.	*Nil* cardiac ...	... ...	Cic. 6 and 3	Very much improved.
90	F.	13	27. 8. 00.	,, ,, ...	No history of rheumatism or chorea. Movements chiefly on left side	Agar. 3x	Improved.
91	F.	15	... ...	... ...	... ...	... ...	,,
92	F.	$13\frac{1}{2}$	14. 9. 00.	... ...	... ...	Agar. 3. Stram. 3. Liq. ars.	,,
93	M.	$12\frac{1}{2}$	25. 10. 00.	Systolic apex bruit	Movements chiefly on right side	Act. r. 1x. Ars. 3	,,
94	F.	10	26. 10. 00.	... ...	Sister of last patient	... ...	Cured.
95	M.	8	5. 11. 00.	... ...	... ...	Agar. 3x. Cicutine (1 in 200)	Improved.
96	F.	15	10. 12. 00.	... ...	No medicinal treatment	... ...	Cured.
97	F.	7	29. 12. 00.	Systolic mitral bruit with thrill	... ...	Agar. 1x	,,
98	F.	14	24. 1. 01.	... ...	... ...	Act. 1x. Liq. ars. Bell. 1x. Ferr. Protox.	,,
99	F.	10	... ...	... ...	... ...	... ...	,,
100	F.	22	28. 1. 01.	... ...	Had previous attack of chorea aged 16. Left arm and leg only affected	Hyoscy. 3x (improved rapidly on this)	Much improved.
101	M.	12	24. 1. 01.	Mitral systolic bruit	Had chorea every year for last three years ...	Ars. 3. Ign. 3x	Improved.
102	F.	10	5. 2. 01.	... ...	... ...	Act. 3x. Caust. 12. Liq. ars.	Cured.

CASES OF CHOREA IN THE LONDON HOMŒOPATHIC HOSPITAL (1895-1905)—*continued.*

No.	Sex.	Age.	Date of admission.	Condition of Heart.	Remarks.	Medicines.	Result.
103	F.	9	19. 2. 01.	... ...	... ...	Ign. 1x. Bap. ϕ. Hep. s. 3. Cupr. met. 6	Cured.
104	F.	8	18. 3. 01.	... ...	... ...	Ign. 3x	,,
105	F.	3½	4. 3. 01.	... ...	General chorea. First attack	Agar. 3x and 1x. Ign. 1x. Ars. 2x	,,
106	F.	13	21. 3. 01.	... ...	... ...	Agar. 3x. Spig. 1x	,,
107	F.	16	3. 6. 01.	Normal	Second attack. Right side only affected. First attack four years ago. Family history of rheumatism	Agar. 3x. Ign. 1x	Improved.
108	M.	9	5. 6. 01.	Mitral regurgitation	... ...	Ars. a. 3x	Cured.
109	F.	27	20. 5. 01.	Normal	Fourth attack. First attack three years previous. Complicated with epilepsy	Agar. 3x. Hyoscy. (1 in 200) Zinc 6	,,
110	F.	4	... ...	... ...	... ...	... ...	,,
111	F.	9	3. 9. 01.	... ...	... ...	Agar. 3	,,
112	F.	14	24. 8. 01.	... ...	... ...	Stram. 30. Agar. 6 and 3x. Act. 1x	,,
113	M.	12	21. 10. 01.	Normal	First attack	Agar. 3x	,,
114	F.	14	23. 10. 01.	Soft apex syst. bruit	Had several previous attacks. History of chorea on father's side	Ign. 1x	Improved.
115	F.	13	... ...	... ...	... ...	... ...	Cured.
116	M.	10	... ...	Mitral stenosis ...	... ...	... ...	Improved.
117	F.	11	16. 9. 01.	... ...	... ...	Agar. 3. Ign. 3. Zinc. met. 12. Act. 2x. Liq. ars. Sul. 12	Cured.
118	F.	10	27. 1. 02.	... ...	... ...	Agar. 3x	,,
119	F.	13	5. 2. 02.	Systolic apex bruit	? ... Bitten by dog. Two previous attacks treated in other hospitals	Ars. a. 3x	Improved.
120	F.	9	6. 1. 02.	... ...	First attack began three months ago ...	Ign. 1x. Stram. 2x. Agar. 2x	,,
121	F.	12	9. 1. 02.	Mitral systolic bruit	Two attacks of rheumatism—the last six weeks ago. Chorea followed	Zinc. 3. Stram. 2x. Ign. 1x	Cured.
122	F.	14	13. 5. 02.	*Nil* cardiac ...	Had rheumatic fever last summer. Chorea followed. Brother has rheumatism	Agar. 3x	,,
123	M.	10	7. 7. 02.	Systolic mitral bruit	No rheumatism. Sharp boy	Agar. 3x	,,
124	F.	24	17. 7. 02.	Irregular action, no bruit	Strong till eighteen. Chorea on and off since. Treated in three other hospitals	Agar. 1x	Improved

125	F.	15	2. 10. 02.	*Nil* cardiac ...	Several previous attacks. Follicular tonsilitis. Rheumatism and chorea in the family	Puls. 3x. Ign. 1x. Merc. bin. 3x	Improved.
126	M	6	23. 10. 02.	... ...	Chorea followed measles. Follicular tonsilitis ensued	Merc. bin. 3x. Ant. t. 3x ...	Cured.
127	M.	11	10. 10. 02.	Systolic mitral bruit	Had rheumatic fever and chorea before. Two other children in family had chorea	Cact. 3. Bry. 3x. Hyoscy. 3x Agar. 3x	Improved.
128	M.	6	6. 10. 02.	... ...	... ...	Agar. 1x. Viscum 1x. Zinc. met. 3	Cured.
129	F	1	9. 12. 02.	Normal	Fourth attack	... ...	Unfit.
130	F	1	17. 11. 02.	... ...	... ...	Bry. 3x. Ars. 2x. Ars. 3x ...	Improved.
131	M.	13	9. 3. 03.	... ...	Had rheumatism and two previous attacks of chorea	... ...	,,
132	F	11	26. 3. 03.	Normal	First attack of chorea	Agar. 3x	Cured.
133	F	8	4. 5. 03.	... ...	Hysterical chorea...	... ...	,,
134	F	18	1. 5. 03.	Normal	Second attack chorea. Rheumatism ...	Act. 3x. Ign. 1x. Zinc. met. 3 Agar. 3x, 2x, and 1x	,,
135	F	15	8. 7. 03.	... ...	Had rheumatism several times. Chorea first in left side, then in right. Chorea and rheumatism in both parents	Act. 3x. Agar. 3x.	,,
136	F	7	27. 7. 03.	... ...	... ...	Ign. 3x	Unimproved.
137	F	15	17. 8. 03.	... ...	Complicated with epilepsy...	Zinc. met. 30	Improved.
138	M.	8	... ...	... ...	... ...	... ...	Cured.
139	F	18	19. 8. 03.	Mitral systolic bruit	Third attack	Puls. 3. Ign. 3	,,
140	M.	10	12. 11. 03.	... ...	Right side affected. No previous attack or history of rheumatism	Sulph. 200	,,
141	F	13	10. 10. 03.	... ...	... ...	Sulph. 30. Stram. 12. Agar. 30 and 3x. Gels. 3.	Improved.
142	F	12	21. 10. 03.	... ...	... ...	Sulph. 200. Act. 2x. Stram. 30. Ars. 3x	,,
143	F	13	22. 12. 03.	... ...	... ...	Sulph. 200. Ign. 30. Zinc. 30	Cured.
144	F	8	17. 12. 03.	Systolic bruit ...	... ...	Sulph. 200. Agar. 12 and 1x. Stram. 12. Ign. 30. Zinc. 30	,,
145	M.	7	20. 1. 04.	Systolic bruit ...	Second attack	Zinc. 30. Sulph. 200... ...	,,
146	M.	8	4. 3. 04.	... ...	... ...	Sulph. 200	,,
147	F	12	4. 1. 04.	... ...	Chorea with paralysis	Sulph. 200. Ign. 30. Zinc. 30. phyt. 30	Improved.
148	F	14	3. 3. 04.	Mitral systolic bruit	Second attack	Sulph. 200. Zinc. 30. Ign. 30	,,
149	F	14	30. 6. 04.	... ...	... ...	Zinc. 30. Hyoscy. 3	,,
150	F	13	20. 6. 04.	Heart affected ...	Had chorea before, also rheumatic fever. Enlarged left tonsil. Mother of patient rheumatic	Merc. bin. 2x	Cured.
151	F	11	22. 9. 04.	... ...	... ...	Zinc. met. 30	,,

Cases of Chorea in the London Homœopathic Hospital (1895-1905)—*continued.*

No.	Sex.	Age.	Date of admission	Condition of Heart.	Remarks.	Medicines.	Result.
152	F.	10	17. 11. 04.	... ...	... ...	Agar. 3x	Cured.
153	F.	7	5. 5. 04.	... ...	Has rheumatic nodules. Father of patient rheumatic	Zinc. 30. Hyoscy. 3 Rhus 6	,,
154	F.	9	3. 8. 04.	... ...	... ...	Sulph. 200. Agar. 30 and 3x. Stram. 30 and 12. Zinc. 30, Ign. 12	Much improved.
155	F.	13	2. 5. 04.	Mitral systolic bruit	Four or five previous attacks of chorea. Rheumatism in ankles	Zinc. 30	Cured.
156	F.	11	12. 6. 04.	Mitral disease ...	Relapse from damp room. Family history of rheumatism	Act. 3x. Ign. 1x. Viscum 1x	Much improved.
157	M.	9	10. 5. 04.	... ...	Choreiform twitchings	Bell. 3x given for enuresis ...	Cured.
158	F.	12	12. 11. 04.	Mitral disease ...	Previous attack of chorea followed by rheumatic fever. Family history of rheumatism	Act. 3x. Cact. ϕ. Ars. 3x. Spig. 3x	Much improved.
159	F.	8½	7. 2. 05.	... ...	Chorea on father's side of family	Agar. 6	Cured.
160	M.	10	13. 2. 05.	... ...	Habit chorea	Ign. 6. Zinc. 6	Much improved.
161	M.	10	28. 2. 05.	Mitral systolic bruit	Rheumatism and chorea	... ...	Cured.
162	M.	13	16. 3. 05.	Endocarditis, pericarditis	Had rheumatic fever and chorea several times. Two others in family had chorea	Ars. 3. Stroph. ϕ. Agar. 1x and 3x	Died.
163	F.	10	15. 2. 05.	Mitral systolic bruit	... ...	Ars. 3	Much improved.
164	F.	16	9. 3. 05.	*Nil* cardiac ...	... ...	Agar. 3	Cured.
165	M.	8	15. 3. 05.	Mitral systolic bruit	Third attack chorea	Ign. 1x. Bell. 3. Ars. 3x. Cham. 1x	Improved.
166	M.	10	4. 4. 05.	Systolic mitral bruit	... ...	Act. 3. Ign. 3x. Agar. 3x. Zinc. 6	Much improved.
167	F.	8	5. 5. 05.	*Nil* cardiac ...	Present attack began after Christmas party. Mother of patient had chorea and fits	Ign. 3x. Hyoscy. 3x	Cured.
168	F.	12	7. 9. 05.	... ...	... ...	Agar. 3	Improved.
169	F.	11	14. 9. 05.	*Nil* cardiac ...	Chorea developed after scarlet fever at two years old. Chronic case. Mother of patient rheumatic	Agar. 3x and 30 and ϕ. Ign. 12. Ars. a. 3 and 30	,,
170	F.	9	26. 10. 05.	,, ,, ...	Slight case.		
171	M.	17	30. 10. 05.	Systolic bruit ...	No rheumatism. Illness began three years ago	Ign. 1x	Much improved.

remained under Dr. Blackley's care for several months. The case was remarkable because absolute aphasia was also present, the history of the onset of which he could never obtain; it was present when he was called in. He could not trace any connection between the chorea and the aphasia. She eventually returned home without improvement, and subsequently died. Dr. Alexander recently had a case which illustrated the truth that each patient must have its own simillimum differentiated. A lad, aged 17, who was serving his apprenticeship as an engineer, had developed a habit spasm, the head twitching to the right side, with an upward movement. He found the symptoms under the drug cicuta virosa, and its administration for a few weeks cured the patient completely.

Dr. GOLDSBROUGH did not think it desirable to take too pronounced a view of the pathological side of chorea; there were many cases which could not be traced to rheumatism, though they might have a rheumatic base. He did not think many men would advocate lumbar puncture and examination of the cerebrospinal fluid in order to settle the pathological diagnosis. There was a kind of heart which he had been accustomed to regard as choreic; there was absence of bruit, but irregularity of action and sound. He regarded the most important indications for treatment those mentioned at the end of the paper, the hygienic ones, especially from the mental side. He did not agree that chorea occurred mostly in the intellectual type of child, but in the child which was mentally unstable. Intellectual development without emotional was not usually associated with chorea. There had been an interesting association between tics, chorea, and epilepsy, and mental disturbance almost amounting to mania. In a case of Dr. Goldsbrough's during her attacks the child for five minutes at a time was absolutely mad, and after the attack she remembered nothing of it. There the disturbance was probably in the frontal lobes of the brain. He had found sulphate of zinc a most useful medicine in some cases of chorea, preferring that to zincum metallicum, and using it in the sixth dilution. In the selection of remedies, Hahnemann's dictum as to the disposition and mental state gave the best indication, when cardiac and articular troubles were absent.

Dr. BLACKLEY wished to refer to his routine practice in treating chorea. If a case came into hospital he usually kept it without any medicine for a week or two, and if it improved he did not give any, even though the case might have been fairly severe. The reason a child got better in hospital was, that it was in a

better moral atmosphere, in the widest sense, than at home, and the patient soon felt that outbreaks of temper did not do. Some of the severest cases in the hospital had been treated with agaricus in the first decimal, usually five-drop doses.

Dr. STONHAM said he had been studying one of the charts exhibited by Dr. Day, and trying to find the explanation for the sudden and extreme drop in the number of cases of chorea occurring in April, with the subsequent rise in May. He thought that if the figures from which the chart was constructed were those representing the number of patients applying for treatment at hospitals or dispensaries there might be a simple explanation of the reduction, viz., that Easter almost always fell in April, and it was a matter of common observation that poor patients abstained from coming to hospitals during holiday times unless there was something serious or painful the matter with them, and they would regard such symptoms as slight twitchings or fidgetting movements in their children as requiring no immediate attention, so that many of the April cases would not be brought till May. He was pleased to hear so many of the speakers report favourably of stramonium in the treatment of chorea, as the pathogenesis of chorea, as shown in the cases of poisoning recorded in the "Cyclopædia of Drug Pathogenesy," exhibits symptoms more like those of chorea than does any other drug. He was disposed to differ from Dr. Day and agree with Dr. Goldsbrough in thinking that it is not the intellectual but the emotional patients who are most subject to chorea. The brain symptoms of chorea were those of emotional rather than of intellectual disorder; and, speaking generally, people of great intellectual development were not easily affected emotionally.

Dr. ROBERSON DAY, in replying to Dr. Clarke, said there was a distinction between tics and chorea. The former affected both sexes equally, and in chorea, as shown in the diagram, the age incidence differed, being met with in younger children. The term aphasia, which Dr. Alexander used to mean speechlessness, should be restricted to those cases where words are wrongly used, things being called by their wrong names; it is a confusion of words, and depends on a lesion of Broca's convolution —the third left frontal. Although the emotional centres are often affected, as pointed out by Dr. Goldsbrough, still the children suffering from chorea who came under Dr. Roberson Day's observation were all sharp, bright and intelligent—children who were fond of learning and books, and frequently at the top of their class.

REMARKS UPON CALCAREA PHOSPHORICA AND KINDRED LIME SALTS.[1]

BY HAROLD VALDEMAR MUNSTER, M.D.EDIN.
Medical Officer to the Croydon Homœopathic Dispensary.

In a brief consideration of the calcarea salts, I want more especially to bring to the front calcarea phosphorica. This is the salt I have made most use of out of the series, my attention being drawn to it more especially because of its being one of the famous Schussler remedies, and, oddly enough, this by a layman. This worthy layman is a firm believer in homœopathy, but pins his faith even more to Schusslerism, if I may use such a word, stating that he never finds the Schussler remedies fail him. His colds yield at once to natrum muriaticum, and he does not seem to care much whether he uses the first or the sixth potency. Calc. phos. he affirms never fails to cure him of those uncomfortable little mouth ulcers that trouble most people at times, sore and unpleasant enough while they last. His custom is very simple; he turns up the index or repertory of whatever book he uses on the tissue remedies, and gives whatever medicine is recommended, and his experience is that the results are uniformly good. He adds that he has not found this the case with any other remedies, homœopathic or otherwise. Lay testimony of this kind is by no means to be despised, especially when it comes from people of good common sense, as in this case. I was recently sent for by a respectable family in Croydon for the simple reason that the good people had noticed much better results follow their own homœopathic prescribing than ever followed the use of remedies ordered by their usual allopathic medical man.

Before proceeding to make a brief survey of the calcium salts, I should like to allude to the subject of *ionisation*. This subject first came under my notice when glancing at

[1] Presented to the Section of Materia Medica and Therapeutics, June 6, 1907.

Hale White's "Textbook of Pharmacy and Therapeutics" (1901 edition) two or three years ago, and what I have to say on the subject is derived from this book. It has been suggested that remedies act upon the animal economy in a state of ionisation. It will do no harm to remind you that when electrolytic substances, *e.g.*, hydrochloric acid (HCl) are dissolved in water, dissociation into ions begins to take place. The ions in solution are so far free from each other's influence that when an electric force is applied to the solution it drags them in opposite directions. In the case of HCl the H is drawn away to one pole of the battery and the Cl to the other in a nascent condition. Now the modern theory of solution is that acids, bases and salts in dilute solution are not present in intact molecules, but rather in the form of atomic ions. Let us look a little closer at these ions. If we take a solution of HCl we shall have in it dissociated chlorine ions, but not free chlorine in the condition that obtains in a solution of chlorine gas. "In no solution of a chloride can we demonstrate chlorine by its physical properties; but in all we can demonstrate its presence by its reactions. Each and every chloride yields a certain set of reactions in virtue of the chlorine it contains, which are precisely the same, no matter what the associated element may be." Thus the ion is neither the electrolyte, nor yet the constituent element of the electrolyte in its ordinary molecular condition; but it is that element in its nascent or atomic condition. Now when a substance is in solution, only a part of it is actually ionised, unless the solution be very dilute. Hence the more dilute the solution the more perfect is the process of ionisation up to the point of complete ionisation. Hale White even remarks that at infinite dilution we may suppose that the process of ionisation is completed. May there not lie in this conception an explanation of the circumstance that we are familiar with as homœopaths, viz., the need of carrying the dilution of certain drugs a long way before we get their curative properties developed, of which as examples natrum mur. and silica may be cited.

There are some interesting facts which tend to bear out this ion theory of solution. The first fact is one we are all

familiar with, namely, the apparently identical action on the system of a series of salts containing one predominating element. An example of this we have in the various iron salts, carbonates, sulphates, chlorides, &c., all of which appear to act in precisely the same manner in anæmia; again, where the metal element is comparatively unimportant we have the similarity of effects on the system of the bromides and of the iodides. This is easily understood if we conceive the action of each salt to be equivalent to the action of its ions. In the case of the iron salts we should with each salt so dissociating get iron set free in the form of its ions, and the effect of the other constituent of the salt being unimportant, the effect of the iron would in each case predominate, however much the several salts of iron might differ from one another in their solid state. Quite otherwise is it with the ferrocyanides. These salts do *not* resemble the simpler iron salts in their action, and here we find the ionic dissociation is not the same, for instead of iron the ferrocyanides yield the group $FeCN_3$, the chemical behaviour and physiological action of which is quite different from that of iron.

The second interesting fact is that in a series of toxic salts, such as the mercury salts, it is found that those salts which most readily dissociate into ions in solution are those which are most toxic. All strong acids and bases owe their strength to the readiness with which they dissociate into their ions in solution.

The last interesting fact I will mention in this connection is that it has been found possible to reduce the toxicity of a given salt by interfering with its ionic dissociation. In the case of the perchloride of mercury, *e.g.*, it has been found that by adding sodium chloride to its solution the toxicity is reduced. The reason of this is that no solution of a chloride can contain more than a certain number of chlorine ions, but when sodium chloride is added to the solution of mercuric chloride then some of the chlorine ions are supplied by the relatively inactive sodium salt. This diminishes the amount of ionised mercury in the solution, and hence the diminished toxicity caused by the mixture.

Cases of Chorea in the London Homœopathic Hospital (1895-1905)—*continued.*

No.	Sex.	Age.	Date of admission.	Condition of Heart.	Remarks.	Medicines.	Result.
56	M.	9	20. 3. 99.	Apex bruit ...	General chorea followed fright	Ars. a. 2x	Cured.
57	F.	19	21. 3. 99.	... ...	Mental condition such that she was unmanageable	Ign. ϕ	Unimproved.
58	F.	11	20 4. 99.	... ...	First attack. Very emotional. Severe general movements, right side. Several attacks of tonsilitis. No rheumatism	Agar. 3x. Ign. 1x. Ars. a. 2x	Cured.
59	F.	5	21. 3. 99.	Mitral bruit ...	Very bad case, not able to speak or feed herself	Ars. a. 2x. Act. 1x	Much improved.
60	F.	8	25. 5. 99.	... ...	Had fright. No history of chorea or rheumatism. Right side most affected	Agar. 3x. Cupr. 6. Ign. 12.	
61	F.	9½	27. 6. 99.	... ...	Right side chiefly affected. No history of chorea or fright or rheumatism	Ars. a. 2x. Ign. 1x. Agar. 3x.	Unimproved.
62	F.	14	25. 7. 99.	Mitral disease ...	Acute rheumatism. Well-marked chorea ...	Bry. 1x. Ars. 3x. Canth. 1x	Cured.
63	M.	9	1. 9. 99.	Mitral disease ...	Third attack. Family history of rheumatism	Agar. 3x	,,
64	M.	7	24. 8. 99.	Endocarditis ...	Rheumatic pains. Sister had chorea ...	Bry. 1x. Ars. a. 3x. Agar. 1x. Spig. 1x. Hyoscy. 1x	,,
65	F.	14	12. 10. 99.	*Nil* cardiac ...	Second attack. General chorea	Agar. 1x	,,
66	M.	9	26. 9. 99.	Peri- and endo-carditis. Heart (left) permanently damaged. Dilated mitral bruit	First attack began two weeks before admission. General chorea. Family history of rheumatism, mother's side. Readmitted December 20 same year	Ars. 3x. Bry. 1x. Phos. 3. Cactus ϕ. Ars. i. 3x. Naja 3. Stroph. ϕ. Ferr. protox.	,,
67	F.	9	11. 10. 99.	... ...	... ...	Agar. 1x	Improved.
68	M.	5	28. 11. 99.	... ...	... ...	Ars. i. 3x. Ign. 3x. Bry. 3 Cactus ϕ. Liq. ars. ♏ii. to ♏ vi.	Cured.
69	F.	13	23. 12. 99.	... ...	Third attack treated in the hospital ...	Sacch. lact. only	,,
70	F.	13	15. 12. 99.	Systolic apex bruit	No improvement until agaricus was given ...	Stram. 1x. Ign. 1x. Agar. 1x	,,
71	F.	25	28. 9. 99.	*Nil* cardiac ...	Second attack	Agar. 3x. Cupr. a. 6. Hyoscy. 1x Tarent. 6. Hyoscy. 3x	,,
72	F.	15	8. 1. 00.	,, ,, ...	... ...	Ign. 1x. Fers. ars. 3x	,,
73	F.	13	17. 3. 00.	... ...	... ...	Agar. 1x. Ign. 1x. Zinc. met. 3. Zinc. val. 1x	,,

74	M.	15	... ...	Endocarditis, mitral systole	... ...	... ...	Cured
75	M.	12	29. 1. 00.	Apex bruit ? ...	Left hemichorea in highly neurotic boy induced by fright. Pulse intermittent	Ign. 1x	,,
76	F	12	... ...	... ...	... ...	... ...	,,
77	F	11	1. 2. 00.	*Nil* cardiac ...	General chorea after fright	Agar. 1x. Ars. a. 3x	,,
78	F	15	15. 2. 00.	... ...	Chorea. Mentally deficient	Hyoscy. 3x. Ign. 12. Ferr. protox.	,,
79	F	12	12. 3. 00.	... ...	... ...	Ign. 1x	,,
80	F	6	5. 4. 00.	... ...	No medicinal treatment	... ...	,,
81	M.	9	... ...	... ...	... ...	... ...	,,
82	F	$7\frac{1}{2}$	21. 4. 00.	Endocarditis ...	General chorea with rheumatism and pneumonia	Liq. ars. Acon. 1x. Bry. 1x. Ars. Iod. 3. Phos. 3x. Hyoscy. ϕ	Much improved.
83	F	13	3. 5. 00.	... ...	... ...	Agar. 3x. Ign. 3	Much improved.
84	M.	9	25. 4. 00.	... ...	Chorea and German measles	Acon. 3x. Liq. ars. Agar. 1x. Puls. 1x	Cured.
85	M.	7	... ...	Endocarditis ...	... ...	... ...	,,
86	M.	13	... ...	Endocarditis ..	... ...	... ...	,,
87	M.	19	13. 8. 00.	Mitral systolic bruit	Had acute rheumatism and after recovery chorea developed same year. Mental condition—"silly"	Stram. 3x. Bry. 1x and stram. 6	,,
88	M.	12	... ...	... ...	... ...	... ...	,,
89	M.	16	3. 9. 00.	*Nil* cardiac ...	... ...	Cic. 6 and 3	Very much improved.
90	F	13	27. 8. 00.	,, ,, ...	No history of rheumatism or chorea. Movements chiefly on left side	Agar. 3x	Improved.
91	F	15	... ...	... ...	... ...	... ...	,,
92	F	$13\frac{1}{2}$	14. 9. 00.	... ...	... ...	Agar. 3. Stram. 3. Liq. ars.	,,
93	M.	$12\frac{1}{2}$	25. 10. 00.	Systolic apex bruit	Movements chiefly on right side	Act. r. 1x. Ars. 3	,,
94	F	10	26. 10. 00.	... ...	Sister of last patient	... ...	Cured.
95	M.	8	5. 11. 00.	... ...	... ...	Agar. 3x. Cicutine (1 in 200)	Improved.
96	F	15	10. 12. 00.	... ...	No medicinal treatment	... ...	Cured.
97	F	7	29. 12. 00.	Systolic mitral bruit with thrill	... ...	Agar. 1x	,,
98	F	14	24. 1. 01.	... ...	... ...	Act. 1x. Liq. ars. Bell. 1x. Ferr. Protox.	,,
99	F	10	... ...	... ...	... ...	... ...	,,
100	F.	22	28. 1. 01.	... ...	Had previous attack of chorea aged 16. Left arm and leg only affected	Hyoscy. 3x (improved rapidly on this)	Much improved.
101	M.	12	24. 1. 01.	Mitral systolic bruit	Had chorea every year for last three years ...	Ars. 3. Ign. 3x	Improved.
102	F	10	5. 2. 01.	... ...	... ...	Act. 3x. Caust. 12. Liq. ars.	Cured.

CASES OF CHOREA IN THE LONDON HOMŒOPATHIC HOSPITAL (1895-1905)—*continued.*

No.	Sex.	Age.	Date of admission.	Condition of Heart.	Remarks.	Medicines.	Result.
103	F.	9	19. 2. 01.	... ...	... ...	Ign. 1x. Bap. ϕ. Hep. s. 3. Cupr. met. 6	Cured.
104	F.	8	18. 3. 01.	... ...	... ...	Ign. 3x	,,
105	F.	3½	4. 3. 01.	... ...	General chorea. First attack	Agar. 3x and 1x. Ign. 1x. Ars. 2x	,,
106	F.	13	21. 3. 01.	... ...	... ...	Agar. 3x. Spig. 1x	,,
107	F.	16	3. 6. 01.	Normal	Second attack. Right side only affected. First attack four years ago. Family history of rheumatism	Agar. 3x. Ign. 1x	Improved.
108	M.	9	5. 6. 01.	Mitral regurgitation	... ...	Ars. a. 3x	Cured.
109	F.	27	20. 5. 01.	Normal	Fourth attack. First attack three years previous. Complicated with epilepsy	Agar. 3x. Hyoscy. (1 in 200) Zinc 6	,,
110	F.	4	... ...	... ...	... ...	... ...	,,
111	F.	9	3. 9. 01.	... ...	... ...	Agar. 3	,,
112	F.	14	24. 8. 01.	... ...	... ...	Stram. 30. Agar. 6 and 3x. Act. 1x	,,
113	M.	12	21. 10. 01.	Normal	First attack	Agar. 3x	,,
114	F.	14	23. 10. 01.	Soft apex syst. bruit	Had several previous attacks. History of chorea on father's side	Ign. 1x	Improved.
115	F.	13	... ...	... ...	... ...	... ...	Cured.
116	M.	10	... ...	Mitral stenosis ...	... ...	... ...	Improved.
117	F.	11	16. 9. 01.	... ...	... ...	Agar. 3. Ign. 3. Zinc. met. 12. Act. 2x. Liq. ars. Sul. 12	Cured.
118	F.	10	27. 1. 02.	... ...	... ...	Agar. 3x	,,
119	F.	13	5. 2. 02.	Systolic apex bruit	? ... Bitten by dog. Two previous attacks treated in other hospitals	Ars. a. 3x	Improved.
120	F.	9	6. 1. 02.	... ...	First attack began three months ago ...	Ign. 1x. Stram. 2x. Agar. 2x	,,
121	F.	12	9. 1. 02.	Mitral systolic bruit	Two attacks of rheumatism—the last six weeks ago. Chorea followed	Zinc. 3. Stram. 2x. Ign. 1x	Cured.
122	F.	14	13. 5. 02.	*Nil* cardiac ...	Had rheumatic fever last summer. Chorea followed. Brother has rheumatism	Agar. 3x	,,
123	M.	10	7. 7. 02.	Systolic mitral bruit	No rheumatism. Sharp boy	Agar. 3x	,,
124	F.	24	17. 7. 02.	Irregular action, no bruit	Strong till eighteen. Chorea on and off since. Treated in three other hospitals	Agar. 1x	Improved

125	F	15	2. 10. 02.	*Nil* cardiac ...	Several previous attacks. Follicular tonsilitis. Rheumatism and chorea in the family	Puls. 3x. Ign. 1x. Merc. bin. 3x	Improved.
126	M.	6	23. 10. 02.	... ...	Chorea followed measles. Follicular tonsilitis ensued	Merc. bin. 3x. Ant. t. 3x ...	Cured.
127	M.	11	10. 10. 02.	Systolic mitral bruit	Had rheumatic fever and chorea before. Two other children in family had chorea	Cact. 3. Bry. 3x. Hyoscy. 3x Agar. 3x	Improved.
128	M	6	6. 10. 02.	... ...	... ...	Agar. 1x. Viscum 1x. Zinc. met. 3	Cured.
129	F	11	9. 12. 02.	Normal	Fourth attack	... ...	Unfit.
130	F	11	17. 11. 02.	... ...	... ...	Bry. 3x. Ars. 2x. Ars. 3x ...	Improved.
131	M	13	9. 3. 03.	... ...	Had rheumatism and two previous attacks of chorea	... ...	,,
132	F	11	26. 3. 03.	Normal	First attack of chorea	Agar. 3x	Cured.
133	F	8	4. 5. 03.	... ...	Hysterical chorea...	... ...	,,
134	F	8	1. 5. 03.	Normal	Second attack chorea. Rheumatism ...	Act. 3x. Ign. 1x. Zinc. met. 3 Agar. 3x, 2x, and 1x	,,
135	F	15	8. 7. 03.	... ...	Had rheumatism several times. Chorea first in left side, then in right. Chorea and rheumatism in both parents	Act. 3x. Agar. 3x.	,,
136	F	7	27. ,7. 03.	... ...	... ...	Ign. 3x	Unimproved.
137	F	15	17. 8. 03.	... ...	Complicated with epilepsy...	Zinc. met. 30	Improved.
138	M	8	... ...	... ...	... ...	... ...	Cured.
139	F	18	19. 8. 03.	Mitral systolic bruit	Third attack	Puls. 3. Ign. 3	,,
140	M	10	12. 11. 03.	... ...	Right side affected. No previous attack or history of rheumatism	Sulph. 200	,,
141	F	13	10. 10. 03.	... ...	... ...	Sulph. 30. Stram. 12. Agar. 30 and 3x. Gels. 3.	Improved.
142	F	12	21. 10. 03.	... ...	... ...	Sulph. 200. Act. 2x. Stram. 30. Ars. 3x	,,
143	F	13	22. 12. 03.	... ...	... ...	Sulph. 200. Ign. 30. Zinc. 30	Cured.
144	F	8	17. 12. 03.	Systolic bruit ...	... ...	Sulph. 200. Agar. 12 and 1x. Stram. 12. Ign. 30. Zinc. 30	,,
145	M	7	20. 1. 04.	Systolic bruit ...	Second attack	Zinc. 30. Sulph. 200... ...	,,
146	M	8	4. 3. 04.	... ...	... ...	Sulph. 200	,,
147	F	12	4. 1. 04.	... ...	Chorea with paralysis	Sulph. 200. Ign. 30. Zinc. 30. phyt. 30	Improved.
148	F	14	3. 3. 04.	Mitral systolic bruit	Second attack	Sulph. 200. Zinc. 30. Ign. 30	,,
149	F	14	30. 6. 04.	... ...	... ...	Zinc. 30. Hyoscy. 3	,,
150	F	13	20. 6. 04.	Heart affected ...	Had chorea before, also rheumatic fever. Enlarged left tonsil. Mother of patient rheumatic	Merc. bin. 2x	Cured.
151	F	11	22. 9. 04.	... ...	... ...	Zinc. met. 30	,,

especially in children. Here there will be lack of appetite, accompanied with peevishness, flabbiness and sluggish circulation manifested by cold extremities. There is ready perspiration, especially about the head, and teething difficulties. There may be diarrhœa and even signs of rickets. Usually there is a history of inadvised feeding or malassimilation of food. The child resents interference and likes to lie still.

The same symptoms will accompany cases of *adenitis*, where calcarea is indicated, but here the calc. iod. should be thought of and given a preference to.

In the *cutaneous sphere* we may note that any petechial eruptions should make us think of calcium salts for their hæmostatic properties. In the same way they help urticaria, which is supposed to be caused by deficient coagulability of the blood, often brought on by excessive use of vinegar and other acids. Here substantial doses are usually given, but perhaps they are not always necessary. Indolent ulcers, accompanying varicose veins, have healed rapidly and well under two-grain doses of calc. iod. For suppurative lesions hepar sulphuris is more often called for, and most efficient it is, whether for boils, styes, acne or abscesses. This year's *Medical Annual* speaks of the lime salts as almost a specific for chilblains. They are certainly very homœopathic.

Even the *urinary and sexual systems* are not beyond the help of calcarea. This year's *Medical Annual* cites the use of lime salts in functional albuminuria as on a par with their use in urticaria. Calc. phos. should certainly be thought of in cases of sexual debility in both sexes, when its general symptoms are present.

In the *respiratory sphere* the calcarea salts are often of signal service, a troublesome, incessant cough, with or without expectoration, should always lead us to consider them. Marked purulence of sputum would suggest hep. s. as preferable, but in children especially I have often observed calc. phos. 3x to act like magic, especially when combined with arsen. iod. 3x. A child is brought to you of the calcarea type with the chest perhaps poorly developed. On auscultation you find coarse crepitations pretty general, there is a hacking, more or less constant, cough, and even sanguineous

expectoration. The child is not ill enough to be kept in bed, but is pale, pasty, flabby, peevish, chilly and has cold extremities. There may be moderate fever with chills and sweats. I recollect such a case being brought to me when I was in Belfast, and I was astonished at the rapidity with which it cleared up under these two remedies given in alternation. I felt sure the child had phthisis pulmonalis before I prescribed, but became somewhat sceptical of my diagnosis afterwards, whether rightly or wrongly, I can hardly say.

In contrast with this case is that of S. A. S., an old gentleman, aged 70, a retired miller, living in the country. He came to me complaining of vertigo, most marked in the afternoons and on changing from one temperature to another, especially from warm to cold. There was even reeling. There was a subconjunctival hæmorrhage in one eye. He came to me on October 1, 1906, and said he was liable to asthma during winter fogs. I observed that his hands were almost blue with cold, and his feet were similarly affected. On physical examination I found a small patch of congestion at the base of his left lung, indicated by moist crepitations. No abnormal heart sounds were present. The circulation was evidently feeble, and oxidation at a low ebb. I prescribed calc. phos. 3x and arsen. i. 3x, 3 h. alt. On October 18 patient returned at my request to report himself. The conjunctival hæmorrhage had disappeared. He had not been troubled with vertigo since his first visit, and he expressed himself as feeling better in every way. His digestion had improved, and the altered appearance of his hands was quite noticeable, the circulation having greatly improved. At this second visit I noted a small patch of eczema over the outer aspect of his right leg. The urine was found healthy. I repeated the medicines, and he did not return, but I heard afterwards from his son that he was keeping much better. The signs at the base of the left lung remained unchanged. This latter condition is one very frequently met with in practice, and, in my experience, apt to stay once it asserts itself in elderly people ; but if any gentleman present could outline a successful mode of treatment, I should

be most grateful. It is a condition which is essentially clinical, and does not appear to be discussed in text-books. I am frequently guilty, as in these last cases, of alternating remedies, but if so I think the results one gets often justify the practice. After all, it is the cure or alleviation of the patient's condition which we aim at, and I think we are always justified in using the swiftest and pleasantest means at our disposal.

In cases of *phthisis* calcarea will often be indicated. Emaciation and profuse perspirations will indicate the phosphate in preference to the carbonate, but here several other members of the second group should receive consideration, viz., calc. ars., hep. sulph., calc. silicica, and calc. iod., *e.g.*, an acid dyspepsia with dislike for milk and thirst for large quantities of water are all calcarea symptoms.

My experience with other calc. salts is not great. Calcarea fluorata is considered of value in cases of *varicose veins* and of *cataract*. One or two cases of cataract which I sent up to Mr. Knox Shaw he put upon this remedy in alternation with causticum, and in each case the process seemed retarded, and for a time there was even some improvement.

I have tried calcarea picrata for furunculi of the ear once or twice, but have been unable to trace any specific effect. I would rather rely upon substantial doses of liq. arsenicalis, as recommended in allopathic works. But this affection is admittedly obstinate.

Calcarea bromata is a remedy to be thought of in cases of convulsions occurring during dentition, also for sleeplessness and peevishness of children. I have usually employed one- or two-grain doses of the crude substance.

One of the most valuable of this series of medicines is hepar sulph., but this remedy would require a paper devoted to itself to do it any justice, combining as it does many of the virtues of its two constituents, sulphur and lime.

I have usually employed the 2x or 3x strength of calc. phos., but these salts appear to act well in any strength that can be prepared. Perhaps I may be allowed to say that I am not a believer in very high dilutions. I use them some-

times, but I never believe them to be what they are termed. A little consideration will prove to any sensible mind that even the thirtieth dilution, so called, cannot be what it is represented to be, and yet I believe there may be power in dilutions so labelled. If we suppose that the earth, *e.g.*, is equivalent to a cube measuring 7,000 miles in each dimension, I calculate that this would mean a cubic capacity of about 200,000,000,000,000,000,000 tons. Taking a drop to equal a grain in weight, there would be much less than a 100,000,000 drops in a ton. But this when multiplied by the number of tons would only add on another 8 more cyphers, *i.e.*, there would be say 2 with 28 cyphers after it. Now if it were possible to obtain such a bulk of S.V.R. or aq. dist. and to mix thoroughly with it one drop of any of our mother tinctures, would any of us really think it could have any appreciable activity in small doses? But to reach the strength or bulk of strength of the thirtieth dilution, you must proceed and add another 32 cyphers. My conviction is that such high dilutions owe any virtue they possess to little portions of lower dilutions or even of the strong tinctures that have clung to the sides of the vessels employed in their preparation. I believe that a vessel which has been tilted out even a million times will still contain attached to it much more medicine than any genuine thirtieth dilution could contain. My contention is not that these preparations are inert, but that the figures which are supposed to describe them are mere absurdities, they are impossibilities. Our atmosphere must be far fuller of all sorts of emanations than any thirtieth dilution could be, and would fearfully contaminate such preparations if it were possible to make them. Possibly one reason why they are so useful in certain hands is because their power for evil is *nil*. If we could agree to limit our dilutions to a point just where it becomes impossible to demonstrate any remains of the drug that is potentised, it would relieve many a conscientious pang to ordinary minds such as I possess.

I have not gone into the orthodox symptomatology of calcarea. It can be found in any homœopathic work on materia medica. What I have endeavoured to do is to

indicate the sphere of action of calc. in a manner that will not burden the memory with too much detail. Almost any remedy will produce headache, but before I would care to prescribe calc. for headache I would like to feel satisfied that there was some cause for the headache that calc. would be likely to touch, some blood condition, such as anæmia or deficient coagulability, or some osseous state that would at once point calcarea out as the remedy. That the headache described in the text-books as belonging to calcarea and the headache in the patient did not quite tally, would not deter me from using calc. if I thought the patient's constitution called for that remedy.

Dr. J. H. CLARKE (in the chair) said that the Society had had a very thoughtful paper from Dr. Munster, for which they were much obliged. Dr. Munster had not given them the exact Hahnemannian method of attenuation. Hahnemann devised a method of attenuating substances in a graduated manner which rendered the notation of his attenuations as accurate as it was possible for any figures to be. One drop of the strong tincture might be attenuated in the proportion of 1 to 99 at each remove, through a series of thirty bottles, and yet the medicine in the thirtieth bottle would be a very potent thing, as a great many of the members now present could testify. The process could be continued, not only in thirty bottles, but in three thousand bottles or more. Dr. Munster had done wisely in giving his results with only one of the principal calcarea salts. He had had very good experience with calcarea phosphorica that would be very valuable for them to consider and discuss to-night. The typical calcarea salt was really an animal product, and was made from the oyster shell. It contained, besides the carbonate of calcium, an animal element which gave it some of its medicinal properties. What homœopaths used was not the mere chemical carbonate of calcium. Calcarea carbonica had some very leading characteristics, and Dr. Munster had mentioned some of them. One was coldness of the extremities. To that coldness might be added dampness. The chilly damp hand of the calcarea patient was well known. The feet were in the same condition. Patients often said that they felt as if they had damp stockings on. Dr. Munster had spoken of the hæmostatic effect of calcarea, and he might have mentioned that this was brought out in the menorrhagia, especially of young girls in which

the menstrual flow was not only excessive but too early. That was almost always met by calcarea. But it must not be supposed that the opposite condition contra-indicated calcarea. He (Dr. Clarke) mentioned this, however, as corroborating the hæmostatic effect of calcarea referred to in the paper. The cough of calcarea was always a very important one. He had cured cases of persistent cough from arsenical wall paper by calcarea. The Italians called it a "fat" cough. It was an irritating cough, ending in bringing up a little mucus, but this relieved the patient only for a very short time, and then another cough came on, and so on. This cough was very well met by calcarea. Most people in this country were more or less under the influence of lime. This was due to the hardness of the water which a great many people were drinking, especially in the Croydon district. A lady came to him the other day complaining of constipation, and he found that she was living in a district where there was a lot of chalk in the water. He advised her to get a still and use only distilled water. She did this, and the remedy had a remarkable effect not only on herself, but on her child, a little girl of three or four, who had also been suffering terribly from constipation, which caused pain and crying with every motion. This passed away completely with the change of drinking water.

Dr. GOLDSBROUGH thought Dr. Munster had a little overlooked the fact that the true test for the attenuation of medicines was not the numerical or any other particular method, but the clinical one. Dr. Goldsbrough had, in many instances, met with the condition in young girls referred to by the president, and it had always been cured by calcarea carbonica in the thirtieth dilution, and not by any less dilution. There was another instance, that of nocturnal enuresis in children, in which the thirtieth dilution served particularly well, and, as a rule, the condition did not require other remedies. Belladonna certainly was indicated in that condition, but calcarea was more often useful. He had listened to Dr. Munster with very great interest. His way of putting the subject was quite refreshing and new compared with the orthodox ways which they read of in the text-books. He thought that, if Dr. Munster considered the higher attenuations a little more, perhaps he would be even more satisfied with the calcarea salts than he had been.

Dr. DECK, senr. (Sydney), said that for years he had taken a daily interest in this subject, and it was very refreshing not to find himself in such a minority as he was in the Colonies. He must thank Dr. Munster for his paper, for he (Dr. Deck) had not used

calcarea phosphorica as much as he might have done. He had been in the habit of using calcarea carbonica. He generally used calcarea salts for chronic enlargement of the tonsils. Calcarea carbonica in high dilution was one of the most wonderful medicines which he had ever come across. He could not find words for the results he had got by that medicine. It had opened a new sphere of usefulness to him. The question of degree of dilution was continually arising, and the question was asked, How could the high dilutions do good? But, if they found that a good result always seemed to follow the use of the high potencies, was it not right that they should use them, rather than let the patient go without the remedy? He did not think that anyone could understand what the high potencies were. Modern scientific research had shown the existence of particles as small as those must be in some of the dilutions which had been run down. Calculation seemed to point to the size of a particle of iron being represented by the fraction of a gramme, in which the numerator was 1 and the denominator was 1, followed by noughts reaching right across the page. These calculations had opened quite a new field in their views of the nature of matter. When Lord Kelvin and some others used to try to prove that atoms were only a certain size, he (Dr. Deck) felt certain that the time would come when that idea would be upset, and that they would be in the future in possession of facts which proved that much smaller atoms did exist, and that the human system was a much more sensitive machine for testing the size of matter than the smallest balance that had ever been used. There was nothing so sensitive as the system of the human body in testing the presence of any substance. He had frequently made a ring of clover flowers and put it round the neck of his wife, and in a few minutes it had caused her head to ache. They knew very little upon the subject of the size of atoms of matter, but many homœopaths had used high potencies for a long time. He had for a long time used the two hundredth. It had been found that radium would give its properties to another substance. Every particle of the substance was full of rapid vibratory forces, which would give some of its character to things around it. How did they not know that in the high dilutions something was not given from one dilution to another? They did not know what the things were, but they tried them, and they found that they were useful.

Dr. E. B. Roche mentioned two classes of patients in which calcarea carbonica had been useful. In some of those cases which threatened a tuberculous condition, he had used it with very good

results indeed. A girl whom he had to treat, had every appearance of going rapidly to the bad, but under these remedies she had improved very much and put on weight, and had been altogether a very successful case. The other affection was cataract. He had cases in which this calcarea salt had kept back the invasion of calcareous deposit, and old people had been enabled by its use, to go without an operation.

Dr. SPEIRS ALEXANDER said that high potencies and their comparative value seemed to be a subject of which they would never grow tired, and one which they could never altogether elucidate. On one occasion a friend of his made a calculation, which was quite as elaborate as that which Dr. Munster had made. He suggested that, if a vessel of water could be obtained of the same size as the orbit of the moon, and into that one drop of a drug were poured, that would represent the thirtieth dilution The answer to that was obvious. A homœopathic chemist would tell them that he could make the thirtieth dilution with some six ounces of spirit. As Dr. Goldsbrough had said so ably, the answer to the question was wholly a clinical one. It was, he thought, increasingly the experience of those who were acquainted with the high dilutions, that certainly they could never be dispensed with. If they were cut out of the *Pharmacopœia*, every one who had had any experience of practice would feel that they had lost some of their best friends. If a drug was well indicated, and it covered the symptoms in totality, they might practically go as high as they liked, even to the one hundred thousandth, and they would cure their patient. He had done so himself many times. When calcarea phosphorica was given, if it was regarded as destined to be divided up into calcarea and phosphorus, the system would seize upon that drug which was homœopathic to its condition. In some of the cases which Dr. Munster had brought before them, it seemed to him that it was hardly likely that calcarea was the drug which cured the condition, but that it was phosphorus. For instance, in hæmoglobinuria and purpura, it was common knowledge that the medicine which was homœopathic to those conditions was phosphorus; therefore, if calcarea phosphorica cured such conditions as those, he should be inclined to credit the phosphorus and not the calcarea with the result obtained. Again, in anæmia, especially anæmia of the aged, it was, he supposed, the experience of many of them that phosphorus was exceedingly efficacious in giving relief and curing such a condition. He thought that they would find that, in the condition known as pernicious anæmia, phosphorus was much more homœopathic to the condition than arsenicum. They

would, of course, be told that if a patient suffering from pernicious anæmia recovered under phosphorus or any other drug, there was a fault in the diagnosis. Dr. Munster had asked a question with regard to patches of chronic congestion in the lungs of the aged. The drug of all others which had helped him (Dr. Alexander) in those cases was sulphur, even in a low dilution. One word more as to calcarea phosphorica. He could not say personally that if calcarea were indicated at all, he had ever had any advantage from calcarea phosphorica over calcarea carbonica, and thought they might give the latter with confidence, and would probably get as good results as from calcarea phosphorica. Calcarea was very much used in adenoids in children, but he did not remember ever curing a single case with it. He could add his testimony to what Dr. Roche had said about calcarea in cataract. He had a patient who had double cataract, and he was put upon calcarea. The sight of one eye cleared up, the cataract absolutely disappearing, so that the sight was completely restored. But the calcarea did not touch the other eye. He therefore supposed that calcarea was, for some occult reason, the simillimum for the one eye and not for the other. Dr. Goldsbrough had referred to nocturnal enuresis. He (Dr. Alexander) had lately had a case in a little boy, which had given him some difficulty. Belladonna made no impression. Bromide of potassium made very considerable impression for a time. It reduced the frequency, but after a time the whole thing recurred. A review of the case led him to give nux 3, and he thought that he might say that the boy was cured.

Dr. STONHAM thought that the subject dealt with in the first part of the paper was one of which they would probably be hearing more and more as time went on. When they were giving a compound drug, they had to estimate the action of both elements. Dr. Alexander had spoken of the body selecting the element it required in the case of a compound drug. He did not think that the drugs acted exactly in that way. He thought that both the calcarea and the phosphorus in the salt had an action, and that they had to calculate the balance of the action of the one and of the other. When they gave calcarea carbonica, they knew pretty well what the action of the lime on the system was. In calcarea carbonica and calcarea phosphorica the carbon and the phosphorus both modified the action of the calcarea. The qualifying action of phosphorus came out in many ways. The whole question was very puzzling, and there was a great deal more to be learned about it.

Dr. HEY said that in order, perhaps, to shake Dr. Munster's faith in low dilutions and his want of faith in high dilutions, he

would like to state that he had seen in a calcarea carbonica patient, one dose of calc. carb. cm., entirely transform the patient in forty-eight hours from being a chilly, morose, weeping, irritable, vomiting person, without appetite, into one whose appetite returned, whose food was retained, and who was cheerful, much warmer, and had a better colour. In another case, one of neuralgia, the patient was in two days transformed with three doses of arsenicum cm. With regard to the breaking up of matter, he would like to remind the meeting of radium. It had already been referred to by Dr. Deck. If they took a milligramme of radium bromide and put it into a spinthariscope, and watched it for two years, they would find that, though it would be giving off minute sparks at the rate of a million a minute, at the end of two years there would be scarcely any diminution in weight. This proves that our ideas of the divisibility of matter are, at present, most imperfect.

Dr. MUNSTER, in reply, said that his contention in the paper was not that the high dilutions were inert, but that they were not what they were numbered, and he was still of that belief. It was all very well to say that, if they took thirty bottles, they would get a certain high dilution; but who could guarantee that it was as was stated? Few men had time to examine the matter for themselves. As regarding cm. and mm., it would be an utter impossibility for anyone to prepare it. He would have to live as long as Methuselah to do so. That was so, at all events, with regard to the mm. which was sometimes prescribed. While he did not deny the virtue of the high dilutions, he did not believe in the figures which described them. It would be a good thing if they were sure that it was always the calcarea ostriarum that was dispensed when they ordered calc. carb. Dr. Munster heartily thanked the members present for the kind way they had received his paper and for the courtesy they showed in expressing their views.

ACONITUM NAPELLUS AND FERRUM PHOSPHORICUM—A COMPARISON.[1]

BY ARTHUR AVENT, L.R.C.P. AND S.EDIN., L.F.P.S.GLAS., L.S.A.LOND.

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MR. PRESIDENT AND GENTLEMEN,—It is not my wish by this short paper to initiate a discussion on the relative merits of, or the differences between, homœopathy and bio-

[1] Presented to the Section of Materia Medica and Therapeutics, June 6, 1907.

chemistry. But for some years I have studied the latter in theory and practice, and have obtained some astonishingly satisfactory results in treatment with the so-called tissue remedies; yet, although the theory as expounded by Schussler is entirely opposed to the law of similars, it is remarkable how closely the homœopathic provings of his twelve, dare I say, drugs tally with the indications for their exhibition as given by him; and as a member of this Society one is prone to conclude that the professors of bio-chemistry, pure and simple, are but digging in a little corner of the vast and fertile field of homœopathy.

True, there are some symptoms assigned to the elect twelve which bio-chemistry claims and homœopathy disowns; but these are, as far as I can gather, the exception rather than the rule, though a very valued friend and patient of mine, who is an ardent believer in, and a successful user of, the "cell salts," would, I fear, put my conclusion down to a misguided devotion to homœopathy; but be that as it may, I owe the extended use I have made of these remedies to his importunity in advocating their claims, and my patients and myself are under a considerable debt of obligation to him.

My object in this paper is to point out the rather remarkable similarity in the materia medica of the two drugs aconitum napellus and ferrum phosphoricum, and to that end, I have collated, in as small a compass as possible, the main symptoms which are common to both; and I would ask you to point out my errors and also to pardon my presumption in coming here and reading what will, I fear, appear to you a very elementary paper.

I am indebted to Dr. Clarke's "Dictionary," Allen's "Encyclopædia," Boericke's "Materia Medica," and Boericke and Dewey's "Twelve Tissue Remedies," for most of my material.

Firstly, then, I will read you extracts from the provings of the two drugs which apply equally well to either; and I will then very briefly give you a few cases which have occurred in my practice during the last twelve months, as partly illustrating their uses.

Mental. — Great fear; anxiety; restlessness; tossing about; annoyed at trifles; delirium; hyperæmia of the brain; forebodings and fears.

Head.—Vertigo; rush of blood to the head; dull heavy pain; soreness to touch; soreness of scalp as if hair were pulled; nausea; congestion of blood in the head, with heat and redness of face; meningitis.

Eyes.—Red, inflamed; feel as if sand in them; acute conjunctivitis; photophobia.

Ears.—Noises; sensitive to noise; inflammatory earache; first stages of otitis.

Nose.—First stage of cold in the head; epistaxis of bright blood.

Face.—Faceache; flushed face; tic douloureux.

Teeth.—Toothache with hot cheek; teething troubles with feverishness.

Mouth.—Furred tongue; inflammation of the tongue.

Throat.—Acute inflammation; pain in the throat; red and inflamed tonsils; painful swallowing.

Appetite.—Loss of appetite and distaste for food; desire for stimulants.

Stomach.—Eructations; flatulence; sensation of swelling pain, and tenderness at pit of stomach; vomiting of pure blood.

Abdomen and Stool. — Constipation; bleeding piles; choleraic discharges with collapse.

Urine.—Frequent desire; hæmaturia; heat and tenesmus in the neck of the bladder.

Sexual.—Orchitis and gonorrhœa; menses too profuse, too protracted; dysmenorrhœa; vagina hot and sensitive; mastitis.

Respiratory.—Pain in larynx; laryngitis; loss of voice and hoarseness; huskiness after exertion of speaking or singing; cough, with rattling of mucus, worse night; hæmoptysis; bronchitis, pleurisy, pneumonia.

Heart.—Palpitation; pulse full; pericarditis.

Back and extremities.—Stiff neck from cold; pain in back and loins; inflammatory swelling of joints; articular rheumatism; shooting pains.

Skin.—Dry and burning; small pimples; swelling and burning heat; measles, &c.

Sleep.— Sleeplessness, with anxiety and restlessness; drowsiness in the afternoon.

Fever.—Inflammatory fevers; inflammation; dry burning heat with thirst; shivering.

Modalities.—Worse at night; touch; motion.

I do not pretend that this list is at all a complete one, but even as it stands I think you will agree with me that it is one of which any single drug might be excusably proud; and I claim it to be common ground to both.

To turn now to dissimilarity. Aconite has a more bounding pulse and apparently more restlessness and anxiety, and has for its very own its characteristic tingling and numbness. Ferrum phosph. has the right-sided tendencies common to all the ferrum salts.

Examples.

C. B., aged 60, came to me a year ago complaining of hæmaturia. An eminent London specialist had advised against operation, and it was evident from the history that he had had a papilloma of the bladder, which had become malignant. He was passing blood profusely and continuously, and had been given large doses of gallic acid, which had upset his stomach and failed to arrest the hæmorrhage.

Ferrum phos. 6x stopped the loss entirely in a fortnight.

He returned again in six months time and reported that he had kept better for two months, but that then the hæmorrhage had started afresh and had continued ever since. He was then emaciated and cachectic, and obviously in a very bad way. Ferrum phosph. was given again, but had no appreciable effect. Eventually thlaspi bursa pastoris, the old-fashioned shepherd's purse, checked the bleeding, but his condition was obviously hopeless, and he died a few months afterwards.

E. H., aged 82.—This patient was complaining of pain in the bladder, with forcing and burning in the urethra. There was constant desire to pass water, which was scanty, burning and dark in colour. She complained of a general feeling of heat and oppression. Her pulse was very slow, hard and intermittent.

Acon. 1x gave astonishingly quick relief to all her symptoms.

R. W., aged 4.—Influenzal pneumonia. This was a very bad

case, occurring in a fat, flabby child, and was interesting in that a well-known physician diagnosed the case when at its worst as acute miliary tuberculosis.

She had aconite 1x and baptisia until the fourth day, when her temperature was 104·6°, and her pulse very irregular and weak, obviously not the pulse of aconite. She then had ferrum phosph. 6x and phosphorus 4x in alternation.

The next day her temperature came down to 103°, and her pulse was less irregular. On the second day her temperature was 100°, and from then she rapidly became convalescent.

M. W., aged 16.—Double lobar pneumonia. Temperature when first seen 104°. Under ferrum phosph. and phosph. the lungs were clear in seven days.

I could continue *ad lib.*, but I must spare you. I have used ferrum phosph. in most of the acute fevers, when formerly I should have used aconite, with results which have been uniformly favourable. It is invaluable in the feverish dentition of infants, though I blush to confess that here I often alternate it with bell. or chamomilla.

Ferrum phosph. I use in either the sixth or twelfth decimal dilution. Aconite usually the first.

Dr. J. H. CLARKE (in the chair) said that Dr. Avent had given them a very valuable contribution to practical homœopathy.

Dr. WYNNE THOMAS said that Dr. Avent, in bringing ferrum phosphoricum before the Society, had done good service, because it was a medicine which, as he (Dr. Thomas) thought, was not sufficiently used. He had hoped that the paper, when comparing the two drugs, would have given them a little more information as to when to use ferrum instead of aconite. He thought that most of them used aconite in fever where the pulse was quick. He thought that a great many cases—even when they suspected pneumonia—would be better if they gave ferrum straight away instead of aconite at all.

Dr. CRONIN mentioned the case of a lady with carcinoma, with a great deal of hæmorrhage. Before the attack of hæmorrhage came on she was always feverish. Nothing seemed to stop the feverishness until a very small dose of ferrum phos. was given directly the attack came on, which was effective, and prevented the hæmorrhage. He kept up that treatment for two years without there being an attack.

Dr. DECK, senr., said that he had used ferrum phos. a great deal

in pneumonia. He had for a short time been looking after a plantation where there were many South Sea Islanders, a great many of whom had been dying from pneumonia. He had been asked to go up and see if he could check the mortality. The cases did not demand aconite at all. They were cases which might be said to be bryonia cases, because they were apathetic, and they wanted to lie down and be quiet and die. There were cases in which there was hæmorrhage in the sputum. He put them on ferrum phos., and not a single case died. When he found that the cases were really pneumonia, he put them on ferrum phos. about the tenth or twelfth dilution—something which he had worked up from the sixth by diluting it himself. These were not the only cases in which he used ferrum phos. for pneumonia. He remembered one case in Sydney where there was a great deal of blood in the expectoration, in which that drug was very useful. He thought that ferrum phos. was one of the most important remedies they had in pneumonia.

Dr. J. Jones said that with respect to the use of ferrum phos. in rheumatic fever, he remembered a case in which all the symptoms pointed to hyperpyrexia, and he was fearing a fatal termination. On giving ferrum phos. 3x, the symptoms almost immediately changed, and in a very few days the patient was convalescent. In that case he had given the ferrum in alternation with kali phos. 3x. There was another trouble in which ferrum and its salts might well be borne in mind, and that was the uterine hæmorrhage of the climacteric. He remembered a case of a lady who suffered from serious floodings for a period of two years. The local doctor had recommended hysterectomy. All sorts of things had been tried before he (Dr. Jones) had seen her. She had been curetted, plugged, and had plenty of all the orthodox treatment, without any avail. When he had been called in, the patient had been bleeding for some days. She passed continually very large clots; the clots became buffed, and the whole case was looking desperate, when one day he noticed that the blood had a slimy appearance. This is given as an indication for ferrum phos. by Schussler. He had no ferrum phos. in his case, but he gave a few drops of ferrum mur. in water—a dose every two hours—and from that time the patient got rapidly well; and when the hæmorrhage returned, the ferrum mur. controlled it directly. This was altogether different from any remedy she had had before, for the remedy that seemed to control the bleeding at one time, would not exert any influence the next. Dr. Jones had no doubt that ferrum mur. saved this lady's life.

Dr. GOLDSBROUGH referred to the question of ionisation. If ionisation happened to ferrum phos., what happened to aconite? A point which the late Dr. Cooper was fond of bringing forward was, that plant tinctures had a life of their own in their effect on the patient. There might be something in the question as to the dissociation of the salt and the retention of the natural molecule, or the natural plant genus. This was what Dr. Cooper called "the aborivital principle" in a plant. It opened up a wide field for thought and for observation, because, after all, they had not had given them fine distinctions between aconite and ferrum phos. as a choice of remedies. They needed differentiation more clearly. From what he had gathered from the discussion, ferrum phos. seemed to be indicated where there was a tendency to a rather rapid disorganisation of tissue. He had had more experience with the ferrum acet. in hæmorrhages than with ferrum phos., and especially in the case of hæmorrhage from the lungs.

Dr. STONHAM said that he thought that the chief difference between aconite and ferrum phos. was in the difference of the pulse. That was an indication which was easily noted. For the short, quick, soft pulse the indication was ferrum phos., and for the hard tense pulse, aconite. Dr. Goldsbrough had raised a question as to what happened to the ions in aconite. He believed that it was only the salts that were electrolytes that were dissociated into their ions in solution, and that a solution of aconite would not exhibit any liberation of ions.

Dr. E. A. NEATBY wished to give Dr. Avent a very warm welcome as a representative of Birmingham. Dr. Neatby was afraid that latterly the light of homœopathy in Birmingham had been somewhat under a bushel. He hoped that Dr. Avent would let others in Birmingham know that the members of the Society would welcome their Birmingham colleagues, and would be very glad to see them at the meetings, and have papers from them.

Dr. SPEIRS ALEXANDER said that there was one use of ferrum salts which had not been mentioned. They had already mentioned nocturnal enuresis; but in diurnal enuresis ferrum phos. was also useful. He could verify the use of the drug in that condition. Like Dr. Neatby, he wished to thank Dr. Avent for coming from Birmingham. He once took the trouble to ascertain the comparative number of papers contributed to the Society by London members and by country members, and he was sorry to find that the London members predominated at least to the extent of four to one.

Dr. CLARKE, before calling on Dr. Avent to reply, said that

Schüssler had done a very great benefit to homœopathy by giving them new kinds of indications for their remedies. Another thing which he did was, to cut down the remedies to twelve, and, after a time, he went one further, and reduced the twelve remedies to eleven. What they might do was to get their materials in an accessible and convenient shape, but they could not cut out of the materia medica any definite positive observation that had been made. With reference to ferrum phos., there was another observation that Dr. Cooper had made, and that was its usefulness in certain conditions of the ear, the condition which he named vascular deafness. With regard to the indications for aconite as distinguished from ferrum phos., in addition to hardness of the pulse, there were the restlessness of the patient and dry skin, of aconite.

Dr. AVENT, in replying, said that he came to the meeting, hoping that he should learn the differences in indications between aconite and ferrum phos. Apparently, the character of the pulse and the restlessness and anxiety of aconite constituted all the distinction between the two.

SOME CASES ILLUSTRATING SURGICAL AFFECTIONS OF THE URETER.[1]

BY DUDLEY D'A. WRIGHT, F.R.C.S.ENG.
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THE history of the operative invasion of the domain of the ureter is an interesting one, and illustrates how both surgical emergency and expediency, as well as imaginative forethought, may combine for the eventual benefit of mankind. I shall not, however, attempt to deal with this part of the subject, but will confine myself to narrating a few cases in which, in one way or another, the ureter and its upper extension—the renal pelvis—has been the object of surgical consideration or attack.

Case 1.—Frederick H., aged 27, presented himself on March 11, 1901, complaining of pain in the right kidney region, generally waking him up in the early morning, and lasting from twenty-four to forty-eight hours. These symptoms commenced about

[1] Presented to the Section of Surgery and Gynæcology, July 3, 1907.

eleven years previously, and he described the pain as dull in character and extending down to the bladder when very severe, but never going down into the testicle. The urine was sometimes thick during the attacks, or afterwards; but occasionally it was quite normal. Frequently no urine was passed during the attacks. Retching and vomiting occasionally occurred with the pain.

Two months before coming to the hospital the patient passed a stone the size of a small pea, accompanied with some blood. This stone was composed of oxalates. Examination showed nothing, beyond a somewhat enlarged right kidney and definite tenderness on deep pressure over the right loin.

As the case was obviously one for exploring the kidney, this was accordingly done through a lumbar incision a finger's breadth below, and parallel to, the last rib. The kidney was found to be enlarged and irregularly lobulated, the cortex in parts being so much thickened that at first these areas gave the impression to the touch of underlying calculi; incision, however, showed them to be irregular masses of very dense fibrous tissue.

On opening up the pelvis of the kidney through the cortical incision, a gush of about 2 ozs. of turbid urine occurred.

The interior of the kidney was searched in vain for a stone, the calyces were dilated, and the organ was in an early stage of hydronephrosis.

The question then arose as to the cause of this hydronephrosis, and in order to explore the ureter a bougie was passed through the incision in the cortex, but some obstruction appeared to prevent the bougie from entering the ureter. Examination now revealed that there existed a pouch somewhat bigger than a large walnut at the junction of the pelvis with the ureter at its inner aspect. The mouth of the ureter opened into the outer side of the pouch, and high up on its wall, in such a way that a valve-like fold nearly surrounded the orifice. It was quite clear that distension of the pouch would cause obstruction to the outflow partly by pushing up this valve, and partly by pressing on the ureter.

The saccule was entirely removed by cutting it away at its junction with the pelvic wall, the ureter being left connected with the latter by only a narrow bridge of tissue. The edges of this gap were now united, first by a continuous suture through all the coats; and, secondly, by interrupted ones through the outer coat. When this had been accomplished, a bougie could with ease be passed from the incision in the cortex into the ureter.

The incision in the kidney was only partly closed, and a drainage tube was placed in the pelvis. This was taken out about the twenty-first day, as everything had gone on satisfactorily.

A few days later, however, the temperature rose, and a swelling formed at the site of the scar, which had now closed over. The swelling was incised, and some urine and pus discharged. A tube was reinserted, and eventually taken out again later on; but as the swelling formed again the tube was replaced, and the patient left the hospital still wearing it.

Later on the patient returned, and as the sinus in the loin was still discharging, it was decided to explore again. This was accordingly done, and it was discovered that a collection of pus existed behind the kidney at the site of the suturing of the ureter and pelvis. This wound had only partially healed, and a leakage of urine was evidently the cause of the abscess.

I concluded that the best thing to do under the circumstances was to remove the kidney, which I forthwith did; but I now consider that this was not good policy, for had I drained the abscess cavity properly I believe it would have eventually healed, especially as on removing the organ it was found to be in a far more healthy condition than it appeared to be at the first operation. The hydronephrotic condition had practically disappeared, and this thickened fibrotic area had quite gone.

The patient made an uninterrupted recovery and left the hospital quite well and strong.

Case 2.—Edward H., aged 16 years, whose left kidney I had removed two months previously for hydronephrosis, was suddenly taken with acute pain in the right kidney region, the pains going down to the groin. Within a few hours complete anuria supervened.

As the boy was at the time some distance away in the country I did not see him until twenty-four hours after the onset of the symptoms. He was then in great pain in the right side and very restless. The bladder contained no urine. The tongue was dry, and the temperature slightly above normal.

From the history and symptoms I concluded that we had to deal with sudden obstruction of the remaining ureter, and expressed this opinion to the local practitioner who had been called in, and suggested exploratory operation, as hot fomentations and hot baths had failed to give any relief.

He, however, was of opinion that the case was one of chill with suppression of urine, as the attack had come on after the lad had been out all day shooting in rather cold weather. With this diversity of opinion the parents were unwilling to allow of

an operation, so that another twenty-four hours passed without any relief being obtained, and the boy was becoming obviously much worse. At this time I was fortunate in being able to obtain the opinion of my colleague, Dr. Byres Moir, who came down and saw the boy, and expressed himself in favour of immediate operation.

Accordingly this was undertaken, and the kidney being exposed it was found that the pelvis was greatly distended, so that on incising it urine spurted out some distance. It was a matter of some interest to see that though the obstruction had lasted over forty-eight hours at the most only three ounces of urine were present in the pelvis.

By pushing forward the peritoneum it was easy to examine the ureter as far as the pelvic brim, but no obstructing body was found. I therefore passed through the incision in the pelvis a long flexible bougie down the whole length of the ureter until it must have entered the bladder, and, in this way, pushed on whatever was occluding the passage. The wound in the pelvis was then closed, the kidney replaced in the external wound, closed around a drainage tube.

The boy recovered from the operation and the wound drained urine freely, and two days later I was pleased to receive a report that he had passed six ounces of urine *per urethram* about fifty-six hours after the operation.

After this he made a recovery which was rather hindered by some suppuration in the deep part of the wound.

I never recovered any stone from his bladder, but I conclude that some grumous sediment which came away in the urine must have been all that was left of the obstructing body, broken as it probably was by the passage of the bougie.

Case 3.—The calculus which I now present was removed from a patient in this hospital who had previously been operated on for stone in the kidney. As the wound had never healed and the constant dribbling of urine was causing much trouble and preventing the patient from going home, it was decided to explore, and, if necessary, remove the kidney. With this idea I operated, but on bringing the kidney up into view, which was not an easy matter owing to the adhesions of the former operation, and examining the pelvis, a stone was felt in it, and the one I have shown you was extracted from an incision made in the posterior wall. The lower pointed end was impacted in the ureter, and appeared to completely occlude the channel.

The patient made a good recovery and the wound entirely

healed, and she was exhibited to the members of this Society some years ago shortly after her discharge from the hospital.

The next case is very similar to the last, except that the condition of hydronephrosis revealed by the operation led me to remove the organ. I think that with my more extended experience I should now not nephrectomise simply for hydronephrosis with stone, except in very extreme cases, for it is surprising how kidney tissue may recover when the pressure exerted by the obstruction is removed.

Case 4.—Arthur S., aged 25, had for four years suffered from sharp, shooting pains in the back. He had passed blood in the urine and, at times, some gravel. He had had five acute attacks of pain which was very severe, being in the left lumbar region and shooting down into the lower part of the abdomen. The last attack like this was eight months ago. For a week before coming into the hospital there had been difficulty in micturating, and increased frequency of passing water, but only a few drops would be passed at a time. On admission, the patient's temperature was 101°. There was much pain and tenderness in the left lumbar region, worse on moving about, and there was also tenderness over the course of the ureter. The urine contained a trace of blood.

A few days later, when the fever had subsided, the operation was performed. The kidney was hydronephrotic, a stone was present in the pelvis, one pointed extremity of it extending into the ureter, another small stone being present in one of the calyces. The kidney with its containing stones was removed, and the patient made an uninterrupted recovery.

The ureter may occasionally be obstructed by becoming kinked or twisted by aberrant blood-vessels. These may come from the renal or lumbar arteries. I have had one such case.

Case 5.—Caroline C., aged 24, admitted to hospital in July, 1904. She was well up to a year ago, when pain came on in the right side, lasting for one or two days, and then being absent for a week or more. During the attack the pain was very severe, compelling her to lie in bed. Vomiting often accompanied the attack at first, but latterly only retching. She has never noticed any blood in the urine.

Examination showed a slightly enlarged and tender kidney on

the right side. It was decided to explore the kidney, which was done through the usual incision. The pelvis and upper inch of the ureter were dilated into a cyst on their posterior aspect. A search was made for the cause of the obstruction, and this was found to be a firm, constricting fibrous band, which ran upwards and inwards, and contained a large blood-vessel. This was isolated and cut through and the ureter freed; during the dissection the cyst wall was somewhat lacerated. A rubber and gauze drain were used, and the patient made a perfect recovery.

The last case I have to mention is that of a patient referred to me last May by Dr. Herbert Wilde, of Brighton, the history being that fourteen days previously he had an attack of renal colic on the left side, which had subsided, but no stone had been passed from the bladder. Twenty-five years previously he had a similar attack, and was treated by the late Dr. Hughes.

The question which needed solution was where the stone was?

There was marked tenderness to deep pressure over the left brim of the pelvis; there was also slight tenderness high up on the left side when examined *per rectum*. I passed a large lithotrity evacuating catheter into the bladder and drew off the urine, but no stone came with it. The patient was then sent to Mr. Caldwell to have a radiograph taken. This showed a faint shadow of an oval body existing just below the pelvic brim, and I concluded that this was the stone.

It is not proposed to do anything surgically for its removal, for its presence does not seem to be causing any trouble at the present time. The amount of urine being passed is up to 40 ozs. daily, and there is now no pain.

Of course it is possible that in time hydronephrosis may supervene, and if the obstruction is complete, the kidney will, of course, be rendered useless; but that it does not follow that any urgent symptoms need occur, is proved by a case on which I made a *post-mortem* examination when I was in residence in this hospital. The patient, an old woman, died of heart disease, and I found that there was complete obliteration of the left ureter at about an inch below the pelvis.

The kidney itself was atrophied, and the pelvis contained a small quantity of clear fluid, in which a few small, dark uric acid stones were present, and which I now show. I should add that the patient never made any mention of pain or other symptoms connected with this kidney.

Dr. J. H. CLARKE (in the chair) remarked that the cases brought forward by Mr. Wright were evidently beyond the reach of the similar remedy. Dr. Clarke quoted the case of a gentleman who had suffered from gravel being cured by ossimum canum.

Dr. NICHOLSON (Bristol) mentioned the case of a lady who had suffered from lumbar pain for two or three years, and was passing mucus, pus, and phosphates. The kidney was explored by a surgeon. On opening it a gush of fluid rushed out, no growth was found, the wound healed, and there was relief of all the symptoms.

Dr. MADDEN, after thanking Mr. Wright for his paper, said he only rose to refer to one question, viz., the diagnosis of renal calculus by the X-rays. He believed that all experts were agreed that they could place more reliance on an examination with the screen than on a radiograph, which often gave very indefinite evidence. He had recently had one or two cases which entirely confirmed this opinion, and in all doubtful cases he thought we would be wise to trust rather to the personal examination of an X-ray specialist, using a good screen, than to a photograph.

Dr. JOHNSTONE mentioned the case of a woman who had a large fibroid removed at the London Homœopathic Hospital. The kidney on the affected side was found much enlarged. She made a good recovery from the operation. But subsequently the enlarged kidney presented as an extensive fluctuating swelling in the region of the umbilicus. The ureter had evidently kinked. Hot fomentations and sedatives were used. The urine was subsequently passed, and was found free from calculus, pus, or blood.

Mr. DUDLEY WRIGHT, in reply, said that in all cases of moveable kidney the ureter should be examined. He had had no trouble after operation in these conditions. The X-rays gave uncertain shadows, and instances which looked like stone might prove to be cystic. He thought Dr. Johnstone's case should be operated on.

SOME ASPECTS OF ABDOMINAL PAIN IN WOMEN.[1]

BY W. CASH REED, M.D.EDIN.

SYLLABUS.

INTRODUCTION :—

(1) Pain in General.
(2) Pain and Temperament.
(3) Pain and Education.
(4) Pain as an Index.
(5) Pain may be Salutary—Instances.

Estimation of Pain.
Referred Pain.

SECTIONS:—

(1) Pain Due to Tired and Stretched Muscular and Fibrous Structures.
(2) Rheumatism in Relation to Pelvic Pain.
(3) Gonorrhœa.
(4) Septic Lesions.
(5) S.W.[2] Corner Pain.
(6) Pain in Abdomen which is not manufactured there.
(7) Syphilis—Three Cardinal Points.
(8) "Resting Pain."

INTRODUCTION.

GENTLEMEN,—I propose in the following pages to deal with some aspects of pain in the abdomen in women, with the object of indicating certain general principles, and also of pointing out some pitfalls into which one is liable if imperfect examination and diagnosis be made. I have found it impossible to deal with the subject of treatment, except incidentally and with the object of knitting together otherwise fragmentary data. The reason lies simply in the fact that the compass of this particular paper does not admit of its consideration to an extent which would be really useful.

The subject of pain is such a vast one, for it is almost as wide as the science of medicine itself, that I should hesitate

[1] Read before the Liverpool Branch, British Homœopathic Society, April 11, 1907, and subsequently amended and its scope enlarged.

[2] "South-West," the region of the appendix, *i.e.*, the right inguinal and neighbourhood.

in this short paper to deal with it at all were it not that I intend to narrow its limits to quite a small area.

Thus I propose to deal with a few only of the causes of pain which are situated in the female abdomen, though on the subject of pain in the abstract I shall generalise a good deal.

As to the cases to be brought to your notice, I have selected such instances as are illustrative from clinical experience up to recent date.

Before particularising, I wish briefly to speak of (1) *Pain in General*, or rather, such aspects of it as are forced upon the attention of all medical men sooner or later. As we listen to the patient's tale of woe, the mind falls automatically into an analytical frame, and perhaps equally into a judicial one. Having analysed the patient's complaint, and selected the chief points of importance from a confused mass of evidence, the latter has again to pass in review with reference to minor points of subsidiary importance. The process of reasoning is exactly opposite to that of the text-book, which labels the disease and then describes its symptoms. This plan has always seemed to me somewhat addling, though I do not presume to say it can be avoided. Perhaps it is necessary; at any rate it is the *form* of academic teaching of medicine, as distinguished from that of practical teaching. The disease is embodied in the patient, who has no difficulty in acting as his or her mouthpiece, and due allowance having been made for irrelevant matter, the listener may now label the disease.

(2) *Temperament.*—No scheme, however, as we all know, can be taken too literally, for the *personnel* of the narrator must be estimated, and this is no easy task when we see him or her for the first time. If we omit the personal equation we are liable to be hopelessly led astray. Speaking broadly, there are two types of patient which puzzle me the most, viz., the *histrionic* and the self-centred. They both exaggerate frightfully, but from perfectly different motives, neither of them laudable, but neither actually vicious. The former exaggerates from that state of mind which sees all life in dumb-show, to whom, "All the world's a stage," but they

the only "players." There is frequently observed in this class of patient a quick sympathy and a kaleidoscopic change of mental attitude, so that the scene of suffering which they are depicting changes while you look at it. This sympathy sometimes takes the form of self-pity, and the change of mental attitude is due to a sudden sidelight, which has shot athwart their vision.

As to the second (the *self-centred class*), they require more patience. They are those who have an overweening sense of the importance of detail, and who have perhaps been unfortunately told that such and such an organ is affected, mostly the ovaries, sometimes the uterus. Now "the fat's in the fire" with these patients. Their minds are overmastered by the particular organ at fault. They have, in short, uterus or ovaries "on the brain." The *ipsissima verba* of the doctor have done infinite harm, and the next man has a Herculean task to find another mental objective. It is well to record patient's exact words in reply to your questions. They are sometimes remarkably illuminating. I well remember the mother of a girl wishing to indicate that the latter was suffering from a cold sensation from the anterior nares to the pharynx, described it thus in Devonshire fashion, "Her nose is like a piece of ice from yur right 'ome to yur." Again, a well-known surgeon of St. Bartholomew's, Mr. Lockwood, tells somewhere how a man in the out-patient department described his sufferings as "crampy veins,"—this is illuminating to a degree. It is, I think, Sir William Bennett who insists upon the close relation of so-called cramps and varicose veins, and instances of this at once occur to me, and they will to all.

Pain, from a purely scientific or physiological point of view, I propose scarcely to touch upon, the subject is so vast. Yet I can hardly dismiss this aspect without briefly alluding to pain as an Index of Disease, and pain as an Expression of Intelligence, for in thinking over my paper these two points of view have come conspicuously before me. To take the latter first:—

(3) *Education.*—From a very interesting book recently published, entitled "Savage Children," by Mr. Dudley Kidd,

the following passage occurs. The author is describing the children of one of the South African Tribes, and he says: "Savage children are evidently less sensitive to pain than ours are, and are strangely slow in locating it. A grown-up Kaffir assured our author that he could well remember suffering from headache while as yet he had no idea where the pain was, and would have believed any one who had assured him that it was in the roof of the hut instead of in his head. Naturally, therefore, they are strangely unsympathetic about pain, and the same black man declared that as a child, though he had continually seen pain inflicted he did not know what it meant, nor did he realise the significance of a threat until one day when, for the first time, his father struck him." This passage needs no comment, but it indicates a very interesting field for observation anent moral and intellectual culture in relation to the perception of pain.

With regard to pain as an (4) *Index of Disease*, it may be *Salutary* and thus useful, though few of us would admit that the pain of toothache, *e.g.*, were a happy inspiration on the part of Nature for the purpose of commending a special molar to the dentist's delicate attentions! Yet pain may be salutary, as I shall show immediately, although it seems absolutely useless, for it cannot, like electricity, be chained and stored for use in the arts and manufactures. We have yet to invent an instrument, similar to the sphygmomometer, which shall record the pangs of the sufferer, and give a tracing of the degree of pain which at a given moment he may be suffering from; otherwise with what mathematical precision we could apportion an anodyne. Such a hypothetical instrument, I submit, might be called an algometer. I believe it was Matthews Duncan who once referred to this subject of measuring pain, but he called his imaginary instrument an odynometer.[1] Is there, then, no standard of pain? In a large section of cases in which the pain is *acute*, I certainly think there is. There are three cardinal symptoms which indicate severe pain in a given case, whether the patient be histrionic, imaginative, self-centred, or, in short, whatever be his or her temperament, viz. (1)

[1] ἡ ὀδυνη.

vomiting, (2) feeble pulse, and (3) collapse. Thus we have a tripod of considerable utility in dealing with degrees in acute pain.

To revert, however, to the statement that pain may be *salutary*. Let me prove it by an instance or two in which its absence as an index may be disastrous. In locomotor ataxy the sensation which indicates a distended bladder may be absent, or markedly diminished, and we have all probably heard of a distressing sequel in such a case. Again, impaired nutrition of a cutaneous surface as, *e.g.*, by urine in the aged, accompanied by blunted sensations, may and often does lead to bed sores. Thus the intelligence of the nurse must take the place of sensation in the senile, and here many a nurse has found the fulcrum of a lasting reputation. Lastly, injury to a joint enforces rest, and the pain of pleurisy or peritonitis does so also as regards the structures involved, in order to curtail an extension of the inflammatory process.

Another point must be mentioned, viz., the

Estimation of Pain.

I have already referred to it when speaking of pain in general, but should like to particularise. I would lay it down as an axiom that in the very young, the estimation of pain is always genuine. I know, *e.g.*, that a child, with a tracheotomy tube inserted, may work itself into a *temper* from discomfort and annoyance, and general disgust with everything and everybody, including its nurse, though she be the embodiment of every virtue, but this is not pain. A child, however, who complains of what is styled "growing" or "rheumatic" pains, can never be disregarded, for its plaint very often means tubercle, and tubercle, moreover, in a stage which is curable.

Referred Pain.

The subject of referred pain almost demands a paper to itself. That in the knee in hip disease, and in the penis from vesical calculus, and in the testis from calculus in the ureter, are all well known. My own recent experience in

this class of case leads me to say a word on two or three instances which I have found most interesting and instructive. Sciatica is not usually associated with uterine flexion; yet it frequently is so. For a flagrant instance, I am indebted to Dr. Hynd, of Wigan, who had a case of severe sciatica in a school teacher. The pain had lasted for upwards of a year, when the girl, failing to get relief from her medical man, consulted Dr. Hynd. The latter at once thought it of pelvic origin, and sent the girl to me. The uterus was found to be acutely retroverted, and we decided to give an anæsthetic and to rectify matters. This was done at home, and the patient was permanently cured from that moment. Again, sciatica and sarcoma in the pelvis, if of infrequent occurrence, fail sometimes to be associated in the practitioner's mind. Yet the connection is so conspicuous that it is infinitely worth while to remember it and thus avoid a pitfall. Again, in so-called sciatica, we may wisely search for a gluteal abscess due to tubercular bone, where pus has welled through the sciatica notch. Such an observation may be of the greatest utility.

For another conspicuous instance of referred pain I am indebted also to Dr. Hynd, of Wigan. The patient, a young married woman, had had one child six years ago. Since then she had not been pregnant. Some four years before marriage she fell down stairs and injured the coccyx. Prior to our consultation, patient had been kept in bed for a month, with the object of curing, if possible, the persistent coccygodynia, but the latter was merely relieved. On making a pelvic examination I found a hard and painful swelling in Douglas' pouch, and the significant fact that pressure thereon was immediately referred to the coccyx. There was no doubt whatever on this point, and we came to the conclusion that the case was one of salpingo-oöphoritis, the pain of which was reflected to the coccyx. I advised abdominal section, and this was by-and-bye performed, the time intervening being occupied by the employment of such agents, medicinal and local, as would assuredly have cured, had it been possible to do so, without recourse to the knife. At the operation I found the right ovary enlarged, cystic and prolapsed; it and

the tube were removed. The left ovary was healthy, and with the tube on that side was left *in situ*. The patient made an excellent recovery, with a temperature scarcely above normal throughout.

Remarks.—One is sometimes inclined to claim too much in a given case as the result of either medical or surgical treatment. For this reason I always like to get to know the patients' estimate of the result, or that of their friends. As in this case the husband was good enough, unasked, to describe the result as "wonderful," I thank him for thus pointing the moral.

Sections.

Perhaps the commonest form of pelvic pain in women, especially amongst the poor and under-nourished, such, *e.g.*, as form the bulk of our out-patients, is:—

(1) *Tired and stretched muscular and fibrous structures.*—A homely illustration will serve best to illustrate my meaning. I was accustomed when in Plymouth to see women only on Tuesday evenings at the out-patient department of our hospital there. The class of cases I now refer to would put the situation in a nutshell, something after the following formula. To the familiar query, "Well, how are you?" the answer would be, "O, I'm very bad to-day, though I was better on Sunday and Monday, but then you see I was washing yesterday, and that never agrees with me." Here is a hint thrown in gratuitously to the soap manufacturers, combine or otherwise, for a telling advertisement. The materials are at hand! The artist "does the rest!" Muscles in women are weak, and after child-birth often subinvoluted. The nerves are sensitive, frequently from want of sleep, and this class of case is often anæmic. These patients frequently feel quite well in the morning, and fit for the daily arduous round, but after they have been on their feet for a short time the old familiar pain returns. It is referred to the sacral region, frequently between the shoulders, to the hypogastrium and down the thighs. The *treatment* is obvious, viz., rest, but this is often, of course, impossible. I used at one time frequently to order these cases a poroplastic

jacket, beautifully made by Cockings' representative in Plymouth, and to whom I often send now. But after all, this treatment only meets the case of a comparatively small portion, and is at best a makeshift, though a most comforting one. Perhaps the best is to give these patients a pessary, for it supports the tired and stretched pelvic floor, and this part of the muscular system is the one most urgently needing help. The medicines I have found most useful are *arnica* and *actæa*, and, as a diet, iron.

Closely allied to this first division of my subject is (2) *rheumatism* in its relation to pelvic pain, and I shall say a few words in the second place under this head. The late Dr. Ord, of St. Thomas' Hospital, was, I believe, the first who conspicuously insisted upon the fact that chronic rheumatism in women could frequently be cured by treating catarrhal conditions of the uterus and cervix. Rheumatism is a toxæmia, and is frequently absorbed *via* the throat as in tonsilitis; by the urethra in the form of the gonorrhœal variety, and by the uterine cervix in abrasion and breaches of continuity in that structure. I believe that rheumatism in women is frequently seen clinically in the form of rheumatism of the pelvic ligaments. Two interesting cases were recently in the hospital, and will serve to illustrate what I mean. One is a patient of Dr. Compston's of Crawshawbooth; he asked if anything could safely be done to repair an extremely bad tear in the anterior lip of cervix, extending right up to the floor of the bladder. This tear had occurred in the last confinement. The apex of the tear, I may remark, was extremely sensitive, and when touched caused great pain. Just prior to coming into hospital, Dr. Compston had ordered her to bed on account of some chest lesion, and whilst she was steadily recovering from that, but still in bed, an attack of acute rheumatism occurred. When the patient came to hospital, I stripped the bladder from the deeply-torn cervix, repaired the latter and restored the former. It happily turned out a success, though densely cicatricial avascular tissue is not ideal for primary union. Of course the rheumatism may have entered the system by some other channel than the cervix, but I submit that if the

cure is now complete, and no other attack of rheumatism occurs in this comparatively young woman, there is presumptive evidence that the *materies morbi* entered *via* the cervix.[1]

The next case is one in which I do not suggest that rheumatism entered *via* the cervix. The point here is the pelvic rheumatism *per se*. A little girl, aged 13, was distinctly ill. There was constant pain referred to McBurney's point and distinct tenderness there, and a temperature which I had verified during a period of some weeks, while she was an out-patient, of one to two degrees above normal. It may be asked why this child was not at once admitted to hospital as a case of appendicitis? The reason is that she had already been an in-patient under one of our colleagues, who, I believe, after the most careful investigation, could not satisfy himself that true appendicitis existed. When the child was admitted for the second time, I was equally in the dark as to the cause of the pelvic pain. It was not now continuous, and the temperature had become normal. In order to make a diagnosis in this occult case, I now examined her *per rectum*, under an anæsthetic. The uterus was, of course, infantile, and was about the size of a filbert. The right ovary was very easily felt, and was very distinct. It was, in fact, larger than the uterus. The left ovary could not be felt. On examining McBurney's point, the tendon of the psoas muscle felt like a ridge and slipped about backwards and forwards under the finger. With this exception, the evidence in this region was negative. Before passing on to the crucial point in the case, I wish to say with reference to the examination *per rectum*, that did the opportunity more frequently arise for examination of a child of this age, I strongly suspect some such want of correspondence in the size of the adnexa would be found more frequently. I submit that here we have a transition in the developmental process which, did we better understand it, would throw light upon that obscure class of case in the adult which we call "infantile uterus."

A week or so after this examination, this little girl's

[1] Patient, I learn, remains quite well twelve months afterwards.

temperature rose, and she had an attack of rheumatism in her left wrist, with—and this is most interesting—a subsidence of the pain in McBurney's point.

Rheumatism and Dysmenorrhœa.

The failure to improve a given case of dysmenorrhœa has resulted in the temporary interment of many a budding reputation. If, however, the fact that rheumatism is a most important contributory agent to pelvic pain of this class be more widely grasped by what I now submit, then the task is a pleasant one, for patients will be benefited, and my friends' reputations maintained. I purposely spoke of *temporary* sepulture, for reputations in such cases are like sutures similarly situated, which have a happy knack of becoming negligible quantities.

Case 1.—Mrs. X., about the menopause, with a grown-up family, consulted me, a month or two ago, for pelvic pain, referred to the hypogastrium, relieved by movement, in fact, she could sometimes walk a couple of miles, when it would recur. It was worse in bed, frequently waking her up in the small hours, and worse also on turning in bed from one side to the other. She thus frequently had to rise at night to apply a mustard leaf in order to get relief.

Some seven years ago she had a child born in a remote country place, with the complication of placenta prævia. The exigencies of the situation resulted in a very prolonged illness, the pelvic factors of which were cellulitis and endometritis. For the latter curetting was done. When I saw patient she complained also of pain in the right arm, with, after use, the usual paretic condition associated with a neuritis. She told me she had had expert advice, and was assured that there was nothing wrong internally, in fact, that the condition was conspicuously normal. On examination I found a great number of cicatrices, with their falciform edges in relief, in the right and left vaults of the vagina and in Douglas' pouch. The uterus was in normal position, but painful on movement.

Here was the key to the situation. Before examination sundry remedies had been employed without conspicuous benefit. Now salicylate of soda (natural) in 5-gr. doses, three times a day, was given. The result was dramatic. The patient has now gone to the extreme North of Scotland, in the confident assurance that all will be well, and in this I believe she is correct.

Remarks.—I remember, many years ago, the late Dr. Bishop, of Edinburgh, the intimate friend of many of this generation of medical men, who was then private assistant to Professor (now Lord) Lister, advancing the view that a very obscure case of painful liver was due to rheumatism of its fibrous structure. He advanced the theory with some qualification, and it was received with that freezing urbanity, which is the prerogative of a lofty, if limited, intelligence in high places! Had salicylate of soda been known in those days, my impression is there would have been a scenic undoing of the opposition.

Case 2.—Mrs. B., aged 30, complained of intermenstrual discharge and pain (mittelschmerz), green leucorrhœa, dyspareunia and hæmorrhage after coitus. She had had three dead-born children. On examination I found a tear on left side of the cervix, with nodular edges, and metritis also. The introitus was healthy, so the dyspareunia could not be due to a lesion of that part of canal. In view of the likelihood of syphilis in this case I gave merc. cor. with distinctly satisfactory result, but the case only partially cleared up. At an interview now she volunteered the information that pain in the womb was much worse in damp weather, and that coitus was specially bad then. She added that she had been subject to rheumatic pains. She was therefore ordered sod. sal., gr. v., *t.d.* At her next visit my notes say: "Patient is wonderfully better in every way, and she says 'the discharge after coitus and all the other symptoms are gone.'"

I should like to have cured these cases with a less contentious remedy, but I did not. Sometimes one employs antagonistic remedies with the object of clearing up some ambiguity about a case, that is for diagnostic purposes, and it sometimes happens in such a circumstance that the patient is cured! If the patients referred to require further treatment, I shall probably give a course of bryonia, or actæa and baths, and waters rich in sulphur. This last, by the way, combined with guaiacum, was a great remedy of the late Matthews Duncan. The combination is significant. I see in the latest publication I have come across on "Dysmenorrhœa," viz., that by Herman in the *Clinical Journal*, the writer lays stress on guaiacum, which seems to be his sheet-anchor in cases of this trouble. One may just men-

tion also Dr. Luff's experience with guaiacol in rheumatic conditions. In the light of the evidence adduced I think it is quite obvious that cases of pelvic pain should be investigated on the supposition of a possible rheumatism underlying all. There is with us but little time to do this sometimes, with the enormous number of out-patients at our dispensaries. Ninety-three thousand was the number of attendances last year in all the branches added together. Recognising, however, more clearly in future the point I have dwelt upon, I shall look to a better record of results in this class of pelvic pain in women.

(3) *Gonorrhœa.*—It would be idle longer to delay reference to what is, after all, by far the commonest cause of pelvic pain in women, viz., gonorrhœa. If this could be eliminated women would be relieved from a thraldom which is simply appalling. All men who work at gynæcology, especially in such great cities as this, must frequently be sick at heart at the suffering inflicted upon the innocent by those who enter upon marriage with an incompletely cured gonorrhœa. I do not of course mean that such a compact is necessarily vicious, it is often a matter of ignorance only. When one considers the fact that men do not have sexual intercourse during the acute stage of gonorrhœa, it is obvious that most women are infected from cases which are more or less chronic in character. My own experience points to the fact that a chronic posterior urethritis is the lethal agent responsible in most cases for the wrecking of women's lives.

The potentialities, appalling in degree, of the penile "morning drop" are not half recognised, considering the number of cases of transmitted gonorrhœa discovered on the honeymoon. I have no desire to moralise, and leave that to abler and better men in another field. I merely state the impressions of a gynæcologist in the slums largely of a great city. To imply, however, that gonorrhœa were more prevalent amongst the poor than the rich would probably be a hideous injustice.

Before proceeding further to consider pelvic pain due to gonorrhœa, it is necessary to generalise a little, or there will be a danger of confusing things which are essentially

different, though they may occur in one and the same patient. I refer chiefly to septic pelvic lesions. This is a big subject, and I only touch its fringe. When speaking of septic lesions, I mean conditions quite independent of the gonorrhœal virus. The mind of a gynæcologist is liable to be obsessed by gonorrhœa in consequence of its extraordinary prevalence; yet he must sometimes, if I may use the term in this connection, seek to depolarise his mind from gonorrhœa altogether. This is specially necessary when dealing with lesions commonly known as septic.

(4) *Septic lesions* of the pelvis are common enough, though I believe far less so than formerly. This, of course, is due to the strides made in teaching practical antiseptic midwifery both to students and midwives. It may provoke a smile to see a student place his hands in a corrosive sublimate solution whilst he slowly counts five. But it's up-to-date science all the same. Probably, too, india-rubber gloves have saved many a woman's cellular tissue from infection, though I am still old-fashioned enough to look upon the latter somewhat in the light of a fetish. Septic lesions of the pelvis are due to trauma, and are dependent upon septic fingers or instruments. The organisms found in these cases are the strepto- or staphylococcus. They are introduced from without and are elaborated within the organism. A well-known red herring is sometimes trailed across the path to confuse the issue, viz., sewer gas. I do not plead immunity from calling in the aid of this malodorous fairy, but it is best to admit at once that in sewer gas poisoning, which, of course, is well known in the puerperium, one does not find the strepto- nor the staphylococcus, so, at least, I believe. In pelvic pain due to a resolved pelvic cellulitis and peritonitis, menstruation is excessive, and the pain is very great, and the latter is due to the implication of the peritoneum. In the intervals of menstruation there is a muco-purulent discharge. The treatment is largely surgical, for foci of infection remain in the endometrium, and from these a certain amount of absorption takes place through the lymph channels and is carried to the adnexa; thus the inflammation is kept up. Therefore, curettage and cauterisation and destruction of these foci is indicated.

(5) *Perityphlitis.*—With regard to the subject of pain in the S.W. corner of the abdomen, a citation of the two following cases will be of interest. They serve to emphasise the great importance (when contemplating pain in this region) of not too hastily rushing to the conclusion that it is infallibly due to inflammation of the appendix. I know of nothing which expresses better the attitude of mind which too readily assumes the relation of cause and effect here, than to speak of it as a mind obsessed or besieged. We often speak of a thing being "upon the nerves," and we know exactly what is meant. I think appendicitis is liable to "get on one's nerves," and it needs a level head, a due sense of proportion, and a wise generalisation of facts, to give a sound judgment in a given case. I am not, of course, speaking of cases in which operative delay would mean gangrene and abscess perhaps in a few hours. In short, all cases of fulminating appendicitis are entirely excluded from these observations. In the cases I am about to refer to, the symptoms were those of appendicitis, and which doubtless existed *inter alia*, but as a factor, and though an extremely important one, still only a factor, in the group of signs and symptoms. Miss X., a patient of Dr. Whitaker's, at Waterloo, aged about 30, had an attack of perityphlitis last summer when away from home. She was then attended by the practitioner on the spot. The present attack commenced with very severe pains in the abdomen. The temperature fluctuated between 99° and 100°, and the pulse was correspondingly rapid. The bowels were costive, but were not much distended, and the pain was severe in the right groin and thigh, also in left side in region of descending colon. The face was much flushed, and the patient was obviously very ill. When asked to locate the pain, the patient placed her hand in the latter region not over the appendix, nor (which was significant to my mind) upon the epigastrium, for so-called "stomach ache" often really spells appendicitis. We examined carefully by the rectum and found a mass which was situated about the middle line, and this was tender and hard. I suggested that we should, contrary to ethics in a single woman, examine *per vaginam.*

This we did, and found that the lump was unmistakably a retroflexed uterus. It was painful, especially if in the least tilted, aud there was no difficulty in diagnosing a fairly extensive cellular inflammation around it, in other words, a parametritis. Dr. Whitaker took specimens of the blood and there and then estimated with much accuracy the leucocytosis. The count was as follows :—

January 8, 1907, at 2 p.m., leucocytes 18,000
„ „ 10.30 p.m. „ 19,660

Here was a difficulty in view of above rendering, for, as is well known, a rapid rise in the proportion of phagocytes indicates operation. In view, however, of the totality of the above signs, we decided to wait for twenty-four hours. We continued bell. and merc. cor., and ordered an olive oil injection to be placed in the rectum and retained, and a saline aperient to be given in the morning. The following morning Dr. Whitaker telephoned that there was no need to come as the patient was very greatly better ; at ten o'clock this morning the leucocytes were 12,000, and on the following day, at the same hour, 5,200. I have not seen her since, but Dr. Whitaker informs me that the recovery, though slow, has been steady, that the parametritis has become more and more circumscribed, and that the peritonitic inflammation has disappeared.[1]

The second case in this section which I wish to bring before you is that of a lady, also aged about 30, and who was under the care of Dr. Hynd, of Wigan. The history was that of a week or ten days of vomiting, with a temperature that oscillated between 100° and 102°. There was persistent pain in the abdomen, chiefly on the right side. The tongue was almost clean, but the vomiting was so great that the patient could retain merely a little orange juice. The abdomen was tender, bowels not much distended, but over an area of about four inches in diameter in S.W. quarter of abdomen, there was a hard, boggy swelling, dull on percus-

[1] In August this case was operated upon in consequence of a persistent muco-colitis with neurasthenia. I found the appendix adherent to adjacent intestine. The former was removed and the latter separated. The patient is making an excellent recovery.

sion and very tender to touch. Its outline was fairly obvious above, but below it merged imperceptibly into Scarpa's triangle, leaving the fold corresponding with Poupart's ligament obliterated. The patient looked very ill. The chief cause of suffering was intense pain on defæcation; so agonising was this, that the doctor had been obliged to keep the patient under the influence of morphia. Before this was resorted to, her screams alarmed the whole neighbourhood. A rectal examination, verified as in the last case by a vaginal one, revealed a diffuse swelling, and, as in the last case, also a retroflexed and tender uterus. This examination was not very thorough, as the patient was so intensely tender. I thought we had to do with a pelvic cellulitis, probably already broken down, but so far not actually pointing in any of the three usual situations, viz., above or below Poupart's ligament, or in buttock through the sciatic notch. I advised the immediate removal of the patient to a private ward, either in the Wigan Infirmary or to one in our own hospital, with a view to operation, which it seemed hazardous to delay. The day but one after, she travelled by road from Wigan to Liverpool in a horse ambulance. Contrary to expectation, she did not suffer from transit. The temperature had even sunk and the pulse become slower. The subsequent history I may condense. The phlegmon gradually subsided, the pain on defæcation lessened, and pulse and temperature became normal. A week after she could take and digest solid food, and only a very slight swelling then existed. One very curious feature in the case, and which I have not hitherto seen marked to anything like the same extent was this, whenever the tender swelling in S.W. quarter was percussed or otherwise manipulated, an involuntary contraction of muscular fibres of abdominal wall would set in, very hard and tender. It was sausage-shaped, with the long axis reaching from the middle of Poupart's ligament upwards and outwards in the direction of and beyond McBurney's point. As the internal structures became less sensitive, this contraction became less and less marked, and finally subsided. This patient, I should observe, was also treated by bell. and merc. cor. I have no doubt the case was one essentially of pelvic

cellulitis, involving especially the region of rectum and right ovary. The signs and symptoms, however, closely resembled those of appendicitis. I may add that before the patient left the hospital, under an anæsthetic it was ascertained that a large and prolapsed right ovary existed.

(6) *Pain in epigastrium which is not manufactured there.* —I wish now to refer to such pitfalls in this connection as in our less experienced days we fell into, and might again unless forewarned. The most common cause of pain in epigastrium is, of course, some form of gastric disturbance producing hyperæsthesia. Gastric mischief, however, of all kinds I am putting entirely out of count at present.

There are four conditions which give rise to pain in the epigastrium which is not manufactured there, and have nothing to do with the stomach : (1) biliary colic ; (2) appendicitis ; (3) caries of lower dorsal vertebræ ; (4) pleurisy and pneumonia.

As to the first, biliary colic, the subsequent history of the case will clear up any ambiguity.

As to the second, appendicitis, I have learnt never to fail to investigate cases of frequently recurring " stomach ache " in the young, especially in the young adolescent, in the light of possible appendicitis. What happens is this : The patient complains of stomach ache, probably of vomiting also, and on being asked to locate the pain does so definitely in the epigastrium. There may, or may not, be a rise of temperature, probably there is to some degree. By-and-bye, this pain subsides, and gives place to the typical pain in S.W. corner of abdomen. Probably, in all such cases as I have described, there is really pain at both sites, but that in the epigastrium is so much the more severe that it overmasters the other, and it so falls out that as the greater pain subsides, the patient for the first time becomes aware of the pain at McBurney's point.

Third : Caries of the lower dorsal vertebræ. The fallacy here is so well known that I need do little besides mention the fact in order to make my list complete. The pain is conducted along the course of the spinal nerves from the site of mischief, but is felt where the nerve endings are

distributed, another instance of the puncta dolores of the older writers.

Fourth: Pleurisy and pneumonia. An acute attack of either the one or the other, or a combination of both, is not infrequently associated with very severe pain in the epigastrium. The symptoms are so acute, and the pain so severe and localised, that mistakes have been made on the assumption that the trouble was an acute abdominal one, and the abdomen opened, with, of course, negative result. There are, of course, certain indices which we might suppose would prevent the error. The pulse and temperature failing to give a definite clue, it might be assumed that the character of the respiration would at least act as an index, yet it has failed to do so in the most competent hands. The inference is that in all cases of acute abdominal pain, especially in and about the epigastrium, we ought to make a point of very carefully examining the chest. In such case, to use an Irishism, we may find that the mischief is after all not in the abdomen, but in the thorax.

I am inclined to include another thoracic condition under this head, and to refer to pericarditis. If the latter is associated with diaphragmatic pleurisy, I submit that the pain is largely in the epigastrium. One point, however, I am quite sure of, and that is the very curious one, viz., that pericarditis often induces very severe pain in the right shoulder.

As regards (7) *syphilis*, a few words must suffice. Experience teaches me that, apart from the outward and visible signs so well recognised of the disease, there is a well-marked triple index of its underlying existence in a case whose primary symptoms are not suggestive of its existence. I am supposing a case in which no obtainable history of syphilis is forthcoming. There is nothing typical in throat or skin, and yet the patient is obscurely ill. I am, of course, excluding cases in which there are para-syphilitic phenomena, *e.g.*, tabes dorsalis, or syphilis of brain, in other words, remote or more chronic forms of the disease.

The three points which I have learnt to rely upon chiefly first in the diagnosis of cases in which I believe syphilis to be in the background, and yet one cannot demonstrate it

until kali. iod. has been given, when the effect is often dramatic, are: (1) A temperature of the moderately hectic type; (2) anæmia, in which hæmatinics are useless; and (3) pains, worse at night.

"*Resting Pain.*"

There is one aspect of pain which has not so far as I am aware received the full recognition which its importance merits. It is one which might well occupy the undivided attention of an essayist on pain; it embraces a field which I believe has been but little digged, though its hidden treasures are extremely abundant.

We are all aware of "resting deformities," and in no branch of medicine or surgery are these more continuously in evidence than in orthopædics. To take but one, a familiar example of daily observation, viz., lateral curvature of spine. In it a feeble vertebral column is thrown out of the straight line by the frequent resting on one hip, and we see the well-known curve with the compensatory one also. Thus we have an instance of resting deformity as the result of tired and stretched muscular and fibrous structures, to which I have already referred. To go a step further, it is probably less obvious, though equally true, that similar forces being in operation, we may get, not a deformity, but an ache, conscious or unconscious, to use a paradox. Take the conscious first. A patient suffers from, say, rheumatoid arthritis of the right knee—I will take such a case, not an imaginary one, but a patient of my own, and of which I have copious notes.

What happens? With the object of relieving the pain in knee when patient rests his or her weight upon it, it is more or less flexed, with the result that a corresponding contraction of the hamstrings takes place. Thus, firstly, we have a "resting deformity." Similarly, with the object of resting the painful joint, more work is thrown upon the other leg, and the stress of this may come primarily on the metatarsus of the other leg and the corresponding thigh. Of the pains thus induced, the patient is only too well aware. Thus we have the *conscious* pain. We may now consider what I have termed the *unconscious* pain, and which is

essentially a neuritis, though of a kind which does not express itself in pain unless this quality be intentionally aroused by pressure. Press here and there at sides of vertebral column where the nerve trunks emerge, and it is a revelation to find how many points of really acute pain are elicited, and of which the patient himself is unconscious until they are thus picked out. Here we have the *unconscious* form of "resting pain." In both cases there is a neuritis, but in the one accompanied by its correlative pain, in the other without its correlative, except when the latter is elicited by slight trauma. I submit that both kinds of neuritis are induced by posture unconsciously adopted for the purpose of compensation, and that thus there is induced muscular and nerve fatigue accompanied by hyperæmia.

There is one other aspect of "resting pain" to which I wish to draw attention, and it has to do with the transmission of so-called "ovarian pain." I am fully aware that it is the fashion to regard this form of pain as a kind of Aunt Sally, at whom all sorts of gibes, anatomical as well as pathological, may be cast! It is a cheap, and therefore no doubt a popular, amusement! But an avowed gynæcologist finds the game beyond a joke.

The form of "resting pain" to which I now allude is, I believe, constantly mistaken for pain due to *pressure*. I speak of that which accompanies ovarian disease, and which is conducted *down the thigh*. Let the following case suffice to bring out the point for which I am contending.

Mrs. B. came to Roscommon Street Dispensary a few weeks ago. She had had one confinement a couple of years ago. The child was extraordinarily large and the labour extremely difficult. There had been very extensive tearing of the cervix high up into the broad ligament. How the uterine artery escaped I do not know. After a time she went to the Samaritan Hospital in this city on account of severe pain in the left ovarian region, and down the corresponding thigh, which often "went to sleep" and was numb. At this hospital the tear was successfully treated by Sims' operation, but, unfortunately, the pain remained, and a radical operation was advised and refused. She now

went to the Stanley Hospital, where similar advice was given and declined. Then she came to us. I reviewed the case very carefully, and in view of the following points was unable to advise any alternative.

The uterus is retroverted. There is but little tangibly wrong with the adnexa on either side. In view of the fact, however, that the trauma incident to the confinement is cured by the operation she has already undergone, and yet the pain remains, it is probable—nay, certain—that considerable ovarian disorganisation still exists. I cannot prove that the gonococcus entered the broad ligament tear, but I am sure that other organisms associated with purulent formation did so—probably in many and various forms—for I am convinced that gonorrhœa infection seldom enters alone. Now, as I cannot find the least evidence of pressure on any adjacent nerve trunk, and I have failed to find the slightest hint of it in cases of abdominal section for conditions precisely similar, I do not believe the pain in the thigh is accounted for by pressure in this case, and I do not expect to find it otherwise on opening the abdomen, to which the patient consents. The probable explanation of the thigh pain is that in the unconscious attempts to relax the abdominal parietes on the left side by flexure of the thigh to relieve the pain in abdomen, the patient has set up a condition of muscular and nerve tension, hyperæmia, and painfulness which has become well nigh persistent. In other words there is what I have termed a " resting pain."

Only yesterday I opened an abdomen, and removed a large disorganised ovary and tube, the latter being adherent to the former. Several adhesions were broken down, and the uterus suspended to the abdominal parietes (ventrifixation). The effect as regards the symptoms I await with much interest.[1]

In concluding this section, I would be ungracious not to allude to the extraordinarily illuminating researches of Dr. Head in regard to painful areas (spinal segments) associated with pelvic disease. Dr. Cuthbert Lockyer, too, is an authority of the highest order in similar investigations.

[1] A fortnight later.—Patient is making excellent recovery, and the pain is " nearly gone."

What I submit is, that many of the more or less distant pains in pelvic disease are neither "referred," nor are they conducted through nerve continuity, but are due to attempts to rest the part involved, and are, *ipso facto*, "resting pains." Their mode of induction is similar to that which induces in other cases, where the anatomical conditions are favourable, "resting deformities." Of course, the two are often associated, but I hope to have shown that they are not necessarily so, and that the resting pain, contemplated as such, may be most helpful as an aid to diagnosis.

CASES, SPECIMENS, &c., EXHIBITED AT VARIOUS MEETINGS.

Cases.

Lead Poisoning.[1]

The patient, a man, a painter in water-colours, suffered from lead poisoning, due to the habit of putting his brushes to his lips in order to produce the required shape. He was anæmic and weak, but on abstaining from work and taking opium and other medicines, he recovered his strength and much of his colour.

Another case of commencing lead colic was shown on the same occasion. The patient was a plumber.

Neither patient has wrist-drop or peripheral neuritis.

Specimens.

Photographs of San Francisco Fire.[2]

Two large panoramic photographs of San Francisco: (1) Just after the earthquake; (2) During the fire. Forwarded by the Hon. J. W. Ward, M.D., Health Commissioner of San Francisco.

Enlarged Prostate Gland.[3]

An enlarged prostate weighing several ounces, removed by suprapubic operation from a man, aged 73.

[1] Exhibited by Dr. A. E. Hawkes, at the Liverpool Branch, March 21, 1907.
[2] Exhibited by Drs. Clarke and Burford, November 1, 1906.
[3] Exhibited by Dr. James Eadie, November 1, 1906.

Carcinomatous Cervical Uterine Myoma.[1]

A uterus removed by vaginal hysterectomy, showing destruction of a cervical myoma by carcinoma, starting in the cervical endometrium. Dr. Neatby remarked, concerning this specimen, that the lesson taught by it was, that danger sometimes occurs in leaving a myoma that has been in existence for a considerable length of time.

The patient had been watched by himself and by their lamented colleague, Dr. Carfrae, for many years, and as the patient was nearing her menopause it was deemed wise not to operate. The patient had a happy menopause; but several years after this myoma, which had never entirely disappeared, became invaded by the carcinomatous growth, and its removal by vaginal hysterectomy was necessitated.

Microscopic section showed both the myomatous tissue of the tumour and cross sections of the growth invading it.

Ovarian Carcinoma.[1]

A large ovarian carcinoma, removed from a patient who came to the out-patient department of the hospital.

The Same (Microscopic Section).[2]

Microscopic section of the foregoing ovarian carcinoma, showing the carcinomatous tissue of the ovary.

Carcinoma of the Cervix Uteri.[3]

A specimen of carcinoma of the cervix uteri.

Dr. Hey remarked that the disease was apparently localised to the cervix, chiefly on the anterior lip. The uterus was removed by vaginal hysterectomy, and the patient did very well. There were no complications. The operation was partly done by ligaturing the lower part of the broad ligament, and putting clamps on the upper part. The clamps were left on for forty-eight hours.

Dr. Burford asked how long ago the operation had been done, and whether the patient had had any distinctly anti-cancerous *régime* since then? His increasing experience led him to attach the very greatest importance to commencing the therapeutic *régime* directly after the successful operation. In his experience, which he had related at the Clinical Evening of the Society (see

[1] Exhibited by Dr. EDWIN A. NEATBY, December 6, 1906.
[2] Exhibited by Dr. FRANK WATKINS, December 6, 1906.
[3] Exhibited by Dr. GRANVILLE HEY, February 7, 1907.

JOURNAL, p. 122), he had seen two cases of vaginal hysterectomy, which were operated upon within a few months of each other.

Owing to some miscalculation or misunderstanding, his instructions to have cacodylate of soda given were not, in one of the cases, carried out; and in that case the other day there were signs of recurrence, though that was not the more severe case of the two at the time of operation. But in the other case, to whom the cacodylate of soda was given from the first, there was entire freedom from any sign of recurrence. During this week (ending February 19), he had been in the wards of the Royal Infirmary, Edinburgh, where he had been insisting on the point he was now making, namely, the necessity of anti-cancerous therapeutic treatment in carcinoma as soon after operation as possible.

Dr. Hey, in reply, said the operation was done on November 24, and the patient had not had any anti-cancerous treatment so far.

Uterine Fibromyoma.[1]

Fibromyoma removed by hysterectomy, showing calcareous and fatty degeneration.

Dr. Neatby remarked, concerning this specimen, that the patient had only complained of any symptoms whatever for about a fortnight. During that time she had become conscious of pain in her abdomen, and it was noticed the abdomen was somewhat swollen. On examination an abdominal tumour was found, very hard and resistant, and showing no signs of fluctuation. An operation was performed, and a large hard uterine fibromyoma removed. In searching for the right ovary, it was found there was a body twisted round the end of the fallopian tube. This proved to be the pedicle of an ovarian dermoid cyst which was embedded in the right flank, and was undergoing necrosis owing to the pedicle being twisted round three and a half times. The lower pole of the right kidney was in contact with the upper extremity of this tumour, which was covered with adherent intestines, but it came away quite easily. Recovery ensued.

Uterine Myoma.[2]

A submucous myoma uteri, with a much enlarged uterine cavity, removed by hysterectomy for severe hæmorrhage, from a patient with low hæmoglobin register. Recovery.

[1] Exhibited by Drs. EDWIN A. NEATBY and FRANK SHAW, March 7, 1907.
[2] Exhibited by Dr. E. A. NEATBY, March 7, 1907.

Multinodular Myoma Uteri.[1]

A uterus showing multiple myomata, in which the cervix had undergone carcinomatous degeneration after the menopause. Removal by panhysterectomy. Recovery.

Ovarian Cyst.[2]

An ovarian cyst much discoloured, as were the contents, the pedicle having been twisted. Removed chiefly for intestinal obstruction. The patient had high temperature—102° F. before the operation, and 104° F. after. Good recovery.

Hepatitis.[3]

The liver of a patient who had lived abroad in the East. A day or two before his death an abscess had almost pointed, and its evacuation was suggested, but the expedient was not adopted. The abscess burst, causing fatal peritonitis.

Aortic Rupture.[3]

A specimen of rupture of the aorta, in which the opening was very small, and the symptoms during life obscure, until accounted for by the *post-mortem*.

Calculous Kidney.[3]

A kidney removed from a patient owing to large and small calculi, too numerous to extract. Good recovery.

Marrow from Humerus.[4]

Microscopic section of marrow from a case of pernicious anæmia.

Eosinophiles.[4]

A stained film of blood, showing 9 per cent. eosinophiles, from a case of pernicious anæmia.

Parotid Gland.[5]

A specimen removed, *post-mortem*, from a patient suffering from secondary parotitis.

[1] Exhibited by Drs. WASHINGTON EPPS and EDWIN A. NEATBY, March 7, 1907.
[2] Exhibited by Drs. A. E. HAWKES and CASH REED, at the Liverpool Branch, March 21, 1907.
[3] Exhibited by Dr. ERNEST HAWKES at the Liverpool Branch, March 21, 1907.
[4] Exhibited by Drs. BYRES MOIR and FRANK WATKINS, April 4, 1907.
[5] Exhibited by Dr. FRANK WATKINS, April 4, 1907.

Endosteal Sarcoma.[1]

Endosteal sarcoma of head of tibia.

Pyosalpinx.[2]

Specimen of pyosalpinx. Salpingectomy. Recovery.

Carcinomatous Uterine Myoma.[3]

Uterine myoma with carcinoma. Operation, recovery. Early recurrence.

Carcinomatous Cervical Uterine Myoma.[3]

Specimen of cervical uterine myoma, invaded by carcinoma. Operation. Recovery. No recurrence—eight months.

Corporeal Uterine Myoma with Cervical Carcinoma.[3]

Operation. Recovery.

Multinodular Uterine Myoma.[3]

Specimen of uterine multinodular myoma, showing simple nodules, and calcareous and carcinomatous degeneration. Operation. Recovery.

Tubal Gestation.[4]

Unruptured tubal gestation, at about the sixth week, removed by abdominal section, after an earlier appendicectomy. Recovery.

Malignant Disease of the Endometrium.[4]

Specimen of malignant disease of the endometrium, commencing to invade the much hypertrophied uterine muscle. Hysterectomy. Recovery.

Ovarian Cystic Tumour.[4]

An ovarian cystic tumour removed from a single woman near the menopause. Recovery.

Uterine Myoma.[4]

A uterine myoma removed from a single woman on account of uterine hæmorrhage, with debilitated cardiac musculature. Hysterectomy. Recovery.

[1] Exhibited by Mr. C. KNOX SHAW, April 4, 1907.
[2] Exhibited by Dr. C. GRANVILLE HEY, April 4, 1907.
[3] Exhibited by Dr. EDWIN A. NEATBY, April 4, 1907.
[4] Exhibited by Dr. BURFORD, May 2, 1907.

Dermoid Cyst of the Left Ovary.[1]

Dermoid cyst of the left ovary, removed after a previous ovariotomy on the right side, ten years ago. Recovery.

Fœtus in Utero with Fibroid.[1]

Uterus, with fœtus in utero *in situ*, removed by Porro's operation together with blocking fibroid. Recovery.

Ovarian Cyst.[1]

An ovarian cystic tumour removed from a patient, a married woman, near the menopause. Recovery.

Uterine Myoma.[1]

Specimen of uterine myoma, removed by hysterectomy from a single lady, also suffering from mammary scirrhus. Recovery.

The President remarked that this case specially interested him. He had seen two cases in which scirrhus of the breast had developed subsequently to fibroid tumour, in neither of which cases had the fibroid been operated upon.

Carcinoma Cervix Uteri.[1]

Cancer of the cervix uteri removed from a patient past the menopause, with atrophied uterus. Recovery.

Carcinoma Cervix Uteri.[1]

Cancer of the cervix uteri after the menopause, with two coincident polypi of the uterus. Recovery after hysterectomy.

Cæcum.[2]

Cæcum successfully removed for malignant disease.

Prostatic Adenoma.[2]

Prostatic adenoma successfully removed by suprapubic cystotomy.

Ovarian Multilocular Cystic Adenoma.[3]

Multilocular cystic adenoma of the right ovary undergoing extensive mucoid degeneration. Early stage of the same condition in the left ovary. Double ovariotomy. Recovery.

Microscopic sections of above from the laboratory of the London Homœopathic Hospital.

[1] Exhibited by Dr. BURFORD, May 2, 1907.
[2] Exhibited by Mr. DUDLEY WRIGHT, June 6, 1907.
[3] Exhibited by Dr. EDWIN A. NEATBY, June 6, 1907.

The Cinematograph as a Demonstration of Operative Surgery.[1]

A new use of the cinematograph consists in reproducing the various stages of an operation from the time the patient is fully anæsthetised until the end of the operation. (The demonstration in question showed the operator and his assistants, but the latter is really unnecessary, and without such unnecessary detail, a closer and more enlarged view of the operation could be obtained, only the actual anatomical region and the moving hands of the surgeon being required.) Every detail of the following operations was reproduced. The time occupied in each operation was extremely short, and the appearance was just as if onlookers were watching actual operations, excepting of course that no colour was observable.

The subject was illustrated by six cinematograph films, which consisted of the following: (1) Extirpation of a cyst of the thyroid body. (2) Extirpation of a unilateral gôitre. (3) Extirpation of a bilateral exophthalmic gôitre. (4) Removal of a tumour of the testicle. (5) Removal of a myxomatous tumour of the thigh. (6) Removal of a tumour of the kidney.

The general technique of the operations was described in the various steps by means of picture slides, or fixed projections, which, with the operator's comments, gave all the explanation necessary.

BRITISH HOMŒOPATHIC SOCIETY.

Report of Council, Session 1906-7.

The Session 1906-7 was inaugurated at a full meeting by the address of the President, Dr. J. H. Clarke, entitled, "The Enthusiasm of Homœopathy." The members of the Society accepted the invitation of the President to supper.

During the Session fourteen papers have been read, divided as follows amongst the sections: Five on Medicine and Pathology, six on Materia Medica and Therapeutics, four on Surgery and Gynæcology. The secretaries of the sections have experienced unusual difficulty in getting papers for the meetings, and the Council takes this opportunity of urging members, both in London and the country, to come forward with short practical papers.

[1] Exhibited by the Charles Urban Trading Company, of 48, Rupert Street, Shaftesbury Avenue, on July 3, 1907.

On January 3 a well-attended clinical evening was held, and at the close of the session a lantern and cinematograph display of surgical operations was given by Mr. C. Urban, F.Z.S., of the Urban Trading Co.

On February 21 a special meeting of the Society was called to discuss a pamphlet issued by the British Homœopathic Association. After a long discussion the meeting adjourned without voting on the motion before it.

Three new members have been elected, and one member has been elected to the Fellowship.

The death of Dr. Lambert has been a serious loss to the Society.

Dr. R. M. le Hunt Cooper has been appointed Librarian *vice* Dr. Lambert deceased.

The circulation of the Journal has been continued to members subscribing. To ensure punctuality a system of fines was decided upon by the Council.

"The American Re-proving of Belladonna" and the *Transactions of the Homœopathic Medical Society of the State of New York* have been added to the Library.

The Council decided that in future new members and visitors should be introduced and presented to the meeting by the President.

A roll book has been prepared to secure a permanent autograph record of all members and Presidents of the Society.

Attention having been drawn to the fact that the present ballot box does not secure secrecy, a supply of cork balls has been procured as a first step to remedying the deficiency.

To facilitate the conduct of business and to strengthen the chair, certain new rules have been drawn up for sanction by the Annual Meeting.

The Indexing Committee has laid on the table copies of the Index.

THE BRITISH HOMŒOPATHIC SOCIETY

DR. BALANCE SHEET—SESSION 1906-1907. CR.

RECEIPTS.	£	s.	d.
To Balance in Hand	65	17	4
,, Dividends on Consols	4	19	4
,, Subscriptions	200	5	6
,, Sale of Publications	10	17	3
,, Half cost of Plates	4	11	0
,, Balance of Dudgeon Memorial Fund	3	7	6
	£289	17	11

EXPENDITURE.	£	s.	d.
By Rent	25	0	0
,, Printing, less advertising	144	8	3
,, Reporting	18	18	0
,, Honorarium to Editor	10	10	0
,, Library	11	13	6
,, Postage and Stationery	7	16	0
,, Cheque returned	1	1	0
,, Refreshments	6	0	0
,, Indexing Account	36	10	6
,, Petty Cash	4	12	5
	£266	9	8
,, Balance	23	8	3
	£289	17	11

Audited July 1, 1907.

WASHINGTON EPPS.

JNO. G. BLACKLEY, *Treasurer.*

PRESENTATION OF THE INDEX OF CLINICAL CASES.[1]

To place a key in every reader's hand to the clinical treasures of our periodic literature—that is the plan of this index.

To put ourselves in touch with the great clinicians of the past, to see them at work, to note their skill and success for our personal behalf—that is what the index enables us to do.

We know no medical literature, in any tongue, so rich as ours in the record of sound therapeutic work; of results we may repeat, in that we have the secret of success; for scientific facts, the law being adhered to, can be repeated at any time all the world over.

Besides the practical object of enriching our personal experience by that of others, the index is planned as a mass of scientific proof. Here there are collected and condensed innumerable verifications of the law of similars; the facts are those contributed in an authentic manner to the journals. This law we daily verify in our practice; but the length and breadth of verification can only be ensured by collecting the results of competent observers at various times under different circumstances.

This index, then, is a double-sided unity; first and foremost it is a practical aid to the physician in his daily work, and especially in his "hard cases," setting forth what others have found to relieve and to cure in similar disease conditions. Second, it is a mass of evidence—of facts, not views, in proof of the validity of the homœopathic law, covering the experience of many reliable observers spread over the Victorian era.

Of what material does the "Index" consist? Of cases *cured* by homœopathic remedies, or of pronounced symptoms, such as vomiting or pain, so definitely relieved as to leave

[1] Index of Clinical Cases reported in the British Homœopathic Journals, with a record of essays and papers on special subjects. Prepared by order of the British Homœopathic Society. Editorial Committee: R. E. Dudgeon, M.D.; Washington Epps, M.R.C.S., L.R.C.P.; George Burford, M.B. (Secretary). London: John Bale, Sons and Danielsson, Limited. Price 5s.

no doubt of the marked and potent influence of the drug. Besides these, there is a carefully arranged list of the more important essays and papers on medical subjects scattered throughout British homœopathic literature during the last century.

To what homœopathic literature is this work an index? It covers all the volumes of the *British Journal of Homœopathy*, of the aforetime *Annals and Transactions of the Society and Hospital*, the *Homœopathic Times*, the *London Homœopathic Hospital Reports*. And of still continuing publications, the *Monthly Homœopathic Review*, the *Homœopathic World*, and the JOURNAL OF THE BRITISH HOMŒOPATHIC SOCIETY, from their first volume up to the year 1896.

How has the index been prepared? The whole mass of British homœopathic serial literature was divided among nine collaborators: Dr. Dudgeon, Dr. A. C. Clifton, Dr. J. W. Hayward, Dr. Charles Wheeler, Dr. Johnstone, Dr. Wynne Thomas, Dr. C. Wolston, Dr. Washington Epps, Mr. Dudley Wright, and a schedule of instructions for abstracting issued to these. Each volume as allotted was to be carefully read through; each clearly reported case where cure was effected by homœopathic remedies was to be analysed, and the name of the disease with the medicines successfully used were to be noted down by a process of double entry. The collaborator was charged to exercise his best discretion; doubtful cases were to be omitted, and only those narratives of cure chosen where the improvement could be clearly assigned to the use of the remedy.

In the carrying out of the directions, the different collaborators have varied very considerably in their selections. Some have kept strictly to clinical cases, and rejected suggestions and recommendations. Whereas others have included numbers of these suggestions and recommendations, even when these are taken bodily from some foreign journal, German, American, French, Belgian, &c. In many cases these are of great interest, as coming from some of the great masters of homœopathy long since passed away. Many of these were collated by the nestor of British homœopathy, our much to be lamented colleague and indefatigable worker, Dr. Dudgeon, who took the first twenty-five volumes of the

British Journal of Homœopathy as his share for abstracting, and who, almost up to the day of his death, was occupied in the revision and correction of the proofs.

Further, the same amount of variation in the selection of extracts will often be noted. This applies especially to interesting cases treated with two or more remedies. Some collaborators have rejected all cases in which more than two or three remedies were given. Others included sometimes cases treated with three, four, five, and even six or more remedies. Many of these latter cases had to be searched for and critically examined by the final editors, and admitted or rejected as was considered best, from their probable aid to the general practitioner and specialist in using this work, either from the disease or the drug side.

Again, in the selection of the essays, some variation will be noticed. Essays which would be considered by many as being both able and valuable have been omitted. This cannot be avoided, when a number of medical men with varying tastes and interests make selections from several hundred volumes. In spite of this, some eighteen closely printed columns of essays find place at the end of this volume.

What was the method of sifting adopted by the editors? Now comes the *pièce de resistance* of the whole work. The editors found themselves in possession of a great amorphous mass of detail, consisting of thousands of references taken down in the order of reading, each independent of others. Our business was to co-ordinate this multitudinous mass of material. The collaborator's sheets were divided into strips, and each entry cut out and arranged in alphabetical order on a new series of sheets. This constituted the manuscript for the printer. The care requisite in the transference of every reference was enormous; no single detail was allowed to be lost, or mislaid, or puffed away by any breeze, and the instructions were that each night the whole MSS. was to be placed in the printer's safe.

At length this bulky MSS. was prepared and put into type, and now the real difficulties of the editors began. The caligraphy of our collaborators was, in most cases, excellent, but in others microscopic.

We submit some specimens of interest; and when the work of verifying each word and figure was over, when, *e.g.*, the task of integrating a mass of entries under cancer with those under carcinoma, and a third moiety under malignant disease had been effected: when the entries under gastrodynia, gastralgia, and cardialgia had been reduced to alphabetical order under one heading: when typhoid and enteric, cimicifuga and actæa, corneitis and keratitis had been assimilated to each other, the proofs gradually became less like Egyptian hieroglyphics, and by about the tenth revise took some colourable resemblance to the final work.

Further, in the nomenclature, the editors had considerable difficulty in, as far as possible, entering each disease (when returned under several names in the different journals and periods of medical science), under one name. Thus gastric fever, typhoid, typhoid fever, enteric fever or enteric, are, in all cases, entered, except where it has slipped our final revision, under enteric or enteric fever. The names used are those advised in the Nomenclature of Diseases authorised by the Royal College of Physicians, London. Cardialgia, gastralgia and gastrodynia are entered under gastralgia.

Again, dysecoia has crept in from the other journals. Even as late as 1878, Dr. Dudgeon himself reported a case of deafness (Λὺς *άκοὴ*) cured with silica 30 under the heading dysecoia, now obsolete.

Had this work no other result, it would still have been of high importance as demonstrating the *lacunæ* which exist in the well-related cases of cure in our literature before 1896. Take influenza for instance; for six years after the first influenza epidemic only two cases of cure by homœopathic remedies had been reported in our journals in detail. Take also hordeolum — one case only of cure, and that under natrum c. Under hay fever there is nothing under anthoxanthum, and only two cases under sabadilla. Under measles, four cases only; with arsenicum, rhus, sabadilla, and zincum. Now for the specialities. Under uterine hæmorrhage there are four references only under china, and two of these are after parturition. There are only four under crocus, and one of these is a post-

partum case. Hydrastis in this affection has one reference. Metritis has one reference only to merc. cor. and aloes. Eye work is better represented, but still not by any means adequately. There are seven references under iritis; thirteen under keratitis; four under phlyctenular conjunctivitis and ophthalmia; sclerotitis has but one reference. The aurists are much in the same quandary of limited representation. Menière's disease has two references only; polypus of the ear one, and that under mercurius; and Eustachian catarrh one, and that under graphites. Now all who know what transpires at this hospital are fully aware that this record in no way, shape, or form corresponds to the enormous list of cured cases in the afore-mentioned lesions. The moral is plain; more reporting of cured cases is positively necessary for the up-to-date demonstration of the value of our work.

While absolutely no pains have been spared to make it flawless, we much fear that here and there the practical use of the work will disclose occasional lapses from perfection. We would suggest that whenever any reader comes across any typographical defect, he should communicate it to the Editor of the Journal, so that other readers may profit by his correction.

In presenting this work to the Society the editors very much regret the length of time taken in its compilation. Had they in the least known, at the beginning, the immense amount of labour involved, and the hours of eye-strain and brain-fag resulting from the sevenfold correction of galley after galley of diamond print and figures, they would certainly never have attempted the work. But they have now finished their task. In size the volume does not bulk large, but in usefulness its compilers hope and think it may take rank near to Bönninghausen.

In conclusion, they wish to record their extreme sorrow that the first name concerned in this presentation cannot be that of their dear and esteemed friend and adviser, Dr. Dudgeon.

WASHINGTON EPPS.
GEORGE BURFORD.

THE PRESIDENT'S VALEDICTORY ADDRESS, 1906-7.

BY JOHN H. CLARKE, M.D.EDIN.

I CANNOT allow the session of 1906-7 to come to a close without one word of sincere thanks to the officers and members of the Society for the great kindness all have accorded to me whilst occupying this chair. I am perfectly conscious that my shortcomings have been neither few nor small, but, at any rate, my intentions have been good. I have kept a single eye to the advancement of our great reform, and for this you have given me credit, and I shall always cherish the recollection of your cordial and never-failing support.

In the opening address of the session I preached the gospel of the Enthusiasm of Homœopathy. I asked that all who should undertake to read papers would so arrange that, no matter to which section of the Society's work the paper might belong, every night of the session should be a homœopathy night. You have well responded to my request. If you will allow me I will recapitulate the titles of the papers read at the ordinary meetings.

November.—Dr. Ord on "The Curability of Phthisis in the Light of Modern Research"; and Dr. Ham on "Sequel to Things New but Old."

December.—Dr. MacNish on "The Relative Value of Local and Constitutional Symptoms in Prescribing"; and Dr. Wheeler on "Experiences of Sanatorium Work in Phthisis as Applied to the Needs of General Practice."

January.—"Clinical Evening."

February.—Dr. Searson on "The Place of Physical Treatment in Therapeutics."

March.—Dr. Murray Moore on "New, Old, and Forgotten Remedies"; and Dr. H. L. Deck on "First Impressions of Homœopathy."

April.—Dr. Neatby on "Uterine Fibroids—whether the

Existing State of the Patient and Tumour, or the Natural History of Fibroids, should be taken as the Guide in Dealing with Them"; and Dr. Alexander on "Jottings from Ophthalmic Practice."

May.—Dr. Blackley on "Latent Gout, its Importance in Relation to Prognosis and Treatment"; and Dr. Day on "Chorea in Childhood."

June.—Dr. Munster on "A Brief Glance at the Calcarea Salts, with Especial Reference to Calcarea Phosphorica, and Cases Illustrating its Use"; and Dr. Avent on "Aconitum and Ferrum Phosphoricum compared."

I have only to read you the titles of these papers to recall to your minds the large amount of valuable and interesting matter that has been brought before the Society, and the extremely valuable, practical and keen discussions which they have evoked. The Society has more than fulfilled the hopes I expressed at the beginning of the session—the session has been pre-eminently a homœopathic one. And, more than that, it has been in the widest sense homœopathic. Homœopathy, in its finer expression, is at this day more popular and more alive in the Society than it has ever been before in the course of its history. And it is becoming more and more distinctively homœopathic every year of its existence. This I regard as of most hopeful augury, because it is in the points in which homœopathy differs from, and is superior to, allopathy, that its great power lies. The mission of homœopathy is to civilise, I might almost say to spiritualise, medical practice. When we think what the millions of suffering humanity—and the suffering animal world, too, for that matter—are daily losing for the want of the help which homœopathy is ready to give, all smaller questions fade into nothingness beside the one great question which burns in our hearts, the desire to make the truth we know prevail for the salvation of the world from disease and suffering. This is our mission, gentlemen, as individuals, and it is the mission of this Society; and I am happy to think that the Society is becoming more and more conscious of its high destiny.

The session we are just concluding has been a notable

one in many ways. You have just had put into your hands, by Drs. Burford and Epps, one of the *magna opera* of the Society—the index to the treasures of its library. This is a work that will rank with Dr. Dudgeon's translation of "The Materia Medica Pura" and "The Cyclopædia of Drug Pathogenesy." During this session we have improved our machinery in the new laws and regulations which the Council have proposed, and which you have just passed; and we have added one to the Materia Medica nights of the session, making them four instead of three. We have established a roll-book, which will provide a closer and more formal bond between our individual units than has existed hitherto, and will, in a way, preserve the unity of the Society and its work from one generation to another. To our Secretary, Dr. Neatby, we are indebted for all the trouble taken in seeing that the wishes of the Council in regard to this have been carried out. During the present *annus medicus* of the Society the seventh International Homœopathic Congress has taken place in Atlantic City, and our Society has taken a not unworthy share in the proceedings on that great occasion.

Gentlemen, I must now bid you farewell as the occupant of this chair, but I leave it with the greatest satisfaction in the possession of my successor. I congratulate you on your choice of a thorough-going homœopath, who cannot fail to carry on to higher achievement the best traditions of this chair.

Mr. President Alexander,
Moriens te saluto!
Gentlemen, Farewell.

SOCIETY NEWS.

Roll Book.

At the first meeting of the Annual Assembly, held on July 3, as had been resolved by the Council of the Society, a Roll Book was presented to the meeting by the President, in which is to be inscribed the names of the officers, fellows, and members, and additional names as from time to time they may be elected.

New Laws.

At the second meeting of the Annual Assembly a series of important alterations in the laws and bye-laws of the Society were made. The whole laws as amended were ordered to be reprinted and circulated among the fellows and members, and attention is called particularly to new laws relating to the conduct and procedure of the meetings.

Experiments with Drugs on the Human Subject.

At the second meeting of the Annual Assembly a resolution, proposed by Dr. Burford and seconded by Dr. Wheeler, was carried: "That the new Council be empowered to appoint a representative to give evidence in reference to the proving of drugs on the human subject before the Royal Commission on Vivisection." At a meeting of the Council subsequently the following were chosen as a sub-committee to make arrangements for carrying out this resolution, namely, Dr. Spiers Alexander (president), Dr. Macnish (vice-president), Dr. Burford, Dr. Wheeler, and Dr. Neatby (hon. secretary).

Officers for 1907-8.

At the Annual Assembly the following officers for the ensuing session were elected:—

President: Dr. A. Spiers-Alexander.

Vice-Presidents: Dr. Macnish, Dr. W. T. Ord.

Treasurer: Dr. J. Galley Blackley.

The following Fellows and members were chosen with the above to form the Council: *Fellows*—Dr. Burford, Dr. Deane, Dr. Byres Moir, Mr. Knox Shaw. *Members*—Dr. C. E. Wheeler, Dr. R. M. Le H. Cooper. *Representative Liverpool Branch*—Dr. A. E. Hawkes.

Officers for 1907-8 (Liverpool Branch).

President: Dr. Edmund Hughes.
Vice-President: Dr. Theodore Green.
Treasurer and Secretary: Dr. James L. Hawkes.
Representative on Council: Dr. Alfred E. Hawkes.

Officers Elected by the Council.

At the meeting of Council held on July 8, the following officers were chosen :—

Hon. Secretary: Dr. E. A. Neatby.
Editor: Dr. Goldsbrough.

Secretaries of Sections.

Materia Medica and Therapeutics: Dr. Wheeler.
General Medicine and Pathology: Dr. Watkins.
Surgery and Gynæcology: Mr. Johnstone.

Meetings for 1907-8.

At the meeting of Couucil the following order of meetings was arranged for the ensuing session :—

1907.—October 3.—Presidential Address.
November 7.—Materia Medica and Therapeutics.
December 5.—General Medicine and Pathology.
1908.—January 2.—Materia Medica and Therapeutics.
February 6.—Surgery and Gynæcology.
March 5.—Materia Medica and Therapeutics.
April 2.—General Medicine and Pathology.
May 7.—Materia Medica and Therapeutics.
June 4.—Surgery and Gynæcology.
July 1.—General Medicine and Pathology (first meeting of Annual Assembly).
July 2.—Second meeting of Annual Assembly (Election of Officers, &c.).

B.H.S. Golf.

Early in the present year, with the idea of promoting good fellowship among those members of the Society who play golf, it was suggested that an annual tournament should be held between May 1 and September 30, and a challenge cup provided.

With this end in view a letter was written to all those members known to play golf asking them if they would play. Entries were received from ten members, and a cup, called "The Dudgeon Cup," provided. The tournament was successfully carried through with the following result:—

First Round.	Second Round.	Third Round.	Final.	Winner.
(1) Byres Moir ...	Byres Moir	Moir	Mason	H. Wynne Thomas.
(2) E. M. Madden				
(3) Bye	Knox Shaw			
(4) Bye	Frank Shaw	Mason		
(5) Bye	H. Mason			
(6) Bye	J. Johnstone	Thomas	Thomas	
(7) Bye	Wynne Thomas			
(8) Bye	E. Capper	Capper		
(9) J. Powell ...	J. Powell			
(10) E. F. Cronin				

SUMMARY OF PHARMACODYNAMICS AND THERAPEUTICS.

Extracts from Exchange Journals by the Editor, in collaboration with J. Galley Blackley, M.B.

Adrenalin. *External use in Neuralgia, Neuritis, and Reflex or Referred Pain.*—H. G. Carleton, of Atlantic City, contributes an article on 500 collected cases in which adrenalin was used locally for neuralgia, neuritis, or referred pain. The application was in the form of an ointment, containing 1 to 2 minims of a 1 : 1000 solution, along the trunk of the nerve at the point on the skin nearest its origin which could be reached. The following are the results reported: (1) The only absolute failures noted were of neuralgia springing from toxic conditions, such as intestinal toxæmia, the malarial plasmodium in the blood, diabetic or lead poisoning, or traumatic or inflammatory reflex irritation of a nerve. Neuralgia associated with degenerative conditions (*e.g.*, tabes dorsalis), was intractable. (2) Unvarying success was attained with functional neuralgia and neuritis situated in any part of the body. Relief was attained in a few minutes after application of the ointment. Recurrences were noticed in a few hours or days, but the intervals gradually became longer. "Transferred" pain is easily relieved by this treatment, *e.g.*, in a case of "achillodynia" due to ovarian disorder. The pains of gout, articular and muscular rheumatism, are easily relieved by the external application of adrenalin. The quantity required is too small to cause the slightest ischæmia or variation of blood pressure. If two or more nerves are involved originating from different ganglia, each requires treatment, but several branches of one nerve may be treated by one application to the main trunk. A number of separate medical observers have contributed to these results. (*Therapeutic Gazette*, May, p. 293.)—Ed.

Boldò in Congestion of the Liver.—Dr. Laurence Olivera, of Havana, has used Boldò, a plant originally gathered from the Andes mountains, in liver states following malaria. Burning weight in the region of the liver and stomach, no appetite, bitter taste, constant headache, constipation, hypochondriasis, yellow

clay-like look, languor, with abscess or fever, appear to be the indications for its use. (*Homœopathic Recorder*, August, p. 358.) —Ed.

Causticum. *Leading Indications.*—In the notes of one of his college lectures, Dr. C. M. Bugle gives the following leading indications for causticum: (1) Lack of control of the will giving rise to involuntary actions, spasms, &c.; (2) paralysis and relaxation, especially of single parts; eyelids droop; involuntary urination; paralysis of vocal cords; inability to expectorate, it must be swallowed; cannot get under secretion in lungs; (3) symptoms come in single parts or isolated groups; partial chill, heat or sweats; (4) aggravation from dry cold air in clear weather; (5) worse in the evening, on awaking, and from coffee. (*Homœopathic Recorder*, July, p. 298.)—Ed.

Colloidal Metals. *Their Therapeutic Uses.*—M. Iscovesco employs gold, silver, and palladium in what he calls electric solution, but which is in reality a liquid containing extremely minute particles of the metal in suspension. His solution of silver is of a strength of 1 : 4000; it contains about 2,000,000,000 granules in the cm., and is of a reddish-brown colour. He uses it exclusively in the form of intramuscular injections, which are quite painless. After the first hour spectroscopic examination reveals the presence of silver in the blood.

When 5 to 10 cc. of this solution are injected into a patient, there is a febrile reaction after five or six hours, provoked by an abundant polyneucleosis. This fever yields to the cold bath. He begins with a dose of 5 cc., and if the reaction is *nil* or insufficient, and the therapeutic effects unsatisfactory, it is necessary, twelve to twenty-four hours later, to inject 10 cc. This may be gradually increased at each injection until the desired effect is produced. M. Gaillard has reported some good cases of typhoid fever in children rapidly cured by intravenous injections of colloidal silver *à petits grains*. (*L'Art Medical*, June, 1907, p. 496.)—J. G. B.

Copaiba Officinalis. *Pathogenesis.*—This drug has been proved by the drug pathogenesy department of the University of Michigan. Professor Dewey contributes a *résumé* of results. He points out that most of that which has hitherto passed for pathogenetic material is vitiated by the fact that it consists of symptoms which occurred in persons taking the drug for diseases of the urinary organs, chiefly gonorrhœa. With regard to the urinary sphere the only alterations from the normal noticed were increase or diminu-

tion of quantity of urine proportionately to the dose of the drug, and (in one prover) little burning on urination. The most marked action of the drug was on the respiratory tract. Rawness and soreness in the nostrils with stopped-up feeling, and a considerable secretion of mucus with, specially, dryness and discomfort in the posterior nares. Crusts on the turbinated bones. Burning and dryness in the nose extending into the throat, which was irritated, sore, raw, and dry. The eyes also burned and smarted. In the gastro-intestinal sphere there were marked eructations, intestinal flatulence, urging to stool, difficult passing of stool, straining, and pain before and after. The stools were small, hard, brown, and difficult to expel. Rather constant manifestations were a dull frontal headache, throbbing at intervals, < on motion in cold air, and on the right side. Tendency of pain to pass from forehead to occiput backwards and forwards. In the female there was early, dark, profuse, strong-smelling menstrual discharge, with pains radiating to hip bones, especially < on left side. Nausea accompanied menstruation. The flow was irritating to the pudenda and caused prostration and weakness. Aching over the pubic bone. (*University Homœopathic Observer*, July, p. 139.)—Ed.

Gelsemium Sempervirens. *Summary of Pathogenesis.* — Dr. A. L. Monroe presents the following leading points on the pathogenesy of gelsemium. It is a narcotic. Its central action is on the brain, spinal cord, nerves, and secondarily on the muscular system. It produces passive congestion with consequent mental sluggishness, and muscular relaxation. Nervous erethism is often therewith associated. There is genuine vascular excitement, with a full, round, compressible pulse. The general state produced resembles the physiological effect of alcohol. The head is full and tense, with dizziness and blurred vision. The pupil is dilated, and diplopia results from oculomotor relaxation. When the symptoms are characteristic it is useful for the effects of fright, in diarrhœas from emotion, in the sexual weakness of men. (*Medical Century*, July, p. 209.)—Ed.

Hyoscine-Morphine for Surgical and Obstetric Anæsthesia. —Dr. Emory Lamphear contributes an article dealing with the use of hyoscine-morphine as preliminary to chloroform, and after, and a substitute for it in surgical and obstetric operations, and this by contrast with and in preference to scopalamie-morphine. He contends that it is almost uniformly effective when given properly. The surgeon must stop occasionally and speak reassuringly to the patient, and a few drops of chloroform may be required when special

structures are pulled upon. Most patients awaken soon after their return to bed. All can be roused if desired. Post-operative analgesia persists for many hours so that pain is practically eliminated. It is of much use in labour. (*Journal of Surgery, Gynæcology, and Obstetrics*, July, p. 347.)—ED.

Magnesium Sulphate. *Local Use in Inflammations.*—Dr. Henry Tucker, genito-urinary surgeon to the Philadelphia General Hospital, reports twenty-six cases of inflammatory states in which solution of magnesium sulphate was applied locally with more rapid subsidence of the pain and inflammation than is usual with ordinary rest and fomentations. The cases treated consisted chiefly of gonorrhœal orchitis and epididymitis, also some cases of rheumatism, two of facial erysipelas, and one of tuberculous peritonitis. The application consists of a saturated solution of magnes. sulph. in water. It is applied on fifteen to twenty thicknesses of ordinary gauze. This is saturated with the solution every half hour or as often as is necessary to prevent drying, depending on the time of the year and the temperature of the room. The gauze is not removed for twenty-four hours; the parts are then washed with water and the dressing reapplied if indicated. The attendants complain that the solution causes partial loss of sensation accompanied by tingling of their hands and arms, which persists for from twelve to twenty-four hours. (*Therapeutic Gazette*, April, p. 238).—ED.

Pyrogen in Septic Conditions. — Dr. L. H. Boynton, of Los Angeles, California, gives three cases of septic states where pyrogen induced a marked improvement and recovery ensued. (1) A varicose ulcer in right leg in a man aged 42. The ulcer was three inches long and an inch and a half wide; edges bluish, inverted, body of ulcer almost black, and discharging a sanious, watery pus that smells like decayed flesh. The ulcer had continued for three years, and radical operative treatment had been advised. Pyrogen 6x internally and a light bandage locally completely transformed the appearance of the ulcer. In four weeks the odour had all gone, the discharge nearly so, and in six weeks it had completely healed. (2) Mrs. C., aged 65, was suffering from cerebral embolism, from which she subsequently died. She also had extensive erythema, accompanied by discharge, viscid, quite profuse, and smelling horribly. Pyrogen 6 and hyoscyamus 5 were given in alternation, with the effect that in twenty-four hours the odour had nearly gone and the eruption greatly improved. (3) Puerperal septicæmia. On February 10, 1907, three days

after confinement with her second child, a woman was seized with high temperature (104°), and pulse 120, with retrocession of milk. The temperature the evening before was 101°, pulse 90. Lochial discharge normal the first day. She received an intrauterine boracic acid douche and baptisia 3x. The temperature in the evening was 103·2°, and pulse 110. Lochial discharge, white, profuse, offensive. With arsenicum and douches this condition went on until February 16, when at 8 a.m. the temperature was 102°, pulse 105, and pyrogen 6x every two hours was given, and a boracic douche every six hours. On February 17, at the same hour, the temperature was 100·2°, pulse 90, the odour abating, the discharge being much less. February 19, temperature and pulse normal, also the discharges. (*The Pacific Coast Journal of Homœopathy*, July, 1907, p. 444).—Ed.

Quinine. *A Mental Symptom.*—Dr. Stonham suggests an inquiry whether persistence of an idea of altered personality, or confusion in personal identity is a mental symptom of quinine. This symptom was experienced in a gentleman who was very sensitive to quinine, and who had had a dose administered for influenza, and in a case of influenza where dreams were peculiarly vivid and personality was confused, China 3x promptly produced dreamless and refreshing sleep. (*British Homœopathic Review*, August, p. 459).—Ed.

Saxonite. *A New Mineral.*—Dr. A. C. Cowperthwaite draws attention to a new mineral named Saxonite, which appears to have remarkable cleansing, deodorising and soothing properties for the skin, and probably mucous membranes. The mineral consists of silica 68 per cent., alumina 17 per cent., iron oxide 3·69 per cent., calcium carbonate 4·4 per cent., carbonate of magnesia 1·53 per cent., alkalies in combination 2·62 per cent., organic matter 1·06 per cent., free sodium carbonate 69 per cent., water 36 per cent. The mineral used in the form of soap has, in Dr. Cowperthwaite's hands, been practically serviceable in acute eczema, scalds and burns, purulent sores, malignant sores, and itching hæmorrhoids. In the form of pill it acts as a mild laxative, will break up a cold, and has been used in bronchitis and asthma. It is the opinion of Dr. Cowperthwaite that the mineral as such is found in the mines deserves thorough proving. (*Medical Century*, June, p. 164).—Ed.

Variolinum.—Dr. Charles W. Eaton, of Des Moines, Iowa, brings additional evidence of the value of variolinum as a prophy-

lactic against smallpox. An epidemic of smallpox has been in progress in Iowa for about five years. Dr. Eaton has collected his evidence from thirteen medical men, who are in active practice. By them variolinum has been administered to 2,806 persons, of whom 547 were known to be exposed to smallpox after the administration, and only fourteen of these contracted the disease. The variolinum was given by the mouth in the 12x or 30x dilutions. (*Medical Century*, August, p. 243).—ED.

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