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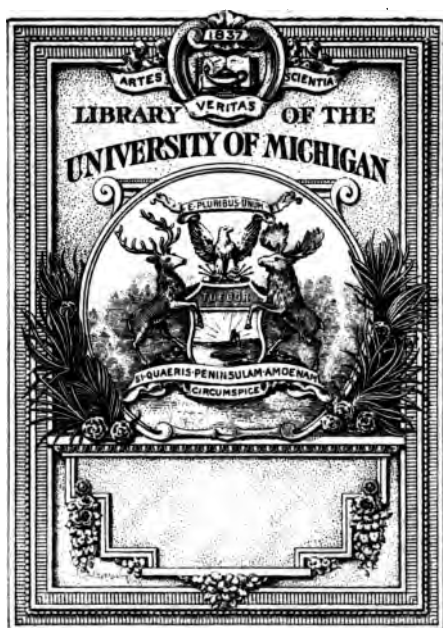
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# The Journal

OF THE

# British Homoeopathic Society

*NEW SERIES*

**VOL VI.**

SESSION 1897-1898

EDITED BY

RICHARD HUGHES, M.D.

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88-89, GREAT TITCHFIELD STREET, OXFORD STREET, W.

—  
1898

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## CONTENTS.

---

Officers and Council.

List of Presidents.

Trustees.

Corresponding Members.

List of Fellows.

List of Members.

Liverpool Branch.

Local List.

Members Resident Abroad.

Papers and Communications.

Summary of Pharmacodynamics and Therapeutics.

Index.



## EXCHANGES.

---

Allgemeine Homöopathische Zeitung.  
L'Art Médical.  
The American Homœopathist.  
The American Institute of Homœopathy, Transactions of.  
The Calcutta Journal of Medicine.  
The Charlotte Medical Journal.  
The Clinique.  
The Dental College of Victoria, Melbourne.  
The Hahnemannian Monthly.  
Homœopathic Journal of Obstetrics.  
The Homœopathic Physician.  
The Homœopathic Recorder.  
The Homœopathic World.  
The Indian Homœopathic Review.  
The Journal of Ophthalmology, Otology and Laryngology.  
The Journal of Orificial Surgery.  
Journal Belge Homœopathique.  
The Medical Century.  
Medical Advance.  
Medical Era.  
Medical and Surgical Record.  
Minneapolis Homœopathic Magazine.  
The Monthly Homœopathic Review.  
New England Medical Gazette.  
North American Journal of Homœopathy.  
Pacific Coast Journal of Homœopathy.  
Revista Homeopática.  
Revue Homœopathique Française.  
Revue Homœopathique Belge.  
Southern Journal of Homœopathy.  
Zeitschrift des Berliner vereines Homöopathischer Aerzte.



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THIS volume comprises the proceedings of the BRITISH HOMŒOPATHIC SOCIETY during its Fifty-third Session, 1897-98.

The Council does not hold itself responsible for the statements, reasonings, or opinions expressed in the various Communications published in the Journal.

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- 1888 ALEXANDER, ARCHIBALD SPEIRS, M.D., C.M.Glasg.; Honorary Physician and Physician for Diseases of the Eye, Ear, Nose and Throat to the Devon and Cornwall Homœopathic Hospital; 6, Sussex Terrace, Plymouth.
- 1890 ALEXANDER, SAMUEL PHILIP, M.D., C.M.Glasg., M.R.C.S. Eng.; Tecumseh House, Kent Road, Southsea.
- 1893 ARNOLD, FRANCIS SORELL, B.A., M.B. B.Ch.Oxon., M.R.C.S.Eng., L.S.A.; 332, Oxford Road, and 96, Deansgate, Manchester.
- 1894 BARRETT, JOHN JAMES, M.D.St.And., L.R.C.P.Lond., M.R.C.S.Eng.; 170, Ramsden Road, Balham, S.W.
- 1891 BARROW, ROGER WILLIAM, M.D.BruX., L.R.C.P., L.M. Edin., M.R.C.S.Eng.; Physician to the Bristol Homœopathic Dispensary; 3, White Ladies Road, Clifton, and 7, Wine Street, Bristol.
- 1868 BELCHER, HENRY, M.D.Univ.Erlang., L.R.C.P.Edin., M.R.C.S.Eng.; Honorary Physician to the Sussex County Homœopathic Dispensary; 28, Cromwell Road, West Brighton, and Steine House, 55, Old Steine, Brighton.

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- 1854 †BELL, VERNON, M.D.Edin., L.R.C.S. and L.M. Edin.; Highland Gardens, St. Leonards-on-Sea.
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- 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.)
- 1865 \*BLAKE, EDWARD THOMAS, M.D.Aberd., M.R.C.S.Eng.; Berkeley Mansions, 64, Seymour Street, Hyde Park, W. (V.P. 1887-9.)
- 1862 \*BLAKE, JAMES GIBBS, M.D., B.A.Lond., L.S.A.; Physician to the Birmingham Homœopathic Hospital, Consulting Physician to the Mason Orphanage; 23, Waterloo Street, Birmingham, and Highfield Gate, Edgbaston.
- 1896 BLAKE, VICTOR JOHN, M.B., B.S.Lond., M.R.C.S.Eng., L.R.C.P.Lond.; Elsinore, Alpine Road, Ventnor.
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- 1871 \*BROWN, DAVID DYCE, M.A., M.D., C.M.Aberd.; Consulting Physician to the London Homœopathic Hospital, and to the Phillips Memorial Hospital, Bromley, Kent; 29, Seymour Street, Portman Square, W. (P. 1884. V.-P. 1883. C. 1892.)
- 1872 BRYCE, WILLIAM, M.D.Edin.; 31, Charlotte Square, Edinburgh.
- 1889 \*BURFORD, GEORGE (*Council*), M.B., C.M.Aberd.; Physician for Diseases of Women, London Homœopathic Hospital; Consulting Physician for Diseases of Women to the Homœopathic Hospital, Tunbridge Wells; to the Devon and Cornwall Homœopathic Hospital, and to the Phillips Memorial Hospital, Bromley; 35, Queen Anne Street, W. (C. 1892, 1895-97.)
- 1879 BURNETT, JAMES COMPTON, M.D.Glasg.; 2, Finsbury Circus, E.C.
- 1892 BURNS, ALFRED HUGH, L.R.C.P.I., L.S.A.Lond.; Cap-pagh House, 27, Edridge Road, Croydon.
- 1873 BURWOOD, THOMAS WESLEY, L.R.C.P., L.M.I., L.R.C.P., L.M.Edin.; Physician to the Ealing and West Middlesex Homœopathic Dispensary; Strathmore, Florence Road, Ealing, W.
- 1864 †CAMPBELL, HON. ALLAN, L.R.C.P.Edin., L.F.P.S.Glasg.; Honorary Medical Officer to the Adelaide Children's Hospital; North Terrace, Adelaide, South Australia.
- 1890 CAPPER, EDMUND, M.D., C.M.Edin.; 2, Newsham Drive, Liverpool.
- 1891 CAPPER, PERCY, M.B., C.M.Edin.; Honorary Surgeon to the Tunbridge Wells Homœopathic Hospital; Westbourne, 14, Lansdowne Road, Tunbridge Wells.
- 1861 \*CARFRAE, GEORGE MANN, M.D.Edin.; Consulting Physician for Diseases of Women, London Homœopathic Hospital; 4, Hertford Street, Mayfair, W. (P. 1888, 1889. V.-P. 1882-83.)



## viii.

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- 1873 CHALMERS, ANDREW CRICHTON, M.D., L.R.C.S.Edin.; 305, Glossop Road, Sheffield.
- 1895 CHAPMAN, GEORGE WILLIAM, M.R.C.S.Eng., L.R.C.P.Lond.; Marion House, Edgar Road, Cliftonville, Margate.
- 1877 †CHURCHILL, SAMUEL, M.D.Aberd., M.R.C.S.Eng.; 1, Cheriton Terrace, Folkestone.
- 1880 \*CLARKE, JOHN HENRY, M.D., C.M.Edin.; Consulting Physician to the London Homœopathic Hospital; 30, Clarges Street, Piccadilly, W., and 3, Newman's Court, Cornhill, E.C. (V.-P. 1888.)
- 1861 \*CLIFTON, ARTHUR CROWEN, M.D., (Hon.) New York, M.R.C.S.Eng.; Consulting Physician to the Northampton Homœopathic Dispensary; 9, East Park Parade, Northampton. (C. 1894.)
- 1892 CLIFTON, FREDERICK WILLIAM, M.R.C.S.Eng., L.R.C.P., L.M.Edin.; 356, Glossop Road, Sheffield.
- 1873 CLIFTON, GEORGE, J.P., L.R.C.P.Edin., L.M., L.F.P.S. Glasg.; Consulting Physician to the Leicester Homœopathic Dispensary; 48, London Road, and 7, Bowling Green Street, Leicester.
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- 1894 COMPSTON, EDMUND LEACH, M.B., Ch.B.Vict.; Crawshawbooth, Manchester.
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- 1891 †COOK, HENRY WILLIAM JAMES, M.B., B.S.Durh.; 88, Collins Street, Melbourne, Australia.
- 1893 CORNETT, HERBERT HENRY, M.R.C.S.Eng.; 9, Priory Place, Doncaster.

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- 1892 COX, RICHARD PERCY, M.D., C.M.Edin. ; 335, Oxford Road, Manchester.
- 1890 COX, WILLIAM SPENCER, 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.
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- 1892 CRAIG, JOHN SMITH, M.B., C.M.Aberd. ; 43, Soho Road, Birmingham.
- 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. ; 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. ; Physician to the Buchanan Cottage Hospital, and to the Hastings and St. Leonards Homœopathic Dispensary ; 26, Grand Parade, St. Leonards.
- 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 Anæsthetist to the London Homœopathic Hospital ; Hon. Physician to the Kentish Town Medical Mission ; 35, Queen Anne Street, W., and 31, Netherhall Gardens, Hampstead, N.W. (C. 1896.)
- 1892 † DEANE, HERBERT EDWARD, M.R.C.S.Eng., L.S.A. ; Surgeon-Major, Army Medical Staff, c/o Grindlay, Groome & Co., Bombay, India.
- 1875 † DECK, JOHN FIELD, M.D. St. And., M.R.C.S.Eng., L.R.C.P. Lond. ; Ashfield, Sydney, New South Wales.

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- 1847 \*DUDGEON, ROBERT ELLIS, M.D., L.R.C.S.Edin.; Consulting Physician to the London Homœopathic Hospital; 63, Upper Berkeley Street, W. (P. 1879, 1890. V.-P. 1874-5, 1881. T. 1883-93. S. 1846-48. C. 1892-95.)
- 1896 DUKE, ALLEN ABRAHAM, M.D., L.R.C.S., L.M.Edin., L.S.A.; Montpellier, North Street, Worthing.
- 1893 EATON, HENRY ARNOLD, M.B., C.M.Edin.; 2, Eldon Square, Newcastle-on-Tyne.
- 1887 ELLIS, JOHN WILLIAM, M.B., Ch.B.Vict., L.R.C.P., L.R.C.S.Edin.; Honorary Medical Officer to the Hahnemann Hospital, Liverpool; 18, Rodney Street, Liverpool.
- 1875 \*EPPS, WASHINGTON (*Council*), L.R.C.P.Edin., M.R.C.S. Eng.; Physician to the London Homœopathic Hospital; 55, Queen Anne Street, W., and 89, Great Russell Street, W.C. (V.-P. 1896. C. 1893-94.)
- 1889 FERNIE, WILLIAM THOMAS, M.D.Durh., L.R.C.P.Lond., M.R.C.S.Eng., L.S.A.; Kimbolton, The Leas, Folkestone.
- 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.
- 1893 FLINT, FREDERICK, M.D., C.M.Aberd., M.R.C.S.Eng.; 8, Ramshill Road, Scarborough.
- 1885 FROST, GEORGE, L.R.C.P.Lond., M.R.C.S.Eng.; Surgeon to the Hahnemann Convalescent Home; Ophthalmic Surgeon to the Bournemouth Homœopathic Dispensary; Clovelly, Poole Road, Bournemouth.
- 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.; Hotel Continental, Cannes, France.
- 1881 \*GOLDSBROUGH, GILES FORWARD (*Council*), M.D. C.M. Aberd.; Assistant Physician to the London Homœopathic Hospital; Cedar Lodge, 133, Coldharbour Lane, S.E. (P. 1895. V.-P. 1893-94. C. 1897.)

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- 1892 GORDON, JOHN NEWLANDS, M.B., C.M.Aberd.; Ophthalmic Surgeon to the Hahnemann Hospital, Liverpool; 70, Upper Parliament Street, Liverpool.
- 1886 GOULD, EDWARD GARDINER, L.R.C.P.I.; Craigmere, Polworth Road, Streatham Common, S.W.
- 1892 GREEN, CONRAD THEODORE, M.R.C.S.Eng., L.R.C.P.Lond.; Honorary Medical Officer to the Wirral Homœopathic Dispensary; 33, Grange Mount, Birkenhead. (P., *Liverpool Branch*, 1896.)
- 1892 GREEN, VINCENT, M.D.Edin.; Senior Clinical Assistant Throat and Ear Department, London Homœopathic Hospital; Physician to the Wimbledon and Merton Homœopathic Dispensary; 13, Lingfield Road, Wimbledon.
- 1895 GREIG, WILLIAM, M.B., C.M.Aberd.; New Wells House, 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.; Oak House, Bacup, Lancashire.
- 1847\*†HAMILTON, EDWARD, M.D. St. And.; 16, Cromwell Place, S.W. (V.-P. 1865-6, 1879. T. 1848-1881.)
- 1892 HAMILTON, JOHN, L.R.C.P.Edin., L.F.P.S.Glas.; 16, Eldon Square, Newcastle-on-Tyne.
- 1894 HARDY, JAMES EBENEZER, M.B., C.M.Edin.; 183, Bath Street, Glasgow.
- 1859 HARPER, JAMES PEDDIE, M.D.Edin., L.R.C.S.Edin.; 43, Hertford Street, Mayfair, W.
- 1878 HAWKES, ALFRED EDWARD, M.D.Bru., L.R.C.P., L.M., L.R.C.S.Edin.; Medical Officer to the Hahnemann Hospital, Liverpool; 22, Abercromby Square, Liverpool. (P. 1892. V.-P. 1893, *Liverpool Branch*.)
- 1888 HAWKES, EDWARD JOHN, L.R.C.P., L.R.C.S., L.M.Edin.; 4, West Cliff Road, Ramsgate.
- 1886 HAYLE, THOMAS HAHNEMANN, M.B.Lond.; 154, Drake Street, Rochdale.

## ELECTED.

- 1892 HAYWARD, CHARLES WILLIAMS, M.D., C.M.Edin., D.P.H. Camb., M.R.C.S.Eng., L.R.C.P.Lond.; Assistant Surgeon and Surgeon to the Throat, Nose and Ear Department, Hahnemann Hospital, Liverpool; 117, Grove Street, Liverpool.
- 1892 HAYWARD, JOHN DAVEY, M.D.Lond., M.R.C.S.Eng., L.S.A.; Surgeon to the Hahnemann Hospital, Liverpool; 15, Prince's Avenue, Liverpool. (V.-P. *Liverpool Branch*, 1897.)
- 1868 \*HAYWARD, JOHN WILLIAMS (*Vice-President, Council*), 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.)
- 1885 HILBERS, HERMANN GERHARD, B.A.Camb., L.R.C.P., L.R.C.S.Edin., L.F.P.S.Glasg.; Honorary Physician to the Sussex County Homœopathic Dispensary; 49, Montpelier Road, Brighton.
- 1887 HILL, WILLIAM REED, M.B., C.M.Edin.; 38, Berners Street, Ipswich.
- 1861 \*HUGHES, RICHARD (*Editor*), M.D. (Hon.), L.R.C.P.Edin., M.R.C.S.Eng.; Physician to the Brighton Homœopathic Dispensary; 36, Sillwood Road, Brighton. (P. 1887. V.-P. 1885-6. S. 1879-84. C. 1892-96.)
- 1892 HUXLEY, JOHN CHARLES, M.D., C.M.Aberd.; 91, Harborne Road, Edgbaston, Birmingham.
- 1882 JAGIELSKI, VICTOR APOLLINARIS, M.D.Berlin, M.R.C.P. Lond.; Physician to the Infirmary for Consumption, Margaret Street; Consulting Physician to the Royal York Bath; 54, York Terrace, Regent's Park, N.W.
- 1894 JOHNSTONE, JAMES (*Council*), B.A., F.R.C.S.Eng., M.B., C.M., D.P.H.Aberd.; Assistant Surgeon and Pathologist to the London Homœopathic Hospital: 47, Sheen Road, Richmond. (C. 1896-97.)
- 1887 †JONES, DAVID OGDEN ROEBUCK, M.D.Trin. Coll., Toronto, L.R.C.P.Lond.; Physician to the Grace Hospital (Homœopathic); 126, Carlton Street, Toronto, Canada.

## ELECTED.

- 1893 JONES, GEORGE REGINALD, L.R.C.P.Lond., M.R.C.S.Eng.;  
73, Withington Road, Whalley Range, Manchester.
- 1866 JONES, JAMES, M.D.Edin., M.R.C.S.Eng., L.R.C.P.Lond.;  
29, Clarendon Road, Lewisham, S.E.
- 1881 JONES, THOMAS REGINALD, L.R.C.P.I., L.M., M.R.C.S.  
Eng.; Physician to the Wirral Homœopathic Dis-  
pensary; 26, Lorne Road, Claughton, and 23,  
Hamilton Square, Birkenhead.
- 1879 KER, CLAUDIUS BUCHANAN, M.D.Edin.; Consulting  
Physician to the Cheltenham Homœopathic Dis-  
pensary; Hadley House, Cheltenham.
- 1875 †KITCHING, CHARLES WATSON, M.B.Lond., M.R.C.S.Eng.,  
L.S.A.; 14, Church Street, Cape Town, S. Africa.
- 1872 †KYNGDON, BOUGHTON, L.S.A.; Bowral, near Sydney, New  
South Wales.
- 1893 LAMBERT, JAMES RUDOLF PAUL, M.D., C.M.Edin.;  
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to the London Homœopathic Hospital; 5, Alfred  
Place West, Thurloe Square, South Kensington, S.W.
- 1891 LOUGH, GEORGE JOHN, L.R.C.P.I., L.M.; Surgeon to the  
Buchanan Cottage Hospital, and Ophthalmic Surgeon  
to the Hastings and St. Leonards Homœopathic Dis-  
pensary; 29, Wellington Square, Hastings.
- 1850 \*MACKECHNIE, JOHN HAMILTON, M.D. St. And.; Physician  
to the Hahnemann Free Dispensary, Bath; Hartley  
House, Manvers Street, Bath. (P. 1885. V.-P. 1872.  
S. 1867-69.)
- 1893 MACNISH, DAVID, M.A., M.B., C.M.Edin.; Assistant  
Physician to the London Homœopathic Hospital; 4,  
Leinster Square, W.
- 1886 MCKILLIAM, ROBERT, M.D., C.M.Aberd.; 6, Grote's  
Buildings, Blackheath, S.E.
- 1892 McLACHLAN, JOHN, M.D., C.M., B.Sc.Edin., F.R.C.S.Eng.,  
L.S.A.; Physician to the Oxford Homœopathic Dis-  
pensary; 38, Beaumont Street, Oxford.

## ELECTED.

- 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.)
- 1892 MAHONY, EDWARD, M.R.C.S.Eng., L.S.A.; Honorary Medical Officer to the Hahnemann Hospital, Liverpool; 30, Huskisson Street, Liverpool.
- 1895 MARCH, EDWARD GERALD, M.D.Brux., F.R.C.S.Edin., M.R.C.S.Eng., L.R.C.P.Lond.; 41, Castle Street, Reading.
- 1885 MARSH, THOMAS CHARLES, L.R.C.P.Edin., M.R.C.S.Eng., L.M.; Assistant Physician to the London Homœopathic Hospital, and Visiting Physician to the Margaret Street Infirmary for Diseases of the Chest and Throat; 31, Gower Place, W.C.
- 1885 MASON, HENRY, M.D., C.M.Glasg., M.R.C.S.Eng.; Medical Officer to the Leicester Homœopathic Provident Dispensary; 52, London Road, Leicester.
- 1888 †MATTHIAS, WILLIAM LLOYD, L.R.C.P.Lond., M.R.C.S.Eng.; Sydney, New South Wales.
- 1893 MEEK, WILLIAM OMBLER, M.B., C.M.Edin., F.R.M.S.; 256, Oxford Road and 26, King Street, Manchester.
- 1893 MILLER, ROBERT GIBSON, M.B., C.M.Glasg.; 10, Newton Place, Glasgow.
- 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. 1892-97.)
- 1892 MOIR, DOUGLAS, M.D., C.M.Aberd.; 333, Oxford Road, Manchester.
- 1889 MOLSON, JOHN CAVENDISH, L.R.C.P.Lond.; Assistant Physician to the London Homœopathic Hospital; 54, Brook Street, Grosvenor Square, W., and East View, Woking.

## ELECTED.

- 1877 MOORE, JOHN MURRAY, M.D., C.M., L.M.Edin., M.R.C.S. Eng., M.D. New Zealand; Hon. Medical Officer to the Hahnemann Hospital, Liverpool; 51, Canning Street, Liverpool.
- 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 Homœopathic Dispensary; 15, Oakfield Road, Clifton.
- 1890 MORRISON, STAMMERS, M.D.Phil., M.R.C.S.Eng., L.R.C.P. Lond., L.M.Eng.; Grafton House, The Pavement, Clapham Common, S.W.
- 1897 MUNSTER, HAROLD VALDEMAR, M.B., C.M.Edin.; 3, Oakfield Road, 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.
- 1895 NANKIVELL, BERTRAM WRIGHT, M.R.C.S.Eng., L.R.C.P. Lond.; Physician to the Hahnemann Convalescent Home, and to the Bournemouth Homœopathic Dispensaries; Surgeon to the Victoria Home for Crippled Children, Westbourne; Woodstock, West Cliff Road, Bournemouth.
- 1888 NANKIVELL, FRANK, M.D., C.M.Edin., M.R.C.S.Eng.; 60, Kirkdale, Sydenham, S.E.
- 1888 \*NANKIVELL, HERBERT, M.D.Edin., M.R.C.S.Eng.; Physician to the Hahnemann Convalescent Home, Bournemouth; Penmellyn, Richmond Hill, Bournemouth.
- 1893 NEATBY, ANDREW MOSSFORTH, L.R.C.P., L.R.C.S.Edin., L.F.P.S.Glasg.; Physician to the Sutton Homœopathic Dispensary; Silverhurst, Brighton Road, Sutton, Surrey.
- 1885 \*NEATBY, EDWIN AWDAS (*President, Librarian*), M.D.Bru., L.R.C.P.Lond., M.R.C.S.Eng.; Assistant Physician for Diseases of Women, London Homœopathic Hospital; 19, Upper Wimpole Street, W., and 178, Haverstock Hill, Hampstead, N.W. (V.-P. 1894-95. C. 1896.)



## ELECTED.

- 1885 NEILD, FREDERIC, M.D., C.M.Edin., L.R.C.P.Edin.; Physician to the Tunbridge Wells Homœopathic Hospital and Dispensary; Belvedere House, Tunbridge Wells.
- 1891 NEWBERY, WILLIAM FREDERICK HOYLE, M.D., C.M., Trinity College, Toronto, L.S.A.Lond.; 109, Cazenove Road, Stoke Newington, N., and 7, Dalston Lane, Kingsland, N.E.
- 1894 NICHOLSON, THEOPHILUS GEORGE HUSBAND, M.R.C.S.Eng.; Anæsthetist to the Hahnemann Hospital, Liverpool; 27, Catherine Street, Liverpool.
- 1892 NICHOLSON, THOMAS DICKINSON, M.D., C.M.Edin., M.R.C.S.Eng.; Physician to the Clifton Homœopathic Dispensary; 2, White Ladies Road, Clifton, Bristol.
- 1895 NIVEN, CHARLES RITCHIE, M.B., C.M.Glasg.; Stipendiary Medical Officer to the North End Dispensary, Liverpool; 82, Queen's Road, Liverpool.
- 1880 NOBLE, JAMES BLACK, M.R.C.S.Eng., L.R.C.P., L.M.Edin.; 167, Kennington Park Road, S.E., and 2, Circus Place, Finsbury Circus, E.C.
- 1876 NORMAN, GEORGE, M.R.C.S.Eng., L.S.A.; Physician to the Hahnemann Free Dispensary, Bath; 12, Brock Street, Bath.
- 1892 OCKENDEN, ARTHUR JOHN, M.R.C.S.Eng.; 25, Regency Square, Brighton.
- 1893 ORD, WILLIAM THEOPHILUS, L.R.C.P.Lond., M.R.C.S.Eng.; Visiting Surgeon and Physician to the Bournemouth Hahnemann Home and Dispensaries; Greenstead, Madeira Road, Bournemouth East, and 4, Bank Buildings, Boscombe.
- 1895 ORR, FREDERICK LAYTON, M.D.Lond., M.R.C.S.Eng., L.R.C.P.Lond.; 4, Upper Surrey Street, Norwich.
- 1886 PINCOTT, JAMES COLE, M.R.C.S.Eng., L.R.C.P., L.M.Edin.; Surgeon to the Tunbridge Wells Homœopathic Hospital and Dispensary; Culverden Grange, 12, St. John's Road, Tunbridge Wells.

## ELECTED.

- 1862 \*POPE, ALFRED CROSBY, M.D.Phil., M.D. (Hon.) New York, M.R.C.S.Eng. ; Watergate House, Grantham. (P. 1881. V.-P. 1873-4.)
- 1879 POWELL, ALFRED JOHN, M.D.Erlang., M.R.C.S.Eng. ; Sewardstone Lees, Anerley Road, S.E.
- 1868 †PRITCHARD, JOSIAH, M.R.C.S.Eng., L.S.A. ; 63, Richmond Road, Montpelier, Bristol.
- 1893 PROCTOR, PETER, M.R.C.S.Eng, L.R.C.P.Edin., L.S.A. ; 17, Hamilton Square, Birkenhead.
- 1884 PULLAR, ALFRED, M.D., C.M.Edin. ; 111, Denmark Hill, S.E.
- 1884 PURDOM, THOMAS EADIE, M.D., C.M.Edin., L.R.C.P., L.R.C.S.Edin. ; Physician to the Croydon Homœopathic Dispensary ; Ellerslie, 25, Park Hill Road, and 40, George Street, Croydon.
- 1893 RAMSBOTHAM, SAMUEL HENRY, M.D.Edin., M.R.C.S.Eng. ; Hon. Medical Officer to the Leeds Homœopathic Dispensary ; 16, Park Place, Leeds.
- 1892 REED, WILLIAM CASH, M.D., C.M.Edin. ; Senior Physician to the Devon and Cornwall Homœopathic Hospital and to the Three Towns Dispensary ; 8, Queen Anne Terrace, Plymouth.
- 1895 REID, ARTHUR LESTOCK, M.R.C.S.Eng., L.R.C.P.Lond. ; Assistant Anæsthetist to the London Homœopathic Hospital ; Thirlmere, St. Albans Road, Watford.
- 1872 †REID, LESTOCK HOLLAND, M.R.C.S.Eng., L.R.C.P.Lond. ; Bowmanville, Ontario, Canada.
- 1894 RENDALL, JOHN MURLY, L.R.C.P., L.R.C.S.Edin., L.F.P. & S.Glas. ; Physician to the Edinburgh Homœopathic Dispensary ; 75, Leamington Terrace, Edinburgh.
- 1885 RENNER, CHARLES, M.D.Würzburg, L.R.C.P.Lond., M.R.C.S.Eng. ; 186, Marylebone Road, N.W.
- 1893 REYNOLDS, EDWARD ROBERT BRADLEY, M.R.C.S.Eng. ; Highcroft, Shepherd's Hill, Highgate, N.
- 1894 RICHARDS, GEORGE PERCY PEEL, M.B., C.M.Edin. (*address not communicated*).

## ELECTED.

- 1892 ROBERTS, ARTHUR, M.D. St. And., M.R.C.S.Eng., L.S.A., D.P.H.; Kingswood House, Princes Square, Harrogate.
- 1893 ROBERTS, WILLIAM HENRY, L.R.C.P., L.R.C.S.Edin., L.M.; Physician to the Dublin Homœopathic Dispensary; 63, Lower Mount Street, Dublin.
- 1878 ROCHE, ELEAZER BIRCH (*Council*), L.R.C.P.Lond., M.R.C.S.Eng., L.M.; Physician to the Norwich Homœopathic Dispensary; Hon. Medical Officer to the Orphans' Home, Norwich, and to the Norwich City Mission; 27, Surrey Street, Norwich.
- 1892 ROCHE, WILLIAM, L.R.C.P.I., L.M., M.R.C.S.Eng.; 81, Downs Road, Clapton, N.E.
- 1891 ROSS, WILLIAM, L.R.C.P., L.R.C.S.I., L.M.; Physician to the Northampton Homœopathic Dispensary; 65, Abington Street, Northampton.
- 1892 ROWSE, EDWARD LEOPOLD, M.D.Brux., L.R.C.P.Lond., M.R.C.S.Eng.; Assistant Physician to the London Homœopathic Hospital; 114, Upper Richmond Road, Putney, S.W.
- 1880 SANDBERG, ARTHUR GREGORY, M.D. (Hon.) Verm., L.R.C.P., L.R.C.S., L.M.Edin.; 151, Brixton Hill, S.W.
- 1893 SANDERS, HORACE, L.S.A.; 77, Camden Road, N.W.
- 1895 SCOTT, WILLIAM, M.D., L.R.C.S.Edin.; Melbourne House, Huddersfield.
- 1892 SCRIVEN, GEORGE, M.D., B.Ch.Dub., L.M., F.R.G.S.; Physician to the Dublin Homœopathic Dispensary; 33, St. Stephen's Green, Dublin.
- 1856 SCRIVEN, WILLIAM BARCLAY BROWNE, A.B., M.B.Dub., M.R.C.S.Eng., L.M.; Physician to the Dublin Homœopathic Dispensary; 33, St. Stephen's Green, Dublin.
- 1895 SEARSON, JAMES, M.D.Brux., L.R.C.P., L.R.C.S.I.; Esthonia House, Ealing, W.
- 1885 SHACKLETON, HENRY, B.A., M.D.Dub. M.R.C.S.Eng., L.M.K.Q.C.P.I., L.M. Rot. Hosp., Dub.; 12, West Hill, Sydenham, S.E.

## ELECTED.

- 1883 \*SHAW, CHARLES THOMAS KNOX (*Secretary, C.*), L.R.C.P. Lond., M.R.C.S.Eng.; Surgeon and Ophthalmic Surgeon to the London Homœopathic Hospital; Consulting Surgeon to the Buchanan Cottage Hospital, St. Leonards, to the Tunbridge Wells Homœopathic Hospital, and to the Phillips Memorial Hospital, Bromley; Consulting Ophthalmic Surgeon to the Hastings and St. Leonards Homœopathic Dispensary; 19, Upper Wimpole Street, W. (P. 1891. V.-P. 1890. S. 1892-97.)
- 1885 SHAW, FRANK HERBERT, M.R.C.S.Eng.; Surgeon to the Buchanan Cottage Hospital, and to the Hastings and St. Leonards Homœopathic Dispensary; 33, Warrior Square, St. Leonards-on-Sea.
- 1895 SHIRTLIFF, EDWARD DICKINSON, M.R.C.S.Eng., L.R.C.P. Lond., L.S.A.; Holmwood, Cowleigh Road, Malvern.
- 1888 SIMPSON, THOMAS, M.D. St. And., M.R.C.S.Eng.; Hon. Medical Officer to the Hahnemann Hospital, Liverpool, and to the Bootle Homœopathic Dispensary; 10, Crosby Road, Waterloo, Liverpool.
- 1885 \*SMITH, GERARD, M.R.C.S.Eng., L.S.A.; Orthopædic Surgeon to the London Homœopathic Hospital; 8, Nottingham Place, W.
- 1896 SMITH, PHILIP DOUGLAS, M.B., C.M.Edin.; 154, Drake Street, Rochdale.
- 1892 SMITH, ROBERT GORDON, M.B., C.M.Aberd.; Hon. Medical Officer to the Hahnemann Hospital, Liverpool; 164, Upper Parliament Street, Liverpool.
- 1893 †SOUTHAM, JOHN BINNS, M.R.C.S.Eng., L.S.A.; Wickham House, Brisbane, Queensland.
- 1893 STACEY, HERBERT GLEESON, M.D.Brux., L.R.C.P., L.M. Edin., M.R.C.S.Eng., L.S.A.Lond.; Honorary Physician to the Leeds Homœopathic Dispensary; 28, Park Square, Leeds.
- 1893 STALEY, JOHN CHRISTOPHER GEORGE, L.R.C.P.I.; Physician to the Rochdale Convalescent Home; The Mount, St. Anne's-on-Sea.
- 1890 STANCOMB, ERNEST HENRY MURLY, M.B., C.M.Edin.; Westbourne, College Place, Southampton.

## ELECTED.

- 1892 STEINTHAL, WALTER OLIVER, L.R.C.P.Lond., M.R.C.S. Eng., L.S.A. ; 128, Tweedale Street, Rochdale.
- 1866 †STEPHENS, SAMUEL SANDERS, M.R.C.S.Eng. ; Stedcombe Manor, Axminster, Devon.
- 1889 STONHAM, THOMAS GEORGE, M.D.Lond., M.R.C.S.Eng. ; Physician in Charge of the Electrical Department, London Homœopathic Hospital ; 128, Broadhurst Gardens, West Hampstead, N.W.
- 1887 STORRAR, WILLIAM MORRISON, L.R.C.P., L.R.C.S.Edin., L.M. ; Senior Physician to the North of England Children's Sanatorium ; Physician to the Southport Hydropathic Hospital ; 15, Hoghton Street, Southport.
- 1892 STUART, PETER, L.R.C.P., L.R.C.S.Edin., L.M. ; Assistant Physician to the Hahnemann Hospital, Liverpool ; 36A, Rodney Street, Liverpool.
- 1877 SÜSS-HAHNEMANN, FREDERICK LEOPOLD ROBERT, M.D. Leipzig ; Tweed Mount, Bath Road, Ventnor, Isle of Wight.
- 1892 THOMAS, BERNARD (*Secretary, Liverpool Branch*), M.B., C.M.Edin. ; Stipendiary Medical Officer to the Hahnemann Hospital, Liverpool ; 44, Grove Street, Liverpool.
- 1886 THOMAS, EDWARD JOHN HAYNES, L.R.C.P., L.R.C.S.Edin. ; Physician to the Chester Free Homœopathic Dispensary ; 18, Pepper Street, Chester.
- 1891 THOMAS, HAROLD WYNNE, M.R.C.S.Eng., L.R.C.P.Lond. ; Medical Officer to the Phillips Memorial Hospital, Bromley ; 79, Tweedy Road, Bromley, Kent.
- 1895 THORNTON, FRED WHITFIELD, M.R.C.S.Eng., L.R.C.P.I. ; 35, New North Road, Huddersfield.
- 1896 TINDALL, ERNEST EDWARD PARTRIDGE, R.N., M.R.C.S. Eng., L.R.C.P.Lond. ; Medical Officer to the Devon and Exeter Homœopathic Dispensary ; 20, Southernhay East, Exeter.
- 1886 VAWDREY, THEOPHILUS GLASCOTT, L.R.C.P.Lond., M.R.C.S. Eng. ; Stipendiary Medical Officer to the Devon and Cornwall Homœopathic Dispensary ; Surgeon to the Cottage Hospital ; 4, Buckland Terrace, Plymouth.

## ELECTED.

- 1893 WADDINGTON, CHARLES EDWIN, L.R.C.P.Lond., M.R.C.S. Eng. ; 2, Marlboro' Road, Manningham, Bradford.
- 1895 WATKINS, FRANK AUGUSTUS, M.R.C.S.Eng.; L.R.C.P.Lond., L.S.A.; Resident Medical Officer, London Homœopathic Hospital, Great Ormond Street, W.C.
- 1862 †WATSON, CHARLES GEORGE, L.R.C.S., L.R.C.P.I., L.M.; Hobart, Tasmania.
- 1897 WATSON, JAMES, M.B., C.M.Edin.; Stipendiary Medical Officer to the Hahnemann Hospital; 259, Smith-down Road, Liverpool.
- 1858 †WAUGH, J. N., M.D. St. And., M.R.C.S.Eng., L.S.A.; Brisbane, Queensland.
- 1893 WEDDELL, JAMES CALL, M.D., C.M., L.M.Edin.; 1, Park Place East, Sunderland.
- 1894 WHEELER, CHARLES EDWIN, M.D., B.S., B.Sc.Lond., M.R.C.S.Eng., L.R.C.P.Lond.; Manor House West, London Road, Norbiton, Kingston-on-Thames.
- 1861 WHEELER, HENRY, L.R.C.P.Lond., M.R.C.S.Eng.; Holmesdale, Winkfield, Windsor.
- 1893 WILDE, HERBERT, M.B., C.M.Edin., L.R.C.P., L.R.C.S. Edin.; 18, Clifton Terrace, Brighton.
- 1893 WILDE, JOHN, L.R.C.P.Edin., M.R.C.S.Eng., L.S.A.; Physician to the Weston-super-Mare Homœopathic Dispensary; Park House, Weston-super-Mare.
- 1891 WILDE, PERCY ROBERTS, M.D., C.M.Aberd.; Physician to the Lansdowne Grove Hospital and to the Bath Homœopathic Hospital; Consulting Physician to the West of England Hydro.; 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.
- 1893 WILDE, STANLEY, L.R.C.P., L.R.C.S., L.M.Edin.; Physician to the Cheltenham Homœopathic Dispensary; Ingleside, Bayshill, Cheltenham.
- 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.

## ELECTED.

- 1892 WILLIAMS, EUBULUS, M.D. St. And., M.R.C.S.Eng., L.M., L.A.C. ; Physician to Müller's Orphan Houses ; 2, Beaufort Road, Clifton.
- 1892 WILLIAMS, LEMUEL EDWARD, M.R.C.S.Eng. ; Surgeon to the Skin Department, and Honorary Assistant Medical Officer to the Hahnemann Hospital ; Honorary Medical Officer to the Hahnemann Dispensary, Liverpool ; 239, Boundary Street, Liverpool.
- 1896 WILLS, REGINALD GRAHAM, M.D., C.M.Aberd. ; Visiting Medical Officer to the Bath Homœopathic Hospital ; 23, Circus, Bath.
- 1892 WINGFIELD, JOHN, L.R.C.P., L.R.C.S.Edin., L.F.P.S. Glasg. ; Honorary Physician to the Birmingham and Midland Homœopathic Hospital ; Aubyn House, Alcester Road, Moseley, Birmingham.
- 1889 WITHINSHAW, CHARLES WESLEY, L.R.C.P., L.R.C.S., L.M. Edin. ; 3, Earlstoke Villas, Lansdowne Road, Clapham Road, S.W.
- 1893 WOLSTON, CHRISTOPHER, B.A.Lond., M.D. St. And., M.R.C.S.Eng. ; Holmdene, Southlands Grove, Bickley.
- 1877 WOLSTON, WALTER THOMAS PRIDEAUX, M.D.Edin., M.R.C.S.Eng. ; Physician to the Edinburgh Homœopathic Dispensary ; 46, Charlotte Square, Edinburgh.
- 1876 WOOD, HENRY THOROLD, M.R.C.S.Eng. ; 86, Seymour Street, W.
- 1889 \*WRIGHT, DUDLEY D'AUVERGNE (*Vice-President*), L.R.C.P. Lond., M.R.C.S.Eng. ; Assistant Surgeon and Surgeon for Diseases of the Throat and Ear to the London Homœopathic Hospital ; Consulting Surgeon to the Leaf Homœopathic Hospital, Eastbourne ; 55, Queen Anne Street, W. (V.-P. 1896-97. C. 1895.)
- 1854\*†WYLD, GEORGE, M.D.Edin. ; Fieldhead, Wimbledon Park. (V.-P. 1876.)

LIVERPOOL BRANCH.

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

MEMBERS.

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THOMAS, B., *Secretary.*

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COX, R. P.	MOORE, J. M.
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THE HISTORY AND LIFE-HISTORY OF UTERINE  
FIBRO-MYOMATA.

BEING THE PRESIDENTIAL ADDRESS DELIVERED AT THE  
FIRST MEETING OF THE SESSION 1897-1898.

BY EDWIN A. NEATBY, M.D.

*Assistant Physician for Diseases of Women, London Homœopathic Hospital.*

GENTLEMEN,—It is my pleasing duty first to acknowledge the honour you have done me in electing me to occupy this chair. Surprise and gratification were at first uppermost in my mind, and the responsibility involved only gradually impressed itself upon me. When I think of the honoured and venerated men, many happily still with us, who have filled this position and added lustre to its dignity and honour to the Society, I feel at once proud of the office, unworthy of it, and determined to do my best to live up to the standard they and you have raised. This Society stands, first, for the upholding of freedom of

thought and action in the branch of science it represents; second, for the support and development of the benign and far-reaching therapeutic method brought into practical shape and use by Samuel Hahnemann; and, lastly, for the general advancement of the art and science of medicine. For these objects its members have worked shoulder to shoulder for over fifty years, an example of unity and tenacity of purpose to all around, and unexampled in the cordiality and good feeling which pervades them. It is my earnest wish that the present session, which I have the honour of inaugurating, may not be behind any of its predecessors in its interest and usefulness, and I feel sure your own wish and efforts will secure this success. . . . I thank you, gentlemen, most heartily for this token of good will you have given me.

#### HISTORY.

From Hippocrates onwards the existence of tumours of the uterus has been known; in the earliest days they revealed themselves solely in connection with pregnancy and parturition. It is not surprising that in the account of early cases moles, polypi and tumours of various kinds were mixed up, for even to-day in the museums of our hospitals and colleges traces exist of a nomenclature and classification which, though not forty years old, are nevertheless obsolete.

##### Faulty Classification.

Galen is said to have recognised and described both "hard and soft polypi." In the 8th century Paulus Ægineta used the term "scleroma."

Coming down to relatively modern times we find an interesting observation made by the celebrated French surgeon, Ambroise Paré, in 1562, in his treatise "De Generatione," chapter xli. He says, "There can be no doubt that just as stones form in the bladder, so they do in the womb, and the woman often has spasmodic pains as if labour would come on." Indeed, as one would expect, most of the early observations respecting uterine tumours were

made in connection with obstetric medicine. For example, a case is recorded by Fabrice de Hilden, in 1646, of a woman who was in labour six days, the delivery being impeded by a large cervical fibroid. The case ended by rupture of the uterus: and at the *post-mortem* the child's head was found in the abdomen. Such an occurrence as this was by no means rare even at much later dates than the 17th century.

So early as 1748 Louis contributed a paper to the *Académie de Chirurgie* in which he summarily disposed of a question which is not yet regarded as wholly settled—"Sterility," he says, "is the necessary result of a foreign body in the uterus:"—"foreign body" here being intended to include tumours.

**Sterility and Tumours.** Lefour, in 1880, presented to the Paris Faculty of Medicine a monograph on fibroids from the obstetrical point of view. He divides the history of the subject into three periods. The first period lasted to 1749, the second begins with a classical and exhaustive article by Levret in the *Mémoires de l'Académie de Chirurgie* in that year. Besides giving the diagnostic features of fibroids from a variety of other conditions, he, more than any one else of the period, brought forward the method of ligaturing fibrous polypi. He also pointed out the influence of pregnancy in causing a rapid and considerable enlargement of these tumours, while the Englishman, Ashwell,<sup>1</sup> in 1836, adduced evidence to show that these tumours may after delivery undergo rapid softening—in some cases amounting to gangrene.

**Influence of Pregnancy and Parturition.** In view of this he advised as a regular practice the bringing about of artificial delivery in order to prevent such an accident. At the same time, an opposite or at least modified view was adopted by the Edinburgh School of gynæcologists, as represented by the writings of Ingleby,<sup>2</sup> who restricts the induction of abortion to a definite set of cases.

<sup>1</sup> *Guy's Hospital Reports*, vol. i.

<sup>2</sup> *Edinburgh Medical and Surgical Journal*, 1836.



In looking over the early English works on diseases of women, one finds that the identity of hard polypi and fibroid tumours ("fleshy tubercles of the uterus") was not

soon or uniformly recognised. Clarke,<sup>1</sup> writing in 1814, describes the hard polypus as "an insensible tumour projecting through the os uteri," and gives signs to distinguish it from inverted uterus and "cauliflower excrescence." He fully describes the operation by ligature, stating that from 4 to 12 days are required to complete the separation of the pedicle; "it sometimes happens that the ligature and cannula fall out of the vagina when the practitioner is not present; for which event the patient should be prepared lest the occurrence should cause alarm." Ordinarily, "after the neck of the tumour is destroyed" the operator has to remove it. The same author, writing on "Fleshy Tubercle," states that "if coloured injection be thrown into the vessels of the uterus,

so as to make the substance of the uterus quite red, none of it passes to the tumours of fleshy tubercle." This was an opinion which lasted for a number of years, but later investigations showed it to be possible in many cases to inject even hard fibroids. It is nevertheless relatively true—hard fibroids being nourished from their capsules and containing very few demonstrable vessels.

That Clarke was an accurate and careful observer many of his statements show; for instance, he states on the authority of his own experience that in cases of fibroids "the os uteri may at the same time be afflicted by the corroding ulcer," that is, by carcinoma—a fact which later writers for a time denied. He also had seen the combination of "fleshy tubercle, the corroding ulcer and dropsy of the ovary," a combination sufficiently rare to be worth recording. A clinical symptom of value mentioned by him also illustrates the same care. Regarding the sense of downward pressure caused by these fibrous tumours, he says, "this will not be much relieved by the horizontal posture, as in simple cases

<sup>1</sup>"Observations on those Diseases of Females which are attended by Discharges."

of prolapse."<sup>1</sup> The various pressure symptoms due to fibroids have long been known and various procedures for their relief described.

By the name "scirrhus," "tubercular scirrhus," or "scirrhous tubercle," Dr. Blundell<sup>2</sup> in a lecture on Diseases of Women, at Guy's Hospital describes the tumours now known as

**Terminology.**

fibroids, or fibro-myomata. They vary, he states, from the size of a pea to that of a nine months' pregnant uterus. He says, however, that the disease is not confined to the womb, but may extend not only to the neighbouring pelvic organs, but "in rarer cases the liver and lungs themselves are included in the disorganisation," here evidently confusing the disease with some form of cancer. Blundell makes an observant remark respecting the earliest stages of so-called "scirrhus," when he says that it is the tumours not bigger than the foetal head which cause many distressing symptoms, that is, they rather than larger ones situated in the abdomen cause these discomforts. In this modern clinicians will fully concur. The same author says that there is little to be done in the way of treatment, and that very active remedies are not advisable. By active remedies he means "much purging,

**"Active Treatment."** copious doses of mercury, conium, and other remedies of the kind."

Palliatives, in the shape of leeches, fomentations, and anodynes are advised. When giving instructions for the removal of uterine polypi he cautions the operator against including any portion of the womb. "This misfortune will cause additional pain, although the woman may recover." He had by ligature extirpated the whole uterus.

[The term "gynæcology," though of fairly modern use in English works, dates much earlier in German medical terminology. In 1828 a "Lehrbuch

**Gynæcology.**

der Gynäkologie" was published in Leipzig by Carl Gustav Ceros. This work, however, includes a complete obstetric treatise.]

<sup>1</sup> *Ibid.*, p. 249.

<sup>2</sup> "Observations on Some of the More Important Diseases of Women." London, 1837.

In 1856 Wallis wrote ("Diseases of Women") that fibrous polypi lessen the number of conceptions and increase the number of abortions. From about this time or a little later, the study of uterine tumours apart from obstetrics took its rise, and has formed a theme for an enormous number of writers both clinical and, especially latterly, pathological.

The surgery of fibroid tumours has advanced by leaps and bounds during the last twenty years. In 1877 Erichsen's

**Surgical Treatment.** text-book of surgery does not refer to removal of the uterus and tumour

by laparotomy for this disease as a practicable operation. This is sufficient to show that, although the question had been raised and was occupying the attention of abdominal surgeons and of the representatives of the newly-developing speciality of gynæcology, hysterectomy for fibroids had not become an operation recognised by general surgeons. In

**Minor Measures.** 1878 Robert Barnes, in his second edition, discusses the value and place of local styptics, dilatation, and incision of the cervix, enucleation, treatment by the actual cautery ("igneous hysterotomy"), and so-called "normal ovariectomy" (removal of the uterine appendages).

**Oöphorectomy.** Only a few years previously Battey had proposed, and was then (1877-1878) carrying out, the last mentioned procedure for reflex neuroses. In 1876 and 1877 Trenholme and Hegar had applied his ideas to uterine fibroids, and Tait did this operation as early as 1872. But Barnes regarded the operation as still *sub judice*, and remarked that it was perhaps premature to condemn it absolutely! He gives more space and support to the earlier mentioned forms of treatment, especially commending from his own experience incision of the cervix. An imperfect description of removal of the myomatous uterus, which apparently he had not performed himself, is given.

Nevertheless, a few operators had been at work; the earlier cases of hysterectomy were done by surgeons who

**Hysterectomy.** encountered uterine fibroids when undertaking operations for supposed ovarian tumours. These were mostly fatal. Nevertheless,

the feeling forced itself upon the profession that hysterectomy was not only a justifiable but a necessary procedure, and as antiseptis and asepsis became more certainly obtainable, its success was secured. As was the case with ovariectomy at

**Extra-Peritoneal.**

first, the stump or pedicle was first treated extra-peritoneally. Even now some of our most successful English operators still advocate and practise this method. The disadvantages of a sloughing pedicle in the abdominal wound have led to attempts being made to do away with the extra-peritoneal treatment by strangulation of the pedicle. Ligaturing the uterine arteries

**Intra-Peritoneal.**

and stitching peritoneal flaps over the uterine stump, after trimming it, accompanied by return of the stump into the pelvis, has been practised with more or less success in England and on the Continent. But recent German writers go farther and

**Total.**

carry out total removal of the uterus, including the cervix, operating either entirely from above or by the combined vaginal and abdominal routes. Into the endless minutiae of variety devised by different operators it is undesirable to enter here. Nor can one state that there is a fixed percentage of success to hysterectomy as a whole for fibroids, or to any particular

**Mortality.**

form of that operation. Rather must it be said that each operator has his own mortality-rate; and each decade of any given operator has its own average, the death rate in the earliest years of course being greatest. Exceptional cases always crop up to interfere with any average. Grouped statistics give a mortality of about 30 per cent., but this is above the average of the last few years. Thomas Keith is said to have attained a mortality of only 8 per cent., while in any recent series by men like Tait, Thornton and Bantock the results are not worse than this. From 15 to 20 per cent. may be roughly suggested as a fairly probable average for grouped operations.

Enucleation has now few advocates; it is almost abandoned. I have never seen it practised in the London Homœopathic Hospital.

With this brief sketch of the history of fibroids I will pass on to the second and more practical part of my subject.

### THE LIFE HISTORY.

The earliest stage in the life of a uterine fibro-myoma which is discernible to the naked eye may be said to be a small discrete body, oftenest observed embedded in the substance of the uterine wall, quite distinct in appearance from the muscular tissue and projecting slightly above the level of the cut surface. Such a minute fibroid is shown in a uterus from which the accompanying drawing (see fig. 1) was taken. It may be described as about the size of a small pea. On examination, such a tumour is seen to be complete and fully developed, though small and not fully grown. It may not unfittingly be compared to a newly-born babe, complete in all its parts, and on the threshold of its life, with capacity for growth, and the prospect before it of subsequent decay. As the embryologist has studied the pre-natal stages of the infant, so the enquiring mind of the pathologist has sought to observe (or failing that, to imagine) a previous stage in the development of fibroids to the

#### Earliest Naked-Eye Appearance.

one alluded to. The earliest theories, such as Velpeau's, advanced to account for the origin of these neoplasms, were those of local irritation, such as (1) effusions of blood, or (2) of "plastic lymph," or (3) of small collections of pus, which were supposed to serve as a nucleus. The effused cells were supposed either to proliferate, and themselves form connective tissues; or to act as an irritant, which stimulated the overgrowth of the tissue normally present.

#### Earliest Ætiological Theories.

Professor James Wood, of Cleveland, whom not long ago we had the pleasure of welcoming as a guest to this Society, very justly remarks:—"That there is exaggerated local nutrition is unquestionable. But just why exaggerated local nutrition should in one instance produce fibroma, in another myoma, and in still another simple hyperplasia . . . it is

hard to determine.”<sup>1</sup> Another American author states simply that “microscopical examination shows that fibroids originate from capillaries which are undergoing obliteration.”<sup>2</sup> The prime cause of *any* vital change seems impossible of discovery. Why should these capillaries undergo obliteration? The latest systematic writer on the subject, Haultain,<sup>3</sup> of Edinburgh, mentions that some speculators state “that they have found bacterial growth acting as a cause,” a statement lately disproved by Marey. Haultain frankly admits that “the actual histogenesis has yet to be proved.” For practical purposes we may be content, for the time being, to allow this to remain.

But there is another group of theories, differing in detail, but having an evolutionary basis, which from their novelty and interest demand notice. Cohnheim advanced a sug-

gestion, unsupported in the onset by any evidence of a demonstrable kind, that tumours may “spring from unutilised fragments of tissue or ‘residues,’ some of which may be due to faults or to embryonic irregularities.” Bland Sutton<sup>4</sup> arranges tumour germs in two classes—“vestiges” and “rests.” “Vestiges” are the remnants of organs which in lower animals are active; of organs which atrophy after birth, *e.g.*, the thymus, and of some which while represented in both sexes, are only active in one. From none of these classes can fibroid uterine tumours be said to derive a “germ” which develops into a neoplasm. “Rests” is a term which is reserved for “detached fragments of glands and isolated portions of tissue and epithelium.” By more pathologists than one it has been surmised that these “rests” may form one cause, at least, of uterine fibroids. It will be remembered that in most of the lower mammals the uterus is practically a double organ, consisting of two muscular tubes. In the human female the two tubes are fused, forming one central

<sup>1</sup> “Text-book of Gynecology.” Philadelphia, 1894.

<sup>2</sup> Garrigue’s “Diseases of Women.” London, 1895.

<sup>3</sup> “A System of Gynæcology,” edited by T. C. Allbutt and W. S. Playfair. London, 1896.

<sup>4</sup> “Tumours Innocent and Malignant.” London, 1894, page 493.

organ. Myomata of the uterus are, perhaps, the most frequent tumours of a woman's sexual organs, while these growths are practically unknown in the Fallopian tubes, or even in bicornuate uteri. Bland Sutton<sup>1</sup> observes that these facts "would seem to favour the view that uterine myomata may in some cases arise from "rests" in the uterine walls due to imperfect coalescence in the embryo.

This theory of the congenital origin of at least some uterine fibroids requires, it is true, further proof before final acceptance. As regards the womb there still remains an unfortunate absence of microscopic proof of the connection between embryonic "rests" and neoplasms which develop during adult life. In support of the theory, however, are the facts that the prostate in the male, the homologue of the uterus in the female, is the seat of similar growths and that here more evidence of their vestigial origin is forthcoming. Similarly regarding the associated gland—the breast, innocent neoplasms, fibro-adenoma and simple adenoma have been traced to congenital sources.

Leith Napier<sup>2</sup> draws attention to the investigations of Arthur Johnstone, respecting the hyaline layer of the blastoderm, "the matrix of all epithelial tissue." As the result of irritation of this layer there are formed connective tissue cells instead of the natural glandular or secreting cells—which new abnormal cells correspond with the round cells of Kleinwachter, found in connection with the capillaries. These round cells "undergo transformation into fusiform bodies and become grouped together."

Before leaving the consideration of the ætiology and taking up the more practical and clinical side of the life-history of fibroids, it is desirable to spend a short time in studying the cause from what may be termed the biological side, rather than the anatomical, which has already been referred to. The first point to be determined here is the age of the patient—or more accurately the period of the sexual life of woman—at which these growths mostly commonly manifest them-

**Biological Causes.**

<sup>1</sup> *Ibid.*, page 400.

<sup>2</sup> The "Menopause and its Disorders," London, 1897; page 205.

selves. Fortunately here there is practically no divergence of opinion. It is proved beyond dispute that uterine fibroids arise in women during the period of active sexual life, that is, between the first and second climacterics. Before puberty and after the menopause their origin is practically unknown. The youngest authentic case I have come across was a girl of 17 years, and even here there appeared to be present a distinct myxomatous element. It was reported at the Obstetrical Society. The tumour grew from the cervix. The few cases on record which appear to be exceptions to this rule are so incompletely described as to make the diagnosis inadmissible.

The next question for discussion is much less easily settled—indeed it is still a subject of controversy, viz., as to what effect marriage and celibacy have on the production of these growths.

#### **Sterility and Fibroids.**

In this connection it must be borne in mind that woman stands practically alone amongst the female mammals. With the exception of some of the higher apes and baboons, woman is the only female animal who has recurring monthly hyperæmia of, and hæmorrhage from, the genital organs. It is of course the hyperæmia and not the resulting hæmorrhage which concerns us. Again, in nature, all animals pair and the females fulfil their physiological object by reproducing the species. The uterus is occupied with its normal function of gestation. In woman then there is more persistent functioning of the sexual organs preparatory to reception of the fertilised ovum, combined with a much less frequent attainment of the physiological object of the functioning and hyperæmia. Along with this go the facts that women suffer largely and, as civilisation advances, increasingly, from fibroids; that women of the well-to-do classes, who are more in the habit of limiting the size of their families than are the poor, suffer in an excessive proportion; and that these tumours are almost unknown in the uteri of the lower animals. This last statement is supported by Bland Sutton, and by my own researches through veterinary works and journals, and the records of comparative pathology. It has been stated that the African race suffer more from fibroids



than the white women, but later facts seem to prove that until the African woman is brought under the influence of civilisation and is subject to its restraints in sexual matters she is freer from uterine fibroids than her white sister. The African woman of North America then, under the restraints referred to, is found to suffer very frequently from fibroids. To sum up, uteri subject to less frequent stimulation (as the lower animals) or subject to frequent stimulation (as in primitive races), but occupied with the physiological process of gestation, become only seldom the seat of myoma. Respecting the relations between fibroids, celibacy and sterility Hofmeier reports<sup>1</sup> 212 cases, all of which were under his own observation.

His figures show that of these patients only 43 were single women—roughly 20 per cent., or 1 in 5.

The married women bore 448 children, or an average of about 2·27 each.

The average years of sterility before the patients came under observation was 8½.

With a view to forming an independent opinion I have so far collected facts from 60 patients who have been observed by myself. My figures differ considerably in one point from Hofmeier's. The single women numbered 20 out of 60, over 33 per cent., 1 in 3, as compared with 1 in 5 in Hofmeier's cases.

The average of children was 2·25 each, and the average duration of sterility before coming under observation was 7½ years.

I am inclined to view sterility as an agent predisposing to the formation of fibroids; while on the other hand I cannot refuse to recognise that, once present, fibroids are themselves a cause of lessened fertility.

I said that the earliest naked eye change was a minute tumour embedded *in the substance* of the uterine wall. If

Situation of the new  
Growth. this statement conveys to your mind the impression that all these growths commence as interstitial fibroids, it will faithfully represent the prevailing and even the most

<sup>1</sup> *Zeitschrift für Gynäkologie*, vol. xxx., 1894.





FIG. 1.

Case of Multiple Myomata, showing early stages of growth. (See pages 8 and 13.)  
(Drawn by Miss Mabel Green.)

modern view of their site of origin—a view definitely supported by the writer in Playfair's System, who writes (page 567): "All fibro-myomas originate in the muscular layers of the uterine wall." Again, in "Veit's Handbuch der Gynäkologie"<sup>1</sup> Gebhard, of Berlin, states similarly, that "the original seat, both of sub-serous and of sub-mucous myomata, is always intra-mural." In characterising these statements as views, I do so intentionally, because though they are plausible I have met with no sufficient evidence to enable me to feel confident that they are founded

on fact. Not only is it difficult to make actual observations at so early a stage as is essential to establish the point, but it may be impossible to settle the question in all cases on account of anatomical considerations. The deeper layer of the endometrium, the muscularis mucosæ, is practically continuous with the general uterine parenchyma. Muscle cells extend thence into the myometrium and up between the glands of the endometrium. In the very nature of things then it may be impossible to say that a tumour arising in this position starts either as interstitial or sub-mucous. Not less is this so with a growth arising near the surface. The peritoneum contains a stratum of unstriped muscle. Consequently Bland Sutton<sup>2</sup> seems to be pathologically accurate when he states that myomata may arise in three situations, (*a*) in the uterine parenchyma (interstitial); (*β*) in the muscular tissue of the mucous membrane (sub-mucous); (*γ*) in the muscle tissue immediately beneath the serous membrane (subserous). If it be granted that the origin is interstitial in any given case, the tendency is for the small nucleus to excite contraction of the muscular fibres and expel the intruder in the direction of least resistance. In the uterus which I have already referred to, there is seen one tumour becoming sub-mucous (see fig. 1). A layer of mucous membrane only covers its inner aspect. As growth increases and pressure continues the tumour may become pushed through the wall externally, carrying some muscular and some peritoneal tissue with it to form a

Are all Fibroids primarily interstitial?

<sup>1</sup> Wiesbaden, 1897.

<sup>2</sup> *Loc. cit.*, p. 127.

pedicle, until a pedunculated fibroid is found, attached only by a more or less slender stalk to the uterus. Or the same force acting in another direction may press the tumour into the cavity of the uterus, forming a fibroid-polypus. The pedicle here consists of muscular and mucous tissue, with the latter of which the tumour is covered. As the mucous membrane is irritated in its passage downward, its covering of epithelium from being cylindrical and ciliated may become not only squamous but stratified, and if pro-

**Effect on Mucous Membrane.**

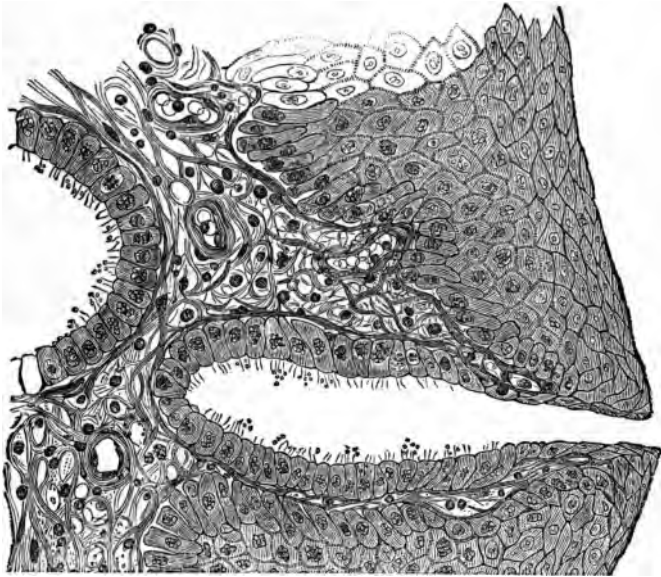


FIG. 2.

truded externally, horny like the epidermis. In figure 2 this stratification of the epithelium is well shown. The drawing is taken by permission from Bland Sutton.<sup>1</sup> While the epithelium is thus altered, the glandular tissue of the tumours which become wholly intra-uterine undergoes atrophy from pressure. Whatever the situation of the tumours (sub-serous, sub-mucous or mural), the endometrium undergoes simple hyperplasia,<sup>2</sup> chiefly of its glandular

<sup>1</sup> *Loc. cit.*, p. 230.

<sup>2</sup> Marchesi, *Ann. de Ostet. e Ginecol.*, 12, p. 817.





FIG. 3.

Multiple Fibroids, from photograph, showing thickening of muscular wall around uterine cavity. (See page 15.)



FIG. 4.

Associated Uterine Fibroid and Ovarian Cyst. (See page 16.)

elements, but also of the connective tissue. The deeper layers of the mucosa are chiefly affected. Clinically these changes are represented by an increased watery and mucous flow, most commonly complained of by myoma patients, and to a slight extent by an increase of menstruation.

The first tendency of a myoma is towards hypertrophy of the muscular substance of the uterus, but this is modified by a variety of circumstances. On the muscular substance a myoma has less and less effect the more it becomes a subserous tumour with a pedicle. The presence of a large number of intra-mural fibroids of a moderate size or of one or more very large ones usually causes stretching and atrophy of the uterine wall. [A specimen handed round of a single moderately sized interstitial fibroid, which was removed by the author at the London Homœopathic Hospital and mounted by the Clinical Research Association, was a good illustration of this thinning]. When a tumour is sub-mucous, and especially if becoming polypoid, or being an actual intra-uterine polypus, the muscular tissue is usually decidedly hypertrophied on account of the frequent expulsive efforts made by the uterus to get rid of its contents. Some degree of hypertrophy may be seen in the case of a uterus shown in fig. 3,<sup>1</sup> where there are multiple nodules in the wall and a polypus in the cavity. Although the small tumours are crowded together yet there is still in some places a thick layer of muscle left, especially round the uterine cavity.

When the abdomen is opened for operation for fibroids it is sometimes found that the ovaries are so tightly crushed

Effect on the Ovaries. against the pelvic wall as to be apparently atrophic. Such a condition does not, however, usually prevent them from functioning. Unless the ovaries suffer by pressure they are very commonly larger than would be the case were no myoma present, *i.e.*, larger than in other women of the same age. (See fig. 6.) It was the size of the ovary and tube which attracted Lawson Tait's attention and led to his practising their removal as an experiment. He, it is true, regarded them as diseased,

<sup>1</sup>From a photograph by Rev. A. T. Cape.



and has expressed the view that disease of the appendages is an active factor in the production of uterine myomas. On this ground he began removing them.

But the condition I refer to here is one of hyperactivity and hypertrophy, due to the increased blood supply to the parts, and is to be regarded as a result rather than as a cause. Secondly, they may react and keep up the growth of the tumour.

Inflammation of the appendages is a not infrequent result of fibroids, sometimes ending in pyosalpinx. I have myself seen cases of both hydro- and pyosalpinx associated with fibroids. Ovarian cysts may also be present. Fig. 4<sup>1</sup> (4,607A, R.C.S.) is an example of this. The patient had very few local symptoms, and died afterwards of acute bronchitis.

Most uteri have multiple tumours, and may present examples of two or three varieties of situation. Some drawings illustrating these varieties are reproduced here.

Situation. [Specimens removed by operation were on the table; other photographs were shown by the lantern.]

Fig. 5 (4,615A) is a photograph of a large polypus with a broad base ( $5\frac{1}{2}$  in.  $\times$   $1\frac{1}{2}$  in.) attached to the fundus and posterior wall, taken by permission from the Royal College of Surgeons. An intra-mural, but almost submucous nodule, is seen in the anterior wall; the adjacent organ is the bladder. This woman, age 40, had her ovaries removed for metrorrhagia; she died on the twelfth day from "syncope."

Fig. 6 shows another fibroid (intra-uterine) polypus with a small pedicle. The large size of the ovaries is notable.

Fig. 7<sup>2</sup> is photographed from a tumour which on removal weighed 8 lbs. The multiple nodules, some very large, are seen, but the most remarkable feature of the specimen is the extremely firm, hard, striated section of the large tumour. It cut almost like cartilage, and the cut surface was as smooth as and firmer than a potato. The fibrous striæ are also well seen. The patient was a young woman, age 33,

<sup>1</sup> Fig. 4 is photographed by permission from the specimen in the Museum of the Royal College of Surgeons of England. The specimens from the R.C.S. were photographed by Mr. Henry George, Curator's Assistant.

<sup>2</sup> Fig. 7, from photograph by Rev. A. T. Cape.



FIG. 5.

Intra-uterine Fibroma, forming polypus with broad base. (See page 16.)



FIG. 6.

Fibroid Polypus, with small pedicle. (See page 16.)





FIG. 7.

Showing extremely smooth, hard Tumour. (*See page 16.*)



FIG. 8.

Inversion of Uterus produced by Fibroid Polypus. (*See page 17.*)

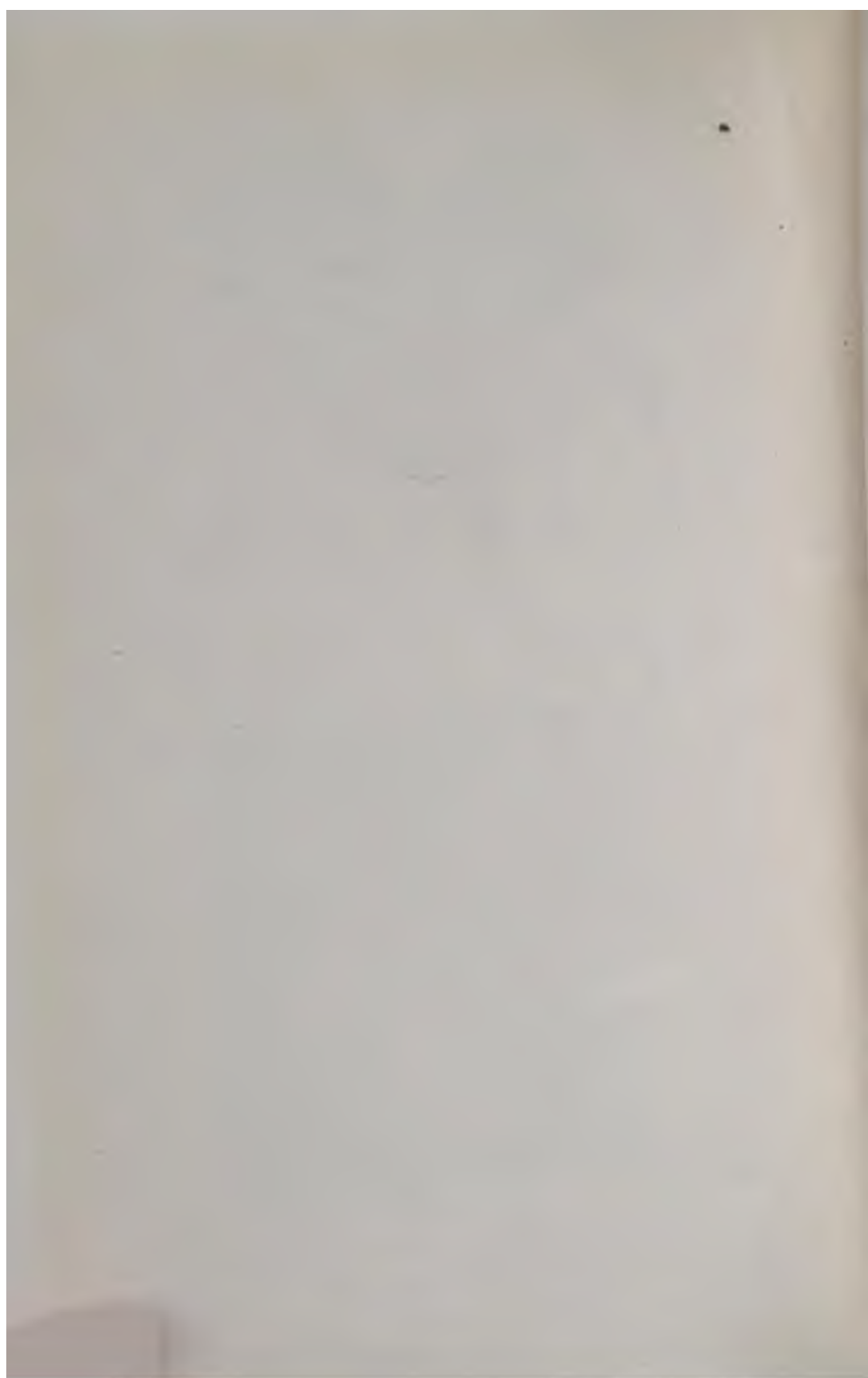






FIG. 9.  
Pedunculated Fibroid of Cervix Uteri. (*See page 17.*)

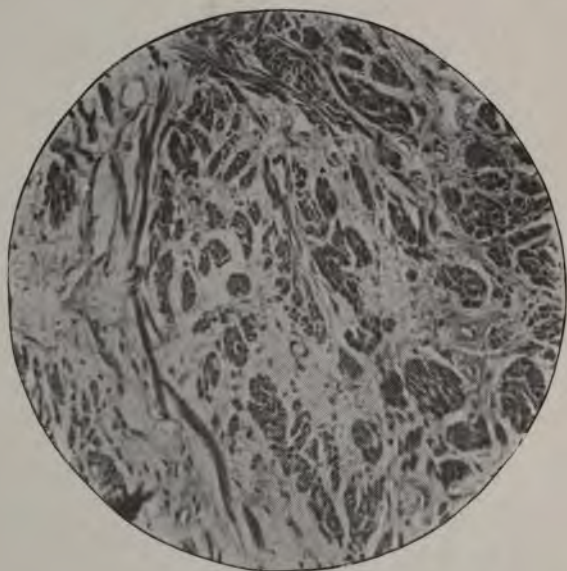


FIG. 10.  
Section from Cystic Myoma, showing rod-like cells and nuclei. (*See page 25.*)

under my own care for some years. Progressive growth being demonstrated, she was advised to have the tumour removed. Recovery was easy.

Fig. 8 (4597, Royal College of Surgeons) is a specimen of some interest; what is seen is an inversion of the fundus uteri, in shape not unlike a polypus. Bristles are projecting from the uterine ends of the Fallopian tubes. Inversion was produced by or associated with an intra-uterine fibroid, which was removed by operation and is consequently not shown. (From the Royal College of Surgeons' Museum).

Fig. 9 is an illustration of a somewhat unusual position for a fibroid, and especially for one of so large a size (by permission from the Royal College of Surgeons' Museum, 4614). From the anterior lip of the cervix hangs a large tumour with a thick pedicle. It was separated by ligature and sloughing: this causes the shaggy appearance of the posterior surface. Adhesions apart, subperitoneal tumours, despite their occasional enormous size, are the least noxious of any. Referring to adhesions, they may be so complete as to nourish the tumour apart from its original pedicle. [A lantern slide was exhibited (4642 R.C.S.) showing a large tumour with portions of intestine, mesentery and omentum attached. It was found loose in the abdominal cavity, but had probably been detached from the uterus. The growth was  $7\frac{1}{2}$  in. and 3 in. in diameter. It was infiltrated with yellow, hard, earthy substance, indicating calcareous degeneration.]

In a similar manner, by adhesion and by subsequent detachment from the uterus, the Fallopian tube sometimes gets credited with fibroids, as in a case reported in the *Obstetrical Society's Transactions* for 1894 (p. 42). In reality fibro-myoma of the tube is of extreme rarity.

The relation between site and locality and the symptoms and progress is real and direct.

Interstitial growths come, in every sense, between the other two varieties. They are more likely to cause enlargement of the uterine cavity and more likely therefore to be accompanied by excessive menstruation.

Submucous growths, especially if polypoid, cause more



pain, chiefly of an intermittent and expulsive character,  
and still more hæmorrhage. This is

**Submucous Growths.** especially the case while a fibroma is becoming polypoid. After it is well pedunculated and perhaps projecting into the vagina hæmorrhage may lessen. Fifty years or more ago it was remarked with reason by Lee, that the source of the bleeding in these tumours is not the whole substance of the tumours or of the uterine tissue, otherwise the larger the tumour the more the hæmorrhage, which is far from being the case. The next most likely source for bleeding is an extended endometrial surface, and in some degree that may be accepted as a *vera causa*. But, as is well known, neither of these sources is adequate to produce the excessive loss of blood which is one of the most dangerous accompaniments of fibroids. The actual vascularity of a hard fibroid is not great, as I have already mentioned; that of the uterine parenchyma and of the endometrium is in proportion to their development. Even with an enormous tumour neither walls nor cavity may be notably enlarged.

The blood vessels of a fibroid nodule ramify in the capsule, where both arteries and venous sinuses are found. Their injection by colouring matter is not easy and after removal almost impossible, but this coloured drawing [which was handed round], which is a well executed representation of the injected original, illustrates the statement I have made. Except in the capsule the vessels are mainly capillary. The cut ends of the capsular arteries and the open mouths of the veins are visible in the drawing. The nearer these vessels are to the uterine cavity, where they have less support, the more strongly contraction of the muscular walls tends to force the tumour into the cavity, the more they are first stretched and then torn. It is this tearing of the capsular vessels which causes the enormous hæmorrhages not seldom met with in fibroids, amounting oftentimes to veritable floodings, blanching the patient and inducing syncope.

It cannot be too clearly borne in mind that a fibroid tumour carried about is a continual menace to a patient's

safety and sometimes to her life. Though it is usually possible to see if a case is going from bad to worse and to counsel active treatment on account of hæmorrhage, the bleeding is sometimes sudden and dangerous. Not three months ago a patient (sent me by Dr. Molson) who had been under observation for some time for multiple fibroids with considerable menorrhagia returned to me after a short interval. She was previously a strong, erect, healthy-looking woman, so well that I could not advise her to submit to the risk of operation, especially as the usual date of the menopause was within sight—she was aged 44. She had a sudden severe flooding which changed her into an aged, blanched, feeble and stooping old woman.

It is only to be expected that hæmorrhage should be especially severe at the menstrual period. The periodic hyperæmia of the tumour is often so great that not only do the patients state the abdomen is enlarged just before and during the first days of menstruation, but an increase in the size of the tumour is demonstrable by measurement. So evidently may this be the case that on one occasion I have fallen into the error of supposing that a tumour was becoming reduced by treatment on account of the difference between a pre-menstrual measurement and that taken some months later, soon after a period.

Cases are recorded where the hyperæmia of menstruation has so enlarged a fibroid occupying the pelvis that impaction has occurred, accompanied with so-called suppression of urine and intestinal obstruction. Slighter degrees of this are quite common. For instance, in a patient recently sent to me by Dr. Vincent Green, where the tumour well filled the pelvis, on two occasions just before the onset of menstruation retention of urine took place. The pressure may be on the neck of the bladder or on the ureter at the pelvic brim. When but slight the depletion following on the onset of the period soon relieves the pressure. In no case is true anuria or suppression present unless possibly in association with a twisted pedicle and gangrene.

Growths of the uterine wall may induce either retention

by pressure on the urethra, or incontinence or pyknuria due to the drag on the bladder by the upward-growing tumour. Unless the pressure is considerable or frequent, kidney damage does not occur; but nephritis (pyelitis), hydro- and pyonephrosis do occur, and cases are reported where these conditions have been cured by the removal of the tumours.

Constipation due to pressure is less frequent than one would expect. It was only present in a small number of my own cases, and in none was it serious. This, of course, is only due to the fact that most frequently a large tumour rises out of the pelvis and relieves the pelvic organs to some extent of pressure. Hæmorrhoids are not seldom present and become a source of considerable discomfort.

All efforts to estimate the average rate of growth have failed, and no average could be of use in prophesying the rate in any particular case. It has been said that a tumour the size of "an egg" or "a man's fist" or "a foetal head" represents a year's growth. But all such statements are misleading. In any individual case only by watching can its rate of progress be determined. The rate of growth is determined partly by the nature of the growth. Soft or œdematous myomata grow more rapidly than hard fibroids. The more pedunculated a fibroid becomes, the less rapidly is it liable to grow on account of the lessening of blood supply. This is true both of intra-uterine and sub-peritoneal growths.

The rate of growth is, *cæteris paribus*, quickest in young subjects, *e.g.*, by the age of 28 Mrs. O. had a large multiple tumour well above the umbilicus.

Miss W., age 28; in summer of 1894, menorrhagia was present and a slight general enlargement of the uterus was found; no tumour was demonstrable. In less than a year it had grown to the size of two fists, and was removed by hysterectomy.

In the case of E. W., in 12 months a tumour grew from the size of a walnut to that of an orange; this patient was 31 years of age.

Mrs. C., on the other hand, first discovered a tumour in 1887; she was then 43 years of age. This steadily grew for

some seven years, and even then it reached only half-way to the umbilicus. Menstruation persisted excessively all this time.

Even between the ages of, say, 25 and 35, the rate of growth is usually leisurely, so that months are occupied in bringing about any conspicuous increase in size.

I believe also, though I am not able to prove it, that the rate of growth is relatively less in a large tumour than in a small one. By measurement it is not easy to establish this, but it is certain that a large tumour often remains stationary for months and years, while this never occurs, in my experience, in small ones. A tumour in a woman who became insane after its disappearance took nine years to attain the size of a foetal head. It disappeared in less than three. (Tait.)

As a rule, however, small fibroids attract little attention. For this reason we have but little information as to rate of growth. This is especially the case with sub-peritoneal tumours, and even interstitial growths seldom give trouble, unless situated low down in the uterine wall. In this situation pressure on the neck of the bladder may induce either painful and difficult or frequent micturition.

Should a rapid increase in size attract attention, this is in most cases an indication that some change other than mere growth is going on. In young and middle-aged subjects this is usually due to cystic degeneration. An example of this is seen in a specimen [shown on the screen (4,643c)] taken from the Museum of the Royal College of Surgeons. Here the tumour was so large that it reached the ribs, and only seven months before operation was it first noticed. This patient was single, and aged 29.

In the case of "E. B.," which I have reported elsewhere, the cyst on the surface of the tumour rapidly increased, as evidenced by measurement in a few months. (The tumour was exhibited.)

Hard myoma may be so easy of diagnosis that it is only necessary to place the hand on the abdomen to be assured of

the nature of the case. At the other extreme comes the cystic myoma, which offers more difficulty in diagnosis than any other form

Diagnosis.

of uterine or even pelvic tumour. Its resemblance to some forms of broad ligament cyst, where the uterus is drawn up and is out of reach, is so great as to defy differentiation. Cases have occurred where a solid tumour has become riddled with cysts, and conveying the sense not only of encysted fluid, but of solid elements more or less mobile therein, and plainly felt on external ballottement. This, together with enlargement of breasts, deposit of pigment in the middle line of the abdominal wall, blueness of the vagina and amenorrhœa, may cause a striking and embarrassing likeness to pregnancy. In this connection a pathological curiosity may be worth mentioning from a possible medico-legal aspect. Large fibroids, especially if rapidly growing, produce lineæ atrophicæ in the skin of the abdomen as does pregnancy. Forcible delivery of a uterine fibroid polypus has caused rupture of the cervix and perinæum. This combination has led to forensic disputes. For the rest, as to differential diagnosis, I do not propose to dwell on this, beyond remarking that it has always appeared to me that the main difficulty is usually one of establishing facts and not of their interpretation.

Difficulty is one of  
Establishing Facts.

Since the day when Lisfranc believed the "contents" of a fibrous tumour to be "plastic lymph," when Levret compared it to "the baked teat of a cow," and M. Roux thought it resembled the inter-vertebral cartilages of old men, some advances have been made in the pathology of "fibromyomata." Broadly speaking, they are known to consist of fibrous tissue and muscular tissue in varying proportions and differing arrangements. Such differences will seem to account for the variety in the consistence of the tumours, and to some extent in the rate of their growth. But the feelings of those most intimately acquainted with uterine fibroids is, that under this term are included distinct varieties of tumours, and that the study of the clinical histories, together with the microscopic structures, will ultimately enable observers properly to classify them.

Taking one extreme, where fibrous tissue predominates, we get the hard fibroid, or fibroma. At the other end of the

scale comes an excess of muscle tissue, and we get the "soft fibroid," or myoma. Myomata are most frequently devoid of capsules, while hard fibroids are commonly encapsuled. (Some micro-photographs were here shown, to demonstrate the minute structure of fibroids in comparison with uterine tissue.)

Having followed the life-history of fibroids from their earliest known origin to maturity, we have next to consider

#### Decadence.

their decadence. Like that of their hosts, their history is very diverse. Maturity is arrived at in different individuals at very different ages, and their later years are characterised by a variety of vicissitudes. In some instances the event proves that they have, in Transatlantic phraseology, "come to stay." It may be regarded as a work of supererogation to attempt to prove this, but I shall do so. In some circles there seems to be the feeling that these growths are not only "innocent" in the technical sense, but wholly innocuous, or at most that they cause only occasional inconvenience from their weight, and that these temporary disadvantages and the tumours themselves vanish like snow before the sun at the benign approach of the menopause.

Mrs. K., aged 65, had had a multinodular fibroid, for many years unrecognised. She had passed the menopause some years. The tumour extended midway between the umbilicus and ensiform cartilage. She had mitral disease, but was able to get about without special dyspnoea or cardiac symptoms. A slight attack of bronchitis came on, and became first serious and then fatal. I came to the conclusion that the embarrassment to breathing and to the circulation caused by the tumour contributed distinctly to her death.

Mrs. W., age 52. Menstruation ceased at about 46. The tumour extended nearly to the margin of the ribs on the right side, and was (as the exhibited specimen proved) of considerable size and remarkable solidity. Six years after the climacteric it had not lessened in size. Moreover, the pressure on the veins of the pelvis caused a persistent varicosis and a state of varicose eczema of the legs. The

weight and discomfort of the tumour caused progressive disability and emaciation, so that 15 months ago she readily consented to operation. That the tumour was to blame for most of the trouble is proved by the fact that she is earning her living, is gaining flesh, and is much less troubled with the leg.

Miss B., age 65, came to London, begging for operation. The menopause took place at 53 years of age. The tumour has remained stationary. When I saw her it extended to the right ribs, nearly to the left ribs, and in the middle line half-way between umbilicus and sternum. Patient walks about the house with difficulty, and after a short walk out of doors is obliged to keep her bed for a day or two.

These examples—all drawn from the last two or three years of my practice—are enough to show that the menopause may occur without causing any diminution in the size of these growths. Without committing myself to any definite size-limit, I should say that in long-standing hard fibroids which extend above the umbilicus it may be asserted that the menopause will not usually exert any notable lessening influence upon them; that it will certainly not cause their disappearance. In the case of soft fibroids the probability becomes a certainty.

Another and more satisfactory termination for fibroids is in resolution. At one time it was thought more necessary to prove an assertion of this kind than  
 Absorption. the contrary. The pendulum has now swung to the other extreme.

Doran is of opinion that absorption is the usual and regular termination of fibroids which have lasted until the menopause without killing the patient or undergoing active degenerative changes. That this is actually so in the majority of cases may be true. The fact that we have no statistics to prove it may be regarded as an evidence of its truth, for patients cured, whether by nature or art, are rapidly lost sight of. It is proper to state that in rare instances atrophy occurs before the menopause. There is a growing tendency among modern gynæcologists to realise that, whatever be true of the majority of cases, there is an

important proportion of tumours which do not pass on to a peaceful and natural "death."

The theory that atrophy of fibroids is preceded by œdema has been advanced chiefly on speculative grounds, because it is supposed that a tumour so softened will be more readily absorbed. The degree of œdema necessary to be of value in facilitating absorption would so visibly enlarge the tumour that it would not pass unobserved. Clinically such enlargement is not a usual precursor of atrophy. œdema is due to venous obstruction, atrophy to diminished arterial supply. The larger a fibroid and the longer it has lasted the less likely is it to disappear spontaneously.

That fatty changes are an accompaniment of atrophy is not unlikely, although it must be confessed that under other circumstances fatty degeneration is uncommon.

#### Fatty Degeneration.

A much more common change in these tumours is the formation of cysts, and this takes place more frequently in soft fibroids and in subserous, pedunculated tumours. It occurs during active

#### Cysts.

sexual life, and also constitutes one of the causes of post-menopausal activity and enlargement of fibroids. œdema is the first stage in the formation of fibroid cysts. Clinically it is accompanied by enlargement of the tumour, which goes on even more rapidly as the cyst-formation becomes defined and fluid accumulates. Cystic fibroids are uninfluenced by the menopause, and tend rapidly to destroy life. Pathologically they are intimately associated with mucoid degeneration of myomatous tissue, though it is not certain they may not originate without such degeneration. Some of these cysts have an endothelial lining, but in others no lining is present. Fig. 10 (4,643) is taken from a cystic myoma. It shows the long muscle-cells, with rod-like nuclei. The fibrous tissue cells occur in little groups or singly, embedded in a large quantity of connective tissue, which at times is dense and homogenous, and at times wavy and of loose texture. (Micro-photographic slides were here exhibited, to show changes associated with hyaline and commencing mucoid degeneration).



At the Medical and Chirurgical Society in 1893, Doran gave three modes of origin of these cysts in benign myomata: they were:—

- (1) Breaking down of solid tissue from fatty or mucoid degeneration, or from local necroses (Uter).
- (2) Dilatation of blood-vessels or blood sinuses.
- (3) Dilatation of lymph channels.

Lymphangiectasis, he said, was probably more frequent than hitherto believed, and obstruction of the lymphatics outside a tumour was very frequent.

I use the expression "benign myomata," because the next change to be mentioned as being intimately associated

**Malignant Change.** with cystic-fibroids is sarcomatous degeneration. This is a change to which both soft (diffuse) and hard (encapsuled) myomata are subject. A case of my own, removed in 1895, shows one large cyst which occupied the anterior surface of a soft myoma which had undergone sarcomatous change. The woman was about 39; it was first noticed only about a year before I first saw her. Recurrence is taking place (1897), but life is still much more bearable than before operation.

Dr. Burford kindly allows me to mention a case of myoma, at the removal of which I had the pleasure of assisting him. The fibroids here were multiple, and so were the cysts. The microscope revealed sarcomatous degeneration.

Sarcoma is the only form of malignant change to which fibroids are subject, though carcinoma may arise in another part of a myomatous uterus. Fig. 11 shows a tumour of the uterus (myoma), which has undergone sarcomatous change: it has infiltrated the uterine wall and is seen growing into the broad ligament. It is one of John Hunter's specimens in the Museum of the R.C.S., and there is no clinical history attached. Fig. 12 shows the micrograph of the same; the rapid growth appears to be pushing the sound tissue before it, rather than infiltrating it. A lantern slide showing the association of a fibroid tumour with carcinomatous degeneration of the uterine tissue was exhibited.



FIG. 11.

Sarcomatous Degeneration of Uterine Myoma. (*See page 26.*) (John Hunter's specimen, R.C.S.)



FIG. 12.

Myo-sarcoma of Uterus. (*See page 26.*)







FIG. 13.

Three of the Fibromata show dense, solid calcification. (*See page 27.*)



FIG. 14.

Large Cystic Myoma. Showing enlarged Fallopian tube stretched across lower nodule and transverse colon across upper. (*See page 27.*)

The causes of post-climacteric enlargement of fibroid uteri may be summarised as follows:—

- (1) Continuous growth of a soft or hard fibroid.
- (2) Development of a soft fibroid in a uterus at the time or previously affected with hard fibroids.
- (3) Cystic degeneration of a hard (?) or soft fibroid.
- (4) Sarcomatous degeneration of the same with or without cyst formation.
- (5) Simple œdema.

An interesting account of a case coming under the second of these heads is recorded by Lawson Tait.<sup>1</sup> He removed the appendages for multiple fibroids; the hæmorrhage ceased entirely for two years, and the tumour nearly disappeared. After that time hæmorrhage recurred, a soft œdematous fibroid was found, and it grew until it required removal. Mr. Tait was sure the soft tumour was not there at the time of the first operation.

A certain amount of activity of the circulation is necessary to remove any morbid deposit or growth. Deficient circulation may result in their shrivelling or shrinking, but not in their complete removal. This is seen in the gradual desiccation which occurs in the tissue of an extra-uterine gestation when past the full term. But removal does not take place. So in some hard fibroids with feeble circulation, when the tumour has long remained stationary, a deposit of lime salts more or less considerable takes place. This is seen quite frequently in the *post-mortem* room in small fibroids which have attracted no notice during life. One of the tumours exhibited showed this change in parts very well—it was in places so hard as to require the saw. Still more complete is the calcification in the next specimen, fig. 13, which had caused great discomfort to its owner. Three of the masses had become dense solid blocks.

Fig. 15 is introduced as an example of the extreme size to which cystic fibroids may attain. The tumour caused death by asphyxia and convulsions; it weighed 27 lbs. after losing many pounds of fluid contents.

<sup>1</sup> *Transactions of the Obstetrical Society for 1892*, vol. xxxiv., page 201.

Mucoid or myxomatous changes are said to be common, especially in large tumours. It seems not improbable that in

**Mucoid Degeneration.** some of these cases the jelly-like material seen to form the cyst wall is of a sarcomatous nature—as was the case in Dr. Burford's specimen already mentioned. One frequent cause of cysts is mucoid degeneration.

The actual conversion of the tissue substance is preceded by œdema of the connective tissue; the cells assume the characteristic spider-like form, to which the term myxoma is applied. Sections of the tissue which forms the boundary of the softened spaces in the tumour exhibit every gradation from fusiform cells to the irregularly branched cells peculiar to myxomatous tissue, embedded in a structural matrix identical in its physical character with the vitreous humour of the eye. Mucoid changes are usually accompanied by rapid increase in the size of the tumour.<sup>1</sup>

Another unfortunate change is gangrene, due as a rule to septic infection. It most commonly follows accidental wounding of the tumour (especially if cystic), *e.g.*, by the sound. It occurs oftenest in tumours undergoing expulsion from the uterus and may follow attempts at their removal.

Necrosis may, of course, also occur from a twisted pedicle. One example of gangrene has come under my notice. A patient introduced to me by Dr. Frank Shaw had a large abdominal tumour with acute peritonitis and high septic fever with rigors. On opening the abdomen the tumour was found to be discoloured and very friable. So much so was this the case that the elastic ligature placed round it to facilitate its removal cut quite through the pedicle, and the tumour came away without any bleeding. Unfortunately the specimen was thrown away before a microscopic examination had been made. The patient died. Of partial gangrene and sepsis after operation (sometimes fatal) I saw several instances in my student days. This is happily rare

<sup>1</sup> BLAND SUTTON, *loc. cit.*, page 133.

now since the days of aseptic surgery and since the plan of enucleation has been largely abandoned.

The first thing necessary in the management of fibroids is that both patient and doctor should realise that treatment is

**Treatment.** necessary, and that the patient should not be relegated to the chance benefits of a distant menopause to cure her "hardening of the womb."

On the circumstances of the individual case, and of the patient too (financially I mean), depend the measures necessary.

If the woman has a fibroid at 25, it is safe to predict that it will be bigger at 35 and still larger at 45. If it induces excessive bleeding at 35, the probability is that it will do so at 45 or 50.

If the symptoms are not urgent, palliative treatment and watching are first required. The amount of hæmorrhage

**Palliative and Medicinal.** first and the rate of growth next must be our guide as to what is urgent and what is not.

For the hæmorrhage a variety of remedies have been suggested. I will not enumerate these from the text-books, but give you the results of my own experience. If there is much evidence of endometritis in the shape of intermenstrual leucorrhœa, the German preparation of hydrastinin (hydrastinin, Merck, introduced into this country by Dr. Burford), in the 2x dilution, 2 to 5 grains every two to four hours, will usually prove of real benefit, materially lessening the bleeding and the leucorrhœa.

Secale is a remedy which may be given either homœopathically or antipathically. If the hæmorrhage is dark, clotted, profuse, intermittent, and accompanied by expulsive pains, the third decimal dilution will usually act well, relieving both hæmorrhage and pain. If the hæmorrhage is excessive but not typical of ergot poisoning, material doses frequently repeated are advisable and reliable—at least as much so as any drug.

In the case of a woman near the menopause, or still more, if past the ordinary climacteric age, secale  $\theta$  steadily,



with extra doses at the period if required; nepenthe or bromide in sedative doses, rest in bed throughout the whole period, occasionally saline aperients, frequently repeated very hot douches (110—120° F.), together with absence of sexual excitement, will not seldom tide a patient over a difficult year or two until the benign influence of the menopause makes itself felt.

I have found better results from trillium in younger women than in those near the menopause. In doses of the 1x strength, two drops every hour during the period, it often produces a good result.

My sheet anchor, for a regular medicine given in the hope of reducing hæmorrhage and size, is iodide of lime. I give the American preparation which contains 12·5 per cent. of free iodine, about one-fifth of a grain for a dose four times a day.

I have thought that definite decrease in size has taken place in the tumours of a few patients who have been taking this preparation. Fifty years ago iodine and chloride of lime were prevalent remedies. It goes without saying that hæmorrhage may be so severe as to require plugging, but if things are as bad as this, it is high time more radical measures were adopted.

Is it possible to state in general terms what cases demand operative interference? Such rules are difficult to make and more difficult to follow. It is never-

**Surgical.** theless desirable to have in one's mind some broad principles as guides, such as the following:

(1) *Cæteris paribus*, the younger the patient the more likely is an operation to be both necessary and successful.

(2) When considering individual cases, operation may be one either of expediency or necessity. Under the former class come—

(3) Women who have to earn their living or occupy public or responsible posts. Such patients require operation when wealthy and unoccupied patients might afford to wait.

Under the heading of necessity come:—(a) All young women (25-35) with demonstrably growing tumours.

(β) cases, irrespective of age, where hæmorrhage is inducing marked anæmia, and has resisted non-surgical *measures*.

- (γ) Cases when pain or weight are inducing malnutrition.
- (δ) Cases where impaction is threatening.
- (ε) Cases where the appendages are markedly diseased.
- (ζ) Cases where the kidneys are suffering from pressure.
- (η) All cases of very large tumours in young women (25-35),  
that is, tumours reaching well above the umbilicus.
- (θ) All soft and cystic tumours.

It is not necessary to state before a Society such as this that I do not suggest that all fibroids require operation. When all these classes have been set aside for operation, there will still remain a large number, indeed, a considerable majority, which do not require operative interference. Some of these tumours are throughout practically symptomless. A few women carry large tumours to their grave unconscious of their existence. But while this side is remembered it should not be forgotten that though ignored they have a baneful effect and may contribute towards an early demise. Indeed, I believe it is a fact that myomatous patients are a short-lived class of women.

Three main operations may be alluded to, they are:—

(1) Removal of the uterine appendages. (2) Ligature of the uterine arteries. (3) Hysterectomy in some form.

(1) The first is suited for small or quite medium-sized tumours of the hard variety. Large, soft and cystic growths are unsuited for this method.

(2) The second may be used as a substitute for the first where it is doubtful if the ovaries can be reached through pelvic impaction. It is also better suited for larger tumours than is oophorectomy. The uterus must be within easy reach by the vaginal route.

(3) Hysterectomy is required in all the other cases needing operation.

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CLINICAL OBSERVATIONS AND INDICATIONS  
AS AIDS FOR DRUG SELECTION IN HOMŒO-  
PATHIC THERAPEUTICS.<sup>1</sup>

BEING THE PRESIDENTIAL ADDRESS DELIVERED BEFORE  
THE LIVERPOOL BRANCH.

BY A. C. CLIFTON, M.D.

GENTLEMEN,—I highly appreciate, and thank you for the honour which you have conferred upon me, by electing me the President of your Society this Session, at the same time saying, that as I do not reside in your vicinity, you will excuse me from compulsory attendance at your future meetings. Under these circumstances, it is with great pleasure that I have the privilege of delivering the inaugural address of your Society this evening, and also of meeting so many of my old comrades once more.

The title or text of my address is “Clinical Observations and Indications as Aids for Drug Selection in Homœopathic Therapeutics.”

By way of introduction, I may say, that the chief reason which led me to select this topic for consideration was the fact that I, with several other of our colleagues, have been engaged in collecting the clinical materials of our English Homœopathic Literature, for the further purpose of their being indexed and published—materials which, by reason that at the present time they are so scattered, are of comparatively little use to us.

Our mutual friend and kind mentor, Dr. J. W. Hayward, and our venerable colleague and diligent workman, Dr. R. E. Dudgeon, have collected the materials from the *British Journal of Homœopathy*. I have done the same from the *Monthly Homœopathic Review*, and the remainder of the work is being carried on by others.

For the reasons just named, I have necessarily become more acquainted than aforesaid with this aspect of our

<sup>1</sup> October 14, 1897.

literature, and am, therefore, able to form a fairer estimate of the value of "Clinical Observations and Indications" in the past, and perhaps to suggest, from that review, what their characteristics should be in the future, as "aids for drug selection in Homœopathic therapeutics." And I here emphasise the phrase "Homœopathic therapeutics" in the foregoing connection, to which my remarks will mainly be confined, only touching on that feature of instruction under other aspects of therapeutics just by way of contrast.

With regard to the old and dominant school of medicine, I think you will admit that while it cultivates, and pays great heed to, the knowledge which may be obtained from the study of physiology, pathology, and in some measure pharmacology, it lays great stress more especially on the teachings from clinical experience; and in that respect it is indeed wise, from the fact that for therapeutic guidance it has but little else to offer.

On the other hand, with regard to our more advanced school of medicine, how do we stand? The same field in every way is open to us for culture (and in no way should it be neglected); but our horizon of therapeutic research is much wider, and its beacon far more certain, formulated as it is in the expression, "*similia similibus curentur*." This, together with the totality of symptoms in each individual case, constitutes the pole-star for the goal of our endeavours in the treatment of all cases of disease that are capable of being relieved and cured; while, in addition, we have a body or code of "Materia Medica," which is infinitely superior both in character and extent to that of the older school referred to.

With these advantages in our favour, the question naturally arises as to what more we want to guide us. If "clinical observations and indications" are suggested, we may further ask, to what extent and in what way may they legitimately and with advantage be used by us? For you are well aware that some of our colleagues maintain that we cannot consistently make use of such means.

In the examination of this question, we should remember that Hahnemann deprecated the publication of cases of

disease on the ground that it would lead physicians to be guided in the selection of their remedies by the name of a disease, rather than by a comparison of the symptoms of a case with the symptoms from drug provings; and this, moreover, at a time when there were fewer means of instruction and light than we now possess. This objection by the master, whose views we ought always to respect, but at the same time, I think, should critically examine as to their force and value—this objection virtually amounts to a condemnation by him of the means now in dispute even in so little a way as aids in homœopathic therapeutics. While, however, it may be considered rank heresy and traitorous for anyone to differ from him on this matter, I am, nevertheless, rash enough to confess that I do; although there is very little doubt that the danger which he saw in this relation was a very real one, and one, moreover, that we fail to steer clear of: nevertheless, be that as it may, more or less, I say that he was wrong in making the said danger a bar to the use of such means.

Admitting, however, for the moment, that the objection is theoretically sound, practically I suggest that it is almost impossible to avoid the evil entirely, or to any appreciable extent; from the fact that like as every man with brain, thought, and judgment, will in every phase of life make use of all the experience at his command, so every thoughtful physician not only will, but ought to, do the same in his special avocation, whether the said experience comes under the denomination of "clinical observations" or otherwise. Moreover, and in the very nature of things, I feel sure that the men who studied under Hahnemann, witnessed his practice, and were warned by him against this supposed evil, would afterwards often be guided in their choice of remedies by what they had seen him prescribe in similar forms of disease to the one they were treating.

Before enquiring further into this matter, it will be well that we should consider and define, so far as we can, what the characteristics of "clinical observations" should be, if we are to accept them as part of our therapeutic measures. Here I suggest that they should consist mainly of records of

cases of disease that have been treated homœopathically, in which there is set forth, in broad but definite and clear outlines, first, the etiology and development of each case, comprising alike the objective and subjective symptoms, including, of course, any mental or moral features peculiar to it, in each successive stage—together, also, with the apparent or presumptive pathological aspects of it; secondly, the medicines and the doses which have been used must necessarily be noted, especially those bearing on any special symptoms or aspects of the case; and thirdly, the dietetic, hygienic, and other measures that have been adopted must be noted, in order that the student may be able to form an opinion with regard to the relative good obtained, on the one hand from the medicines employed, and on the other from the general measures adopted.

Further, and in the same direction, I think that "clinical observations" bearing on (so-called) "characteristics" and "keynotes" of drug action may worthily be considered and noted, in order to correct or confirm their accuracy, inasmuch as they are largely theoretical, having been derived mostly from a study of the pathogenesis of the said drugs; for while I have found them very useful as finger-posts and aids in my practice, I am also sure that many of them are very faulty and unreliable.

Bearing on the question of the faultiness of the (so-called) "*Characteristics and Keynotes of Drug-action*," which I have just alluded to, I ought to, and do now, say that as I have contributed to our journals my experience somewhat largely years ago, in relation to the same, it is now with sorrow I confess that I have been a great sinner in that matter, inasmuch as my subsequent experience has shown me that although many of my inferences were fairly sound, some others were not so, owing to the fact that they were founded on insufficient data, derived from a too limited sphere of observation, and also from the non-recognition of many influences other than those from the drugs employed. Hence I say they were somewhat comparable to guessings at the truth, or snapshots in a murky atmosphere. But while I so far condemn myself, I ask for your kind indulgence, on the

ground that they were like the observations and suggestions of many able men, albeit honestly and in good faith conceived and believed in.

My demands in this respect may appear to some too exacting, but if "clinical observations" are to be of real and practical use to us, I cannot modify them, and in this view I am largely confirmed from what I have recently seen in the work on which I have been engaged. Although we have there a considerable amount of clinical material of great value, and corresponding to our wants, we have, I think, nearly an equal amount of a much lower order, in which there is but little if any similarity apparent between the symptoms of the cases and those of the drugs employed. The choice, moreover, of the remedies has often been based on pathological, and even on empirical grounds, and on general indications of a very uncertain nature, rather than on homœopathic and particular indications of a far more reliable character. Some of the records are also damaged by the alternation and frequent change of medicines, and although every man must be allowed to prescribe as he may think needful, I nevertheless hold that the records of such cases can be of but little practical value to the student, and may be ruled out in the consideration of this aspect of the case.

While, however, I view many of the "Clinical Observations" in this unfavourable light, in contrast with very many of a satisfactory character, I can also confidently say that during the last five or ten years (a little more or less) we have had clinical materials of a far better order, and these also furnished in a much clearer, more definite and eligible manner, thus affording a good augury in that respect for teaching purposes in the future.

We started from the ground that knowing and acknowledging (as we do) the scientific character of homœopathic therapeutics, together with its resources of instruction, we must further consider whether we can consistently with its principles and teachings make use of clinical observations and indications in the treatment of disease—the question being answered in the affirmative sense by some, but denied by others. Having now considered some of the aspects of

the case, and, moreover, defined that which is of great importance for the better elucidation of the subject, viz., what the characteristics of clinical observations must be if we are to accept them for any real and practical teaching purpose, we are now brought to what, I think, is the real crux of the matter in dispute. This, I would suggest, mainly consists in ascertaining in the first place to what extent the means of instruction and enlightenment at our command are adequate to our wants; and, secondly, how far our knowledge of the means, and consequently our abilities to use them, are adequate for the purpose.

In relation to the first part, viz., our means, we all know that our "Materia Medica," while far in advance in the knowledge derived from the study of drug action to that of any other school, is, nevertheless, in a very confused and unsatisfactory state, and much below our requirements. Moreover, our repertories for affording us help to unravel the secrets of the "Materia Medica" and storehouse of knowledge in order to direct us in the choice of appropriate medicines for the cases before us, are also equally unsatisfactory from the fact that they are so complicated, so uncertain, and at the same time so difficult to use with anything like the promptitude and alacrity which, under ordinary circumstances, the time at our disposal admits of being given to them.

I have intimated that our "Materia Medica" and codex of drug provings must undergo great alteration and improvement in the future to meet our requirements; and I say, moreover, that it will never be taken up by the general profession until it is greatly altered and brought more in line with advanced and specific thought. So also I say that our repertories must be made simpler, more direct, and easier of reference, and although that but little beloved and greatly despised "Cypher Repertory" has largely helped me, and I think is by far the best we have, I contend that it will never be accepted and used with the enthusiasm its promoters and labourers imagined.

In relation to the second part, viz., our knowledge of the means and our abilities to use them, I think you will admit



that we are here also largely deficient, and that very few men have attained within a reasonable distance of sounding the depths and resources of our "Materia Medica." This I suggest has been greatly owing to the fact that many if not all of us started in our professional career with only a glimmering of the knowledge from that source, from not having studied, and, so to speak, mastered it in the same way as we have other branches of study.

Hence I say there is a lack of co-ordination and want of harmony with the requirements of homœopathic therapeutics.

For the reasons which I have just now suggested, I think no one need wonder that, strive as we may to select and adapt our measures in conformity with the fundamental law of our faith, we nevertheless often fall short of the goal of our endeavours for the cure of disease with anything like the efficiency and promptitude which the case demands.

If you may think my arguments so far are fairly sound, I must now ask you to go a step further, and say with me that under all the circumstances of the case we cannot afford, and indeed ought not, to dispense with the collateral aid obtained from clinical research, and from any other side lights or glimmerings of knowledge from any source whatsoever; but that we should rather cultivate and augment the means of instruction from such sources. Only while we may make use of such means in the treatment of disease, we should, nevertheless, allow them to take but quite a secondary place in our *armamentaria* as aids and nothing more than aids.

Taking now as granted (if I may) that to this extent we are in the main agreed, another question necessarily arises, viz., in what way may these means be used and not misused consistently with the principles of our faith? My reply here is, that they ought only to serve as "tips," directing us to the consideration of special points in relation to the characteristic symptoms of the case before us on the one hand, and on the other the characteristics of drug action in relation to the same,—in this way again being no more than aids in our therapeutics.

Further, I contend that we ought ever to be collecting,

augmenting, analysing, and comparing one with another all the clinical observations, indications, suggestions, tips, and other side lights which may be obtained ; and I say that the physician who will do so and also arrange and set in order all the knowledge from such sources, for every emergency, as stepping-stones in his practice will generally be the most successful physician.

I almost fancy hearing a whisper of protest at the mere mention of the word "tip" in this relationship. While, however, it is a somewhat slang term, I yet hold to it as expressive of much consistent help that we get in general life and may also get in our professional avocations ; and when you know the origin of the word you may perhaps to some extent excuse its use here. In old English taverns a receptacle for small coin was placed in a conspicuous position, and over it was written, "To Insure Promptness." Whatever was dropped in the box was divided amongst the servants. In the course of time an abbreviated form of notice was used—to wit, "T.I.P." Now, in the course of my life, while I have willingly given many, and I hope some good tips, I have also gladly received a much larger number, and I am still open to accept many more and to divide them among my fellow servants "to insure promptness" in some measure for the good of all.

Here, however, there is again great danger of these means being abused, but if the red light or red flag, often flaunted before our sight, should make us so timorous as to prevent us from using dangerous means, we will never accomplish much good, inasmuch as there is no path, no means of instruction free from danger ; in fact, some of the most dangerous means may with ordinary care lead to the best results. At the same time it goes without saying that only a fool will choose the dangerous path for the mere sake of showing his bravery and skill.

Having contended for the reasonable use of some aids in our therapeutics, having suggested also the dangers in that direction, and yet having rather scoffed at danger as a hindrance in that respect, nevertheless, from a somewhat wide observation of the practice of homœopathic physicians,

as exemplified especially in our literature, I am convinced that there is a large amount of loose, indefinite and un-homœopathic prescribing by them, and that, moreover, on the lines which we have just now allowed to be legitimate as aids in our therapeutics, but which have been greatly abused or misused. Hence I think it may not be amiss to indicate some of the ways in which such error may befall us. It has been my experience to have been asked by many men, questions like which I now indicate: "What is the best remedy for Whooping Cough, Neuralgia, Quinsy, Hæmorrhoids, Sciatica, and other forms of disease?" My reply has generally been, "Although from my study of the 'Materia Medica,' and experience of the beneficial action of some remedies in these forms of disease, I necessarily at once think of particular remedies as applicable to the cases before me; at the same time I am quite ignorant of any 'best remedy,' otherwise than from the pathogenetic symptoms of a drug corresponding to the totality of the symptoms of each case. What that best, or specific remedy may be, you must find out yourself, from a similar study of the 'Materia Medica' with the aid of our repertories." I have given my interrogators such tips and help as I could: they have left me somewhat sadder (though I hope wiser) men, because I could not show them a "short cut" to the accomplishment of their desires.

Furthermore, although I will neither insult, or cast so much as a shadow on, your intelligence, by suggesting that any of you would ask similar questions to those which I have described, nevertheless I am sure that this error in a somewhat less concrete form is by no means uncommon amongst us; for the reason that most men like to be saved the labour of the pick, the rake, the sieve, and the shovel, for finding the auriferous ore. And indeed, life being so short as it is, I think no one can be blamed, for ascertaining so far as possible the shortest road to the accomplishment of his legitimate desires after truth, which, however, is sometimes (as proverbially) the longest way.

The error which I have just alluded to has not been confined to the rank and file of homœopathic practitioners, but has been committed by some of our leaders of light and learning. As an example, take the following out of many

others which might be adduced in support of it. Some twenty years or thereabouts ago one of our leading men of high repute, a sound homœopathic practitioner, suggested in one of our journals that we had no specific for shingles. In a subsequent number of the same journal, I somewhat hastily, in a way characteristic of my want of deference to authority, replied in this way: "It is true we have no specific for the disease called shingles, but we have several specifics for various and individual manifestations of that disease"; and, bearing on that aspect of the case, I gave the history and general outlines of eight or nine cases which I had treated with quickly curative results, in which the etiology of each case had been different from the rest, and each case had presented different and distinct symptoms, and also had been cured by different remedies, corresponding to each case. This single illustration of our tendency to generalise rather than particularise, to treat patients from the name of a disease, which Hahnemann denounced, might be multiplied a hundred fold; in fact, I think it is a fault that most of us commit sometimes.

In conclusion, I would say that in the examination of the question from which we started, I am now very conscious that to a great extent I have been labouring a subject that required but little labour, from the fact that some, and even the main, points in relation to it seem to me so obvious and need no examination. I have, however, laid before you my views of the various aspects of the case for your kind consideration and criticism.

Before parting, however, let me, as an "old hand," urge upon you, as the inheritors of a glorious tradition and grand force in Homœopathic therapeutics in this city, shining out from the names, worth and work of Drysdale, Chapman, Hilbers, Moore and some others, who have "crossed the bar," but the memory of whom will ever remain green and sacred to us, that you in your several activities carry on the same work with fidelity and zeal, increasing in all knowledge, faith and truth, and thus leave a goodly inheritance for your successors; and in all your work that you will adhere to the principles of the motto, "*In certis unitas, In dubiis libertas, In omnibus charitas.*"

ON THE DIAGNOSIS AND TREATMENT OF BRAIN DISEASE, WITH SPECIAL REFERENCE TO CONDITIONS REQUIRING SURGICAL INTERFERENCE.<sup>1</sup>

BY GILES F. GOLDSBROUGH, M.D.

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INTRODUCTION.

IN introducing the subject announced for discussion, I must not forget to mention that some phases of it were ably and well handled by Dr. C. E. Wheeler<sup>2</sup> before the Society so recently as June last, and also a paper was read to the Liverpool Branch by Dr. P. Douglas Smith<sup>3</sup> in April. Both these papers were well discussed, so that some apology is almost necessary for obtruding a similar subject on the notice of the Society again so soon.

But if a re-opening of the subject appears to members of the Society in the nature of an infliction, their pardon may be asked, and a humble request made that they should read the recent papers presented to the Society again, and also the discussions thereupon, so that they may be impressed with the sense of want of finality which the subject has reached, the lack of principle which guides the treatment of brain disease, and the at present absolutely unsatisfactory nature of the results of that treatment. It has been the recollection of these facts which has set me thinking upon the subject, not that I have any better results to offer than are already known to attend the treatment of this class of disease, nor do I believe in any finality of principle which can be formulated out of theoretical knowledge.

It is perfectly true that the only sure way to a satisfactory

<sup>1</sup> Presented to the Section of Medicine and Pathology, Nov. 4, 1897.

<sup>2</sup> JOURNAL OF THE BRITISH HOMŒOPATHIC SOCIETY, vol. v., p. 299.

<sup>3</sup> *Ibid.*, vol. v., p. 226.

state of brain therapeutics is by the application of various methods of treatment over a very large number of cases, and conclusions drawn from them must be the basis of principles for future guidance. But while these cases are being furnished, and while knowledge of the anatomy and physiology of the brain is proceeding apace, principles may be foreshadowed and discussed, resting upon the knowledge already obtained and the lessons to be gathered from unsuccessful cases. This is all that I hope to attain in my sketch of the subject this evening. I presume that here at least it will be generally agreed that whatever success is to be obtained in therapeutics, with the highest degree of probability will be by the application of the homœopathic rule of selection of remedies. We have that principle at least at hand for our guidance in the first place, and, accepting the totality of the morbid phenomena observable as our picture of the disease, it is our duty to apply the rule of selection now, in the first case which comes to our hands. Although, however, we accept the totality of the morbid phenomena observable in a given case as our picture of the disease, no man will urge that these phenomena are all of equal significance and value in the selection of the remedy. Still other principles must come into play; and in no anatomical region is this more forcibly the case than that of the brain. Let me speak of this point first in some detail. The success of a remedy administered according to the rule of similars requires on its behalf the possibility of an impulse towards health of the whole organism. On what does the possibility of such an impulse depend? Is it not upon the integrity of the central nervous system? If, therefore, that part of the central nervous system is damaged which has for its function the control of the chief vital organs of the body, as for example the medulla oblongata, not only is such damage of the greatest possible seriousness to the welfare of the organism at large, but what standard of value can be placed upon symptoms of disease of the controlling organ itself as guiding indications for a remedy in the case? In thus citing the medulla oblongata, I have doubtless named the group of centres most important of all in their organic control of

other organs and systems of the body, while other parts of the brain are less concerned in this general control, and the value of symptoms of other parts stated generally may be greater as indications for remedies than those of the medulla ; but then opens the still wider question, as to how far symptoms derived from disease or loss of the nerve elements themselves in any situation may be of value as indications for remedies. The following conclusion seems to me to be certain, that if nerve cells are destroyed and complete paralysis results therefrom, the symptoms of that destruction are of no value, they are merely negative conditions and there is no vitality to work upon as far as the actual lesion of the centre is concerned. On the other hand, if the destruction of nerve cells is limited in character, there are other cells often found to take up the functions of those destroyed ; or if the destruction is only partial or limited to the conducting path, we know that regeneration and restoration of function can take place. I need scarcely detain you with instances of this noticed in recovery from hemiplegia, paresis from neuritis, &c. Such a conclusion has an important bearing on the possibility of cure in all lesions affecting the nerve elements. Each cell-element is, in fact, to be looked upon as an organ, which, if destroyed, may have its place taken by others of its kind : but may not the effects of destruction be permanent ? Another conclusion in relation to the nerve elements which obliges the physician to take far more serious account of symptoms of them than of other organs, is the relative instability of those elements, almost in proportion to their functional control. And although kind nature has enclosed the central organs in closed cavities which are an admirable protection in the ordinary performance of functions, and the highest adaptation is provided for, if injury finds its way there, or a lesion gross or microscopic is set up, those very provisions of nature are themselves a source of danger ; they offer to the diagnosis of disease an almost infinite modification of symptoms, the result of localisation, and no less so to therapeutics in the problem as to what symptom or symptoms should or should not be taken as indications for medicine.

## ON DIAGNOSIS.

In view of these facts and conclusions, the problem of diagnosis in brain disease is of even more importance as preliminary to the choice of a plan of treatment, than it is with other organs of the body, and let me repeat what may seem to most of my readers an ancient truism—this problem should always be solved as completely as the case will admit before any plan of treatment is entertained. Although a conclusion as to the pathological character of a lesion may not positively assist in the choice of remedies, it is necessary in the first place to determine whether any treatment is likely to be available at all, or whether the case is one coming under the possibility of surgical aid; and it will also assist in determining the relative value of symptoms as indications for medicines.

It is no part of my intention to enter into the diagnosis of the various types of lesion concerning the treatment of which I shall have to speak—information on the subject can be readily obtained in the text-books on the subject, of which Gowers' work is a monumental one in the English language.

Gowers particularly insists in his work on the adoption of distinctive methods in diagnosis. He shows that the complexity of the symptoms of disease of the central nervous system, combined with the present uncertain knowledge of anatomy and physiology, renders the diagnosis of many cases a matter of exceptional difficulty. The phenomena presented for investigation are often dependent and interdependent not simply on the presence of the lesion itself, but on the effects of such a lesion; and a diagnosis of the whole condition is not complete until the complexity of these effects is unravelled and they are correctly assigned to their different local causes. For the purpose of this diagnosis, he advises a rigid application of a rule which divides the localisation of the lesion, or anatomical diagnosis, from the question as to the nature of the lesion, or pathological diagnosis. The localisation of the lesion is determined by the character and grouping of the symptoms, the nature of the lesion by the character of onset of the symptoms—in other words, by the



history of the case. For further elucidation, the two conclusions formed as to the seat and nature of the lesion are compared with causes which can be discovered, and the whole conclusion reviewed in the light of each of the separate conclusions. True it is that in the diagnosis of a case, an inference in regard to the seat is affected by the probable nature of the lesion and by the discoverable causes, and *vice versâ*, but the value of the method rests in the mental process which it obliges the investigator to follow. Now, it has occurred to me that some such mental process would be of value to the practitioner of Homœopathy when called upon to treat this class of diseases. I am aware that we all, consciously or unconsciously, go through a similar mental process in the diagnosis of our remedies for any given case, and there is nothing very new in this proposal; but we do not, I presume, as a body of men, follow a distinctive method, or try to assign value to our conclusions from one point of view or another. At least, we are not agreed as to the value to be assigned to one aspect of a case rather than another, and it is to this point specially I wish to direct your attention.

In the diagnosis of the case for treatment, I propose that the order in which the diagnosis of the lesion is conducted should be reversed. The diagnosis of the seat and cause and character of the lesion, we will presume to have been made. In a consideration of a plan of treatment we have to consider:—

- (1) The pathological inference as of value in suggesting the plan.
- (2) The weight to be attached to causation in the case.
- (3) The significance of symptoms.
  - (a) As regards their localisation.
  - (b) As regards their history or sequence.
  - (c) As regards their functional character.

It would be possible to apply this method to all diseases of the brain, but I purposely apply it this evening to a few only, and for the purpose of this discussion those which are susceptible of surgical as well as medical treatment. I propose to make a passing reference among injuries to

concussion, and to abscess and aneurism, and deal more in detail with hæmorrhage, tumours and meningitis. My survey of the subject must of necessity be brief and fragmentary, and I claim that it will be suggestive only.

#### CONCUSSION.

The pathology of concussion of the brain was first carefully studied by Duret,<sup>1</sup> and it is probable that his conclusion as to the disturbing wave of cerebro-spinal fluid causing sudden and primary anæmia of the brain, and impinging its energy in the neighbourhood of the medulla oblongata, is sufficient to account for the genuine symptoms of concussion, which if severe enough sometimes cause instantaneous death. The resulting minute hæmorrhages would be secondary effects of this process. The conclusion for treatment to be gathered from such a pathological inference would be that of waiting until a condition of relaxation of the spasm and reaction from the sudden blow had set in, as indicated by the first symptoms of returning function. Then the symptoms might be considered and a homœopathic remedy given. Such remedies at the very outset we may find in camphor and veratrum album. Camphor might be given as an inhalation before the power of swallowing is regained, and as soon as the vomiting has occurred, a few frequently repeated doses of pilules of veratrum album administered in the third or sixth dilution. I need not detain you by dwelling on the general management of concussion of the brain. As soon as reaction has fully set in the state passes out of that of concussion and becomes one of possible hæmorrhage or inflammation, the former of which I propose now to consider.

#### HÆMORRHAGE.

I propose here to exclude hæmorrhages resulting from fracture of the skull (such cases belong to surgery exclusively), and to consider those only which result from concussion and actual lesions of the blood-vessels themselves.

<sup>1</sup> "Études sur les Traumatismes cérébraux," 1878.

(a) *The value of the pathological inference* as a guide to treatment depends very much upon whether the bleeding is known to be continuing, upon the estimated size of the clot, and upon the actual damage done. The most important indication under this head will accordingly be an arrest of the bleeding, and, if possible, a prevention of its recurrence. Apart from injury such indications will be best met by a study of the condition of the heart and blood-vessels at the onset of the attack, and an application of homœopathic remedies according to the symptoms shown by these, such remedies actually being arnica, aconite, and belladonna, &c., the separate indications for which I need not name to you. If the coma resulting from the onset of the hæmorrhage is too great to permit of swallowing, I see no reason why the medicine should not be given in form of suppository or hypodermic injection. I need only remind you that there are some general measures coming under this head which may be adopted to quiet the circulation. The value of the pathological inference is also manifest as forecasting the absorption of the clot, and a consequent restoration of damaged function, giving a basis for the consideration of the various symptoms which may arise in the course of the patient's recovery.

The pathological inference is necessarily also of much value in considering whether surgical aid should be sought or not, the decision, of course, being taken along with the symptoms of localisation.

(b) *The weight of causation*.—Hæmorrhage from injury which does not lend itself to operative interference will be best treated by arnica first in low dilutions and subsequently in the higher. The general treatment of such cases you are thoroughly familiar with.

Next to injuries the two most important factors in the production of cerebral hæmorrhage, which may exist separately, but which often coincide in their effects, are weakening of the arterial wall and increase of the blood-pressure. The first effects of these causes are usually the occurrence of miliary aneurisms, which may exist in many parts of the brain prior to rupture of one of them taking place. These

factors are almost invariably the result of disease of other organs, such as kidney disease, gout, syphilis, purpura or scurvy, pernicious anæmia, or leucocythemia. If any of these causes either of heightened blood-pressure or disease of the arteries or both exist, after the immediate effects of the onset of the hæmorrhage have subsided or become stationary, a consideration of these causes may lead to the conclusion that the disease which induces the altered vascular condition is itself the most pressing indication for treatment. If, on the other hand, the hæmorrhage results from senile degeneration of the arteries alone, which is rare, with or without a hereditary predisposition, I need scarcely point out that the cause here will lead to the applicability of the salts of baryta to such a condition.

(c) *Consideration of symptoms and their localisation.*—The consideration of symptoms due to cerebral hæmorrhage will have been largely overlapped when the value of the pathological inference and the consideration of causation have been fully considered, and it must be a matter of judgment in each individual case whether when the actual symptoms caused by the onset of the lesion have passed away, symptoms arising from the disease which causes the hæmorrhage should have attention, or those which arise from its destructive or disturbing effects. The latter are the only ones which come under our present review. They may arise from various conditions such as the immediate effects of the contiguity of the clot. For example, the paralysis induced, and the resulting inflammation of the surrounding area; those due to irritative inhibition possibly affecting functional regions at a distance from the clot; and those resulting from anæmia of the brain, generally or locally associated with the actual pressure and the inflammatory area. It may be impossible to separate these into groups by any fine distinction of symptoms; the subdivisions I have suggested enables a general grouping to be made, and it will be readily seen which symptoms are of value as suggesting remedies.

On account of the mechanical conditions under which localisation symptoms arise they become of little value as

symptoms on which to select medicines. It is only the anatomical functional regions which can be mapped out as being the sphere of drug influence which are of service in this direction, say, the cerebrum itself, the cerebellum or medulla, or of parts of the cerebrum, the motor or sensory or speech areas. On the other hand, from the surgeon's point of view, localisation symptoms are of the utmost value: no operative interference can be undertaken without them.

Then as regards the history or onset of the symptoms and their sequence. This will depend largely on the severity of the hæmorrhage, and can scarcely become of value in the selection of the remedy excepting when gradual recovery is naturally taking place; then every new manifestation of power may be of value. It is this, the functional quality or character of the symptoms, to which we must look for indications for medicines, as for example, the following: A complete palsy resulting from pressure will be left out of account, whereas a partial loss of power would be a valuable indication, showing that the damage from pressure is slight and will probably be overcome. Symptoms of inflammatory reaction are also valuable indications, such as a moderate pyrexia, a quickened pulse, headache, vertigo, irritability of temper or mind. As regards irritative inhibition of function, if the symptoms can be separated from those of actual loss, they may be grouped along with those of inflammatory action, the actual test being the observation of returning power in any part, and the acceptance as a symptom of that phase which indicates weakness combined with irritability, as exemplified in the tendency to hyperæsthesia or perversion of sensation and to choreiform or athetoid movements. As regards the symptoms of anæmia which often show themselves later, they may be grouped along with those of partial restoration of function,—depression of emotion, weakness of mind and lack of mental co-ordination of what power remains being the most important. Now, if this grouping of the symptoms has any value, the following remedies will come under consideration:—Arnica (in a high dilution), hypericum, belladonna, veratrum viride, gelsemium, and later on phosphorus, sulphur, plumbum, and picric acid. One

general suggestion should be borne in mind, viz., the fostering in every way of the tendency to recovery which so often characterises these conditions. With regard to surgery in hæmorrhage from non-traumatic causes, such can seldom be favourably considered. I can only consider such aid being available in hæmorrhage into the substance of the cortex on its surface or in the meninges of that region.

#### ABSCESS OF THE BRAIN.

(a) *Value of pathological inference.*—Treatment of abscess of the brain rests almost entirely on the diagnosis of the condition. Accordingly, the pathological inference here is of the utmost value, and on account of the conditions in which the pus forms, the bony wall of the cranium almost without means of direct communication externally, and the delicate and functionally important structure involved by the presence of an abscess, render treatment by surgical interference of primary importance. When surgical treatment has been considered, however, I see no reason why—subordinate to it—the power of such remedies as mercurius, hepar sulphuris, silica, over suppuration should not be of use here as elsewhere.

(b) *The weight of causation* is to be considered by the physician when there is suppuration in any distant organ: for special example the lung may be cited, where the abscess in the brain is the result of septic embolism, or a condition of general pyæmia. I have no experience to offer, but would merely suggest that in such a condition the inoculation by an attenuated sepsin might be thought of.

(c) *The consideration of symptoms and their localisation.*—Symptoms of an inflammatory character in the early period of the history of the abscess may well be considered as calling for treatment, as also those of the terminal period. When we remember that these are in greater or less severity—headache, optic neuritis, general convulsions, mental disturbance leading to coma and pyrexia—belladonna is strongly indicated, and may be given alternately with mercurius, hepar, or silica.

## TUMOUR.

(a) *Value of the pathological inference.*—The value of a pathological inference in tumours of the brain is with certain exceptions of purely secondary importance in treatment. The exceptions are syphilitic and tubercular growths.

If a tumour has been diagnosed, and there is a history of syphilis ; or, if not, in the case of a woman whose husband has suffered from that disease, anti-syphilitic treatment may result in relief or permanent cure.

That this treatment should be in the first place by iodide of potassium in increasing doses is now generally agreed. But the use of aurum in its various forms should not be overlooked. The value of a diagnosis of a tubercular growth is the exclusion of the syphilitic and other forms, and the opening up of a class of remedies suitable to the tubercular diathesis, which should be steadily persevered with over a long space of time, whether from the condition of the symptoms other remedies are called for or not. Notably among these remedies are *calcareo carbonica*, *calcareo iodata*, and *arsenicum iodatum*. A case of this character I have under treatment at the present time is receiving distinct amelioration of her symptoms by the use of *calcareo iodata*. With the exception of tubercle and syphilis, the diagnosis of the nature of an intracranial growth is practically impossible, except by the presence of a growth elsewhere. Accordingly, a conjecture as to the existence of a glioma or other form of sarcomatous growth, or some of the rare forms of tumour, such as fibroid or osteofibrous, is of little value in the endeavour to ameliorate the condition of the patient.

(b) *Weight of causation.*—Remarks which apply to the pathological inference apply also to the weight of causation in tumours. Excepting syphilitic and tubercular their causation is unknown, saving perhaps hydatids, or cysticerci.

(c) We pass, therefore, to a *consideration of symptoms and the significance of localisation*. This is a primary question in treatment next to that of the actual diagnosis of a tumour being present, and the exclusion of syphilis and tubercle

The first question which presents itself is whether the case may be amenable to surgical interference. This should be considered before considering the relief of symptoms to be sought for by medicine. Gowers states on the authority of Allen Starr that only about 6 per cent. of tumours of the brain are removable, although 18 per cent. are accessible. Full consideration of the subject should therefore be given to the locality of the tumour. I may briefly enumerate the symptoms which indicate a tumour exerting pressure on or in the cortex, from which, in addition to the membrane alone, or bone, a growth could be removed. Hemiplegia or monoplegia indicating a precise locality of the cortex; convulsions with a local commencement, especially if recurring occasionally; clonic or tonic spasm. A slighter degree of impairment of sensation, chiefly at the extremity of the limb, may possibly be added to these; and impairment of tactile sensibility, unsteadiness of gait or psychical disturbance, sometimes attend tumours of the cortex. Symptoms indicating disorder or loss of the special sensory areas, for speech, sight and hearing, mind-sight and general tactile sensation, are produced by tumours in the parietal, occipital and temporo-sphenoidal regions. These symptoms occurring in a case along with others indicating tumour, such as headache, vomiting and optic neuritis, serve to indicate the necessity of seeking immediate surgical treatment for the case. I leave further detail suggesting more precise localisation, as belonging to the surgical aspect of the question. If the case is decided not to come within the range of practical surgery in a consideration of the symptoms, what can be done to relieve the patient? The ordinary text-books advise the cautious use of sedatives. Are we, who are aware of the value of drugs selected according to the rule of similars, to follow this advice because we think and know the case is insusceptible of cure? Certainly not, until we have exhausted the category of medicines selected according to the group of symptoms the patient presents. Or if one symptom or symptoms causes much distress, we are justified in endeavouring to relieve that by a homœopathically selected remedy before resorting to other measures. In surveying



the list of symptoms of tumour—headache, optic neuritis, vomiting, vertigo, affections of speech, motor paralysis or contracture, convulsions, sensory perversion or loss, affections of the cranial nerves—here again it is the functional quality or character which is of primary importance in the selection of a remedy, especially such functional characters as indicate whether they arise from pressure, irritative inflammation, anæmia, or have a general constitutional character. Take headache, for example: the quality and degree of intensity of the pain are surely of more importance than the special region in which it is situated. And if regions are to be taken into account, if pain in the bone or membranes can be distinguished, this distinction is of more importance than the topographical localisation. Or take motor disturbance, the occurrence of paralysis or contracture, and of paresis rather than paralysis, is of more importance than whether the arm, leg, or speech is affected. Still further, if the selection of remedies can be pushed so far, a general topographical localisation would be of more importance than special, the choice thus lying between the motor and sensory, or basal areas, rather than between different parts of either of these regions. As regards sequence, the variation in time of the functional quality of the symptoms may be of some value, otherwise the sequence of individual symptoms could only be taken to indicate progressive involvement of structure, and consequent perversion of function.

Accordingly, if we accept this direction, we may find indicated very nearly a similar group of medicines for acute symptoms as are indicated in hæmorrhage, such as arnica, hypericum, aconite, belladonna, gelsemium, or glonoine; and if sub-acute or chronic, aurum, mezereum, silica, phytolacca, and others.

In leaving this subject let me suggest that the dilution of drugs which in their pathogenesis produce nervous irritation or inflammation (aconite and belladonna for example) is of the greatest importance in their administration for conditions where the irritation or inflammation is not idiopathic but secondary, as it is in tumour of the brain.

## ANEURISM.

I mention aneurism only to suggest that if it can be diagnosed from other forms of tumour, by means of a murmur heard either by the physician or the patient, the pathological inference at once would open the door to surgical treatment, or to the administration as medicines of the salts of baryta. I have seen one case of this kind, a woman of 49 years of age, where the aneurism was in the neighbourhood of the left ophthalmic branch of the internal carotid artery. The characteristic sound heard by the patient was like "puffing through a cylinder." The sound was heard also by the stethoscope all over the head, and down the neck. The symptoms commenced with pain and vomiting, there was ophthalmoplegia, ptosis, irregularity of the pupil and some sensory loss of the face. I could not be quite certain whether the aneurism was intra-orbital, but the sequel was very important from the cerebral point of view. The course of the case extended over some months, and eventually the aneurism burst into the cranium, causing right hemiplegia, coma and death. No *post-mortem* was allowed.

## MENINGITIS.

(a) *Value of the pathological inference.*—The decision that a case is one of meningitis is of little value in treatment until the element of causation is carefully considered.

Certain classes of remedies may be suggested, or surgical treatment may be thought of in a general way, but no decision can be come to until the form of meningitis or its cause has been investigated. I therefore pass to this aspect of the subject.

(b) *Weight of causation.*—It will be generally agreed that in meningitis, which can be traced as a consequence of adjacent disease of the bone of the nose, eye or ear, or from traumatic causes, if suppuration has set in, surgical aid should be sought at the outset, and I leave to Mr. Wright the discussion of these cases.

When meningitis is a sequel of acute specific diseases, of pneumonia, or of a general septicæmia, primarily the case would be one for medical treatment, and surgical means could only be resorted to in exceptional instances for the relief of pressure, such latter instances being determined in the first place by the condition of the patient favouring recovery from a trephining operation, and secondly, from a consideration of the symptoms at the time. Such also would be the general conclusion as to tubercular meningitis. Sometimes, however, the causes are mixed, a traumatism may occur in a tubercular patient, so also may acute specific disease or pneumonia. In other cases I believe a toxæmia may result from tuberculous conditions in other organs. In all such cases the diagnosis is a matter of difficulty, and conclusions as to treatment drawn from them are uncertain. Such mixed cases may also be very misleading as regards the significance of the localising symptoms, and so present difficulty in deciding upon the advisability of surgical procedure.

The following case which occurred in my practice in June last, and which was operated on by Mr. Dudley Wright, in the hospital, is very instructive from these points of view:—

E. H., age 6 years, a thin, dark, female child, seemed quite well on June 2nd. On the 3rd she was seized with vomiting of all food, felt tired, and complained of slight headache and could not sleep much. I saw her on June 4th. The case looked like one of acute indigestion and was treated accordingly. The vomiting however continued, and was in two days attended by other symptoms which made me suspect cerebral trouble. There was a slow pulse, a slight rise of temperature, a sighing respiration, and obstinate constipation. The child had received veratrum, iris, and nux vomica meanwhile. On the 7th there appeared some improvement, the vomiting had ceased, the child was very quiet, still complained of headache, did not sleep much, and sighed now and then. The tongue continued coated and bowels constipated. On the 8th there had been a little more sleep, otherwise the condition was the same. On the 9th the symptoms had altered in a number of respects. There was convergent strabismus of the left eye, the pupils were dilated and

the head thrown back. The child lay very quiet, did not speak unless spoken to, she seemed distressed at the light of the room. The pulse and respirations were characteristic of meningitis, exhibiting a marked irregularity of rhythm, and in respiration a number of long pauses. The temperature was one degree above normal. On the 10th all the symptoms were intensified, the patient, however, was still conscious and there was no paralysis beyond that of the muscles of the eye. On the afternoon of this day she appeared to fall into a quiet sleep, and on rousing from this in the evening could not speak. This was the commencement of the period of unconsciousness which terminated in death on the evening of the 14th. Marked choreic movements were noticed on both sides of the body on the evening of the 10th, which lasted with more or less severity for twenty-four hours. Paralysis of the left side then ensued, commencing in the arm, then the leg, and finally the face. On the morning of the 13th this paralysis continued with unconsciousness, there was double optic neuritis, and the corneal and pupillary reflexes were all diminished. Mr. Wright saw the child this morning and we agreed that trephining, and allowing the fluid to escape which was apparently causing the pressure symptoms, might give the child a chance of recovery. I should add that the only cause we could discover for the meningitis was a blow which had been received on the head three weeks before, from a fall from a swing in the school playground. There was no history of tubercle in the family of the patient, nor did she exhibit any signs of a tubercular condition. The patient was accordingly removed to the hospital and the skull trephined in the right rolandic region; no fluid however escaped, and the left occipital region was then subjected to the same process, and drained, but only a very small quantity of fluid escaped.

A *post-mortem* examination was made eighteen hours after death. There was a moderate amount of meningitis at the base, about 1½ oz. of fluid escaped from there, and there was considerable congestion of the membranes covering the left occipital lobe, and an increase of fluid in the lateral ventricles. At the upper part of the central lobe of the cerebellum was a mass about the size of a hazel-nut, looking like tubercle, and large numbers of miliary tubercles were found in the right pleural cavity. An examination, by Mr. Johnstone, of the cerebellar mass and of the small tubercles failed to show any tubercle bacilli.

A lesson regarding the causation in this case is that the absence of tubercle can never be reckoned upon, and the

treatment of a tubercular condition may always be justifiable. A recognition of the presence of tubercle would, I think, have precluded surgical interference in this case.

The following remarks may be made under the head of (c) *Consideration of the symptoms and the significance of localisation*:—The first genuine symptoms which would decide the question of diagnosis of meningitis in this case, were the occurrence of a convergent strabismus in the left eye, the dilatation of pupils, sensitiveness to light, retraction of head, quietness and apathy of mind, combined with the characteristic conditions of respiration and pulse. Are these symptoms to be taken as indications for the choice of remedies? We know well that they have been accepted hitherto as indications, but that success in the treatment of tuberculous meningitis at least has been practically *nil*. I have examined all the available notes of cases which have been admitted into the London Homœopathic Hospital during the past ten years, and find that out of twelve cases there is only one recovery. This was the case of a child  $3\frac{1}{2}$  years old, whose illness commenced with the characteristic irritability, and later it was attended with a hydrocephalic cry, and convulsions. It cannot be said to have been tuberculous. The obvious moral of the non-success in treatment of this disease is that it has not been recognised early enough. The presence of symptoms indicating local pressure indicates also that damage has been done to important centres or conducting paths, and when these symptoms advance to such an extent that coma ensues, that damage has reached a permanent damage of the mental functions, and even if life is preserved, the mind is sure to be impaired. It is in the recognition of early symptoms, and constant suspicion that tubercle may be present, that hope of success, not in treating the disease itself, but rather in its prevention, may be entertained. And by what remedies? Rather those that are given primarily on the basis of causation than on the actual presence of the symptoms, viz., calcarea and iodine. Here I believe, too, the use of iodoform will best come in. A survey of its pathogenesis points to meningitis as a diagnosis of its effects, and

a strong resemblance to tuberculous meningitis, but it cannot be expected to have the power of repairing damaged nerve centres, so that its value will be seen before this damage has occurred. As regards the non-tuberculous forms of meningitis I have had success with bromide of potassium in a few cases seen quite early, and where I had reason to expect tubercle. The symptoms calling for its use are, the absence of irritability, apathy of mind, headache, dilatation of pupils, sensitiveness to external impressions. I have given  $\frac{1}{16}$  gr. of bromide of potassium in frequently repeated doses, with removal of all these symptoms in two days. In infants during dentition, with retraction of the head, in the early stage without local pressure, I have found gelsemium of much value.

Is there any prospect of permanent benefit from trephining or lumbar puncture in tuberculous meningitis? I fear not. By the time the symptoms are sufficiently localised to point to where pressure is greatest, the damage to nerve centres is already very great. In the case I have read the procedure was a mistake; although pressure symptoms were very marked, very little fluid escaped. The symptoms of arrest or perversion of function were evidently due to localised inflammation without exudation of fluid, but also probably to a toxæmia liberated from latent tubercle, the shock of the blow on the head being the exciting cause. On another occasion these elements will have to be taken into consideration in determining the question whether surgery should be resorted to. I venture it as a safe conclusion that it is only when the pressure from fluid can be precisely localised by the persistence of one set of symptoms to the exclusion of others, that a trephining would be justifiable. For the success of a lumbar puncture the normal variation in the pressure of the cerebro-spinal fluid is to be presupposed. Yet, in an inflammation like meningitis this variation is sure to be interrupted by inflammatory products. This might be in the base, barring an even pressure there or through the foramen of Magendie, in the fold of membrane forming the roof of the fourth ventricle. Thence the aqueduct of Sylvius, leading to the third ventricle, is almost sure

to be interrupted. Also the foramina of Munro, leading to the lateral ventricles. Such a puncture in meningitis would, in my judgment, prove of very doubtful value.

The conclusions, then, drawn from a survey of symptoms indicating meningitis as suggesting successful treatment by medicines are :—

(1) The early and general symptoms only of value. (2) When localising symptoms have set in, serious damage has been done, and recovery cannot be hoped for. (3) Treatment from the point of view of causation or the general condition is far more likely to prove a success.

In this hasty and imperfect review of an immensely wide subject, I have endeavoured to keep in mind the various points of view from which cases of brain lesion may be considered for medical treatment, and in conclusion would urge, that even if they seem to overlap and are of very different degrees of value, all points are worthy of being considered, and that one should never be excluded at the expense of another.

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## SOME ASPECTS OF INTRA-CRANIAL DISEASE VIEWED FROM A SURGICAL STANDPOINT.<sup>1</sup>

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IF it was without hesitation, it was certainly not without some inward misgivings that I accepted the invitation of the Committee of the Section of Medicine and Pathology of this Society to read a paper to-night dealing with the surgical aspects of intra-cranial lesions. I consider, however, that such an honour could not lightly be declined, and since in the treatment of the subject they most kindly left me a free hand, I recognised that they had done their best to lighten, as far as possible, a somewhat arduous task.

<sup>1</sup> Presented to the Section of Medicine and Pathology, November 4, 1897.

In undertaking this duty my endeavour will be rather to evoke an interesting discussion than to impart instruction to my colleagues, the majority of whom I have no doubt have a better acquaintance with the subject-matter of this paper than I have.

The excellent paper read by Dr. Wheeler at a recent meeting of the Society has left but little to be said on the subject of meningitis, but as Dr. Goldsbrough has mentioned in his paper a case which he was good enough to ask me to operate upon, I would like to make a few remarks on meningeal inflammation and its treatment.

For clinical purposes, the division of meningitis into tuberculous and non-tuberculous forms would be eminently convenient were we in a position to place every case met with in one or other class. As it is, we know of no method whereby the two varieties can be diagnosed with certainty, except in those cases where the meningitis is of evident traumatic origin. As Dr. Wheeler pointed out, those cases, in which retraction of the head comes on early as a marked symptom, are usually of non-tuberculous origin. This hypothesis is supported by the fact that cases showing this sign not uncommonly recover. It is possible that lumbar puncture, of which I shall have more to say later, may help us in arriving at a diagnosis. The fluid is said to flow more quickly through the canula in tuberculous than in non-tuberculous forms (20 to 40 cm. in a few minutes as against 5 to 10 cm.). Further, the copper reducing substance found in the fluid is less than normal, or may be absent, in tuberculous cases. The injection of tuberculin might also prove of service.

It seems to me, however, that when the patient has passed through the first stage of the disease, and symptoms of compression have asserted themselves—the stage at which the surgeon's aid is most likely to be called in—it matters not so much that we diagnose the cause, so long as we recognise the meningitic nature of the complaint, a conclusion not always so easily arrived at in the case of children in whom difficult dentition, middle ear inflammation, and many other conditions, may give rise to head symptoms. The diagnosis



having, however, been made, the surgeon may well ask himself these questions: Is operative interference justifiable? If so, what operation shall be done? And, lastly, what prospect of cure can I hold out?

And here I would pause for a moment to say that it is my belief that even in tuberculous forms medicinal treatment is not absolutely hopeless. Personally, I think that iodoform is not used enough. I would recommend that it be thoroughly rubbed into the scalp as well as given internally, and that the patient be saturated with the drug, and that fearlessly, for most tuberculous children stand it uncommonly well.

To return, however, to the question of operation: with all said and done we must confess that up to the present the expectations raised by the first reports of surgical treatment in these cases have scarcely been realised. At the same time, inasmuch as patients have been cured by this means, we must go on feeling our way until we find out which are the suitable ones and which are not. It is plain, however, that in this as in everything else we must not expect miracles, and, therefore, directly we see that medicines are making no headway, the sooner the question of operation is considered and answered the better are the patient's prospects.

Hitherto, the aim of surgery in meningitis has been rather to relieve one of its symptoms, viz., the cerebral compression caused by the accumulating fluid, than to treat the condition itself. It is an attempt to get rid of a handicap in its fight against a serious and often fatal disease. Three methods have been used to get rid of the excess of cerebrospinal fluid. First, by tapping the lateral ventricles directly through a trephine hole made in the vault of the skull; secondly, by tapping the large sub-arachnoid space which exists between the fourth ventricle and the cerebellum through an opening in the occipital region; and, thirdly, by puncturing the spinal theca in the lumbar region, and drawing off the fluid by that means. In the first two methods the drainage is kept up continuously; in the last it is effected through a trocar and canula, and only a definite quantity is withdrawn.

I have had no experience of the first method of tapping the ventricles, and it seems to have fallen into disuse, but I have had a slight experience of both the other operations.

Dr. Goldsbrough has given the details of a case in which I have tapped from the occipital region. In this instance, as symptoms had pointed to irritation of the motor area of the brain, I had first trephined over that region, hoping to find a local cause, but finding none I made a second opening in the occiput with the object of drawing off any excess of fluid. This operation failed to give relief, but little fluid came away, and *post-mortem* examination showed that it was very little in excess.

The operation itself is a simple one. A trephine opening is made  $\frac{3}{4}$ -inch below the external occipital protuberance and a little to the left of the middle line. This may expose the lateral sinus, which must be avoided in incising the dura-mater. A curved director is now passed inwards and forwards between the cerebellum and its falx until fluid escapes. It can be easily demonstrated on the cadaver that if the director be passed too far the fourth ventricle stands in danger of being injured, which, so far as I can see, is the only serious risk of the operation. This is, however, a serious drawback, and the risk run might be considerable in such a case as the above narrated one, where, owing to the absence of an excess of fluid, the director might be passed too far in on the supposition that the sub-arachnoid space had not been pierced.

The last method, viz., tapping the spinal fluid by lumbar puncture, is even more simple than the two former ones. The patient is laid on his side, chloroform may be given if coma is not present, and the back arched as much as possible by acutely flexing the thighs and body. A line drawn across the back between the two highest points of the iliac crests crosses the upper border of the spine of the fourth lumbar vertebra, and the puncture is made at the lower border and a little to the side of the spine of the third lumbar vertebra with a fine hydrocele trocar and canula. The skin having been rendered aseptic over the area, the puncture is made with the trocar, which is pushed onwards until the point

touches the lower border of the lamina, when the handle of the instrument must be raised and the point pushed on so as to pass beneath the lamina. The ligamentum subflavum will now be encountered, and a little extra force needed to penetrate it, after which the theca will be pierced. If the trocar be now withdrawn the fluid will issue drop by drop from the canula. The point below the third lumbar vertebra is chosen for the reason that in the child at birth the spinal cord extends no lower than this point, whereas in adults it reaches only to the lower border of the first lumbar. Puncture at the lower border of the third lumbar is, therefore, even in the youngest child, free from risk of injury to the spinal cord. During the tapping the pulse must be watched, as collapse may occur from the withdrawal of too much fluid.

I have used this method in one case of tuberculous meningitis. It so happened that a short time ago two young boys under my care in this hospital for multiple tuberculous joint disease simultaneously developed meningitis. The disease ran a very rapid course in both, reaching its climax in a few days. Owing to the numerous joint complications I did not think it justifiable to trephine and drain. The elder of the two boys died first, the other lived a few days longer, and at the time that the compression was at its height, and coma was fairly marked, I performed lumbar puncture. I think that Dr. Burford and Dr. Watkins who were with me at the time were struck with the simplicity of the method. The fluid came away fairly quickly, and 180m were withdrawn in a few minutes. Examination failed to reveal any tubercle bacilli, and no copper reducing substance was present.

One great advantage of this method, besides its simplicity, is that it can be repeated several times if necessary. It certainly appears to be fairly free from risk, the only accident of note being puncture of the large veins lying on the inner aspect of the vertebral canal, though this is not serious. Dr. Lebhartz has performed 150 punctures in 85 cases without untoward results. Mya, however, says that death may result from the too sudden withdrawal of fluid. He

performed it 80 times in 33 cases of meningitis and chronic hydrocephalus, and in many of the latter the patient walked home after the aspiration.

Speaking for myself, I would say that the simplicity of the method and its comparative freedom from risk has much to commend it, and patients' friends are more likely to consent to its performance than to trephining. I think that it will prove the best means of relieving tension in tuberculous and simple meningitis, and perhaps in hydrocephalus, and also for relieving the severe headache of otherwise inoperable tumour of the brain; whilst for septic meningitis of the convexity due to injuries or other causes, trephining over the diseased area would certainly be the best treatment.

#### INTRA-CRANIAL SUPPURATION.

A localised collection of pus may occur between the duramater and bone, or form a sub-cranial abscess; between the dura and brain as a sub-dural abscess; or, again, as a cerebral abscess within the substance of the brain. These conditions can scarcely be dealt with satisfactorily with medicines alone, but fortunately in a large number of instances they are amenable to operative measures.

Sub-cranial abscess usually occurs as a result of some injury of the bone with or without a scalp wound. In either case inflammation of the bone takes place, and if septic organisms gain an entrance suppuration occurs, the pus lying between the bone and duramater. The pus may take some time in forming, so that if a breach of the surface has existed this may have healed before the abscess appears. A serous exudation takes place at the same time into the tissues of the scalp overlying the seat of the abscess, and forms the so-called Pott's "puffy tumour." The condition is really one of septic osteomyelitis, and must be treated as such by incision, removal of the area of bone affected, and drainage.

Some cases of sub-cranial abscess have, however, a different origin. I refer to those due to septic extension from the frontal sinuses, or middle ear or mastoid. I have

had several examples of the latter kind under my care, the pus lying on the upper surface of the petrous bone, or around the lateral sinus. The condition is a very serious one, and commonly fatal unless steps be taken to give a vent for the pus.

Cerebral abscess may be the result of an injury, or be due to the direct entrance of organisms from some adjacent septic centre, such as the middle ear. A severe injury to the head without an external wound may cause an abscess, part of the brain substance being lacerated or contused, either on the side of the injury or on the opposite side by "*contre-coup*." The injured region is invaded by organisms and suppuration ensues, which is usually chronic and localised. Apart from the above mentioned causes cerebral abscess may be due to disease of the cranial bones, and multiple pus collections occur in pyæmia, and not uncommonly in cases of bronchiectasis. In any case the abscess may be localised or diffuse. If the former, a well marked pyogenic membrane may be present, and the abscess often remains in a quiescent condition for a considerable period, and then by suddenly enlarging proves fatal by bursting into the ventricles or on to the surface and setting up septic meningitis. A curious case occurred in the hospital some years ago. The patient, a young woman, was admitted during the influenza epidemic with the usual grippe symptoms. One day, whilst an enema was being administered, she suddenly became comatose with stertorous breathing and other symptoms of cerebral compression, and died in about half an hour, the heart continuing to beat two minutes after respiratory action had quite ceased, as is usual in death from brain pressure. *Post mortem* a large abscess in the right temporo-sphenoidal lobe was found. It had not ruptured and a well marked capsule was present; the pus was very foetid. It was afterwards ascertained that the patient had suffered from suppurative ear disease and had had a polypus removed from the ear some years previously.

The symptoms of the acute form of abscess come on quickly after the injury which starts it, and a fatal result may rapidly occur. In the sub-acute and chronic forms the

symptoms are often very slight, and may, as we have seen, give rise to no suspicion of any serious disease. Besides the three cardinal symptoms of a gross brain lesion, viz., headache, vomiting, and optic neuritis, any of which may certainly be absent, the chief signs to be looked for are a persistently subnormal temperature, with occasionally exacerbations; obstinate constipation; and a peculiar mental attitude characterised by slow cerebration and loss of memory.

Certain localising symptoms may, however, be present. Thus, paralysis of one side of the body from pressure on the internal capsule or the motor areas of the cortex may occur; or the speech may be affected from direct involvement of the speech centre; or, again, there may be inco-ordination of gait and head retraction if the abscess be in the cerebellum. Pressure on the medulla may be exerted by such an abscess, and cause slowing of the pulse and respiration. In a case of mine the abscess, which was secondary to middle ear suppuration, occupied the flocculus and exerted pressure upon the medulla and hypoglossal and spinal accessory nerves. I trephined and punctured the cerebellum in various directions but failed to strike pus. The patient died, and at the *post mortem* an abscess in the flocculus which had ruptured, and two smaller collections in other parts of the cerebellum, were found, and it appeared that the needle had just missed one of the latter.

In treating a cerebral abscess by an operation, we should aim at getting at the pus with the least amount of damage to the parts around. Now, in those cases where localisation can be effected, no special difficulty exists; but in a large number of instances it is impossible to say whether the pus is in the temporo-sphenoidal lobe or the cerebellum, and in such any operation will be of an exploratory nature. Fortunately a method devised by Dean enable us to expose these parts of the brain through one incision. This is accomplished by turning down a flap behind the ear, and applying the trephine at a spot  $1\frac{1}{4}$  inches behind and  $\frac{1}{4}$  inch above the centre of the meatus of the ear. By this opening a part of the lateral sinus and the dura above it are exposed, and by enlarging the opening slightly upwards the temporo-

sphenoidal lobe is exposed, and can be explored. If no pus be found, the cerebellum can be explored by enlarging the opening downwards and backwards. The whole operation can usually be quickly carried out, and inasmuch as the majority of cases are secondary to middle ear disease in which the lateral sinus may be involved, this operation has the advantage of exposing that structure.

In the case of cerebellar abscess above mentioned I made use of a similar flap, but each part was exposed by separate trephine holes, so the operation took somewhat longer than it might otherwise have done. One disadvantage of this method of Dean's is that if the mastoid has been previously opened for suppuration, the proximity of this septic area lays the others open to the risk of infection, a result which actually occurred in a case in which I made use of it. To avoid this risk some advocate a separate opening for exploring the temporo-sphenoidal lobe at a point of  $1\frac{1}{2}$  inches behind the meatus, and one inch above Reid's base line (*i.e.*, a line running from the lower border of the orbit backwards through the centre of the meatus). This method was first proposed by Barker.

#### INFECTIVE THROMBOSIS OF THE CRANIAL SINUSES.

Thrombosis of the cranial sinuses is of two kinds. The first or non-inflammatory type which occurs in patients suffering from marasmus or other wasting diseases scarcely concerns the surgeon. The second, the infective inflammatory form, is of the greatest importance, for prompt action based upon a knowledge of the nature of the disease and of the parts involved will enable us to save many a patient from certain death.

It is impossible to enter fully into the pathology of the complaint in this paper: suffice it to say that of all of the sinuses the lateral is the one most frequently affected, the exciting cause being suppuration in the middle ear.

In such a case the organisms invade the sinus and cause disintegration of its endothelial lining. This eventually leads to thrombosis, and the clot may then undergo organisation which finally leads to the obliteration of the sinus;

or, as more commonly happens, the clot breaks down into a suppurating mass, which, loaded with septic organisms, gets washed into the general circulation, and sets up a fatal pyæmia. An inflammatory fluid, which eventually becomes purulent, usually collects around the inflamed sinus, and forms a sub-cranial abscess as already mentioned.

The symptoms of this affection have been dealt with in a masterly manner by McEwen in his work on Pyogenic Diseases of the Brain and Spinal Cord. He divides them into two groups, viz., general symptoms, and local ones, which are determined by the anatomical position of the sinus affected.

The general symptoms are, headache, which may be generalised or only over the part affected; vomiting; very rapid pulse; temperature of a remittent type, and very often rigors. According to his experience the symptoms take on a more or less definite form, such as, first, the *pulmonary*, in which after the disease has existed a week or two, lung signs, such as dyspnoea and stabbing pain in the chest, possibly due to infarctions, occur. Secondly, the *typhoid* type, in which, at the end of the second week, there is abdominal pain, meteorism, diarrhoea; the stools often being pea-soupy and very offensive. A dark measy rash not raised above the surface nor disappearing on pressure may also occur. And, thirdly, the *meningeal* form, in which symptoms of meningitis are present.

The local symptoms vary according to the sinus affected. In the case of the longitudinal sinus, œdema of the scalp, swollen veins in the occipital and frontal regions, epistaxis owing to impeded venous circulation in the nose, and convulsions followed by coma and death, usually complete the picture. In the case of the cavernous sinus, exophthalmos and œdema of the lids and surrounding parts together with ptosis and squinting are present.

If the lateral sinus is involved, swelling and tenderness along the course of the internal jugular, with enlarged cervical glands, may be found. Œdema over the mastoid is often present; it is, however, a mistake to suppose that swelling over the mastoid always occurs when the sinus, or



even the mastoid itself is diseased. As a case in point I would refer to a patient under Dr. Moir's care who had a two years' history of discharge from the left ear. Severe pain occurred in the ear two days before coming under observation, and when I saw the child with Dr. Moir, the only local signs were an enlarged gland in the neck and great tenderness to touch at the extremity of the mastoid. And yet operation revealed a quantity of foetid pus in the mastoid cells and around the lateral sinus, which itself contained a purulent thrombus. In this case I removed the clot from the sinus, and ligatured the internal jugular low down in the neck. Apart from a sharp attack of double pneumonia, which Dr. Moir's skill successfully combated, the patient made an excellent recovery.

As I have dealt fully with the method of treating these cases in a contribution to the third volume of the *London Homœopathic Hospital Reports*, I will pass on to the consideration of some points connected with

#### INTRA-CRANIAL HÆMORRHAGE.

As the result of an injury, bleeding may take place between the dura mater and skull, or beneath the dura or arachnoid; or again, it may occur in the substance of the brain, and occasionally such hæmorrhages are accompanied by inundation of the ventricles, and it is possible to deal surgically with all these conditions.

The symptoms of hæmorrhage will be both general and local; the latter depending upon the part affected, the former upon the compression of the brain by the increased tension.

Hæmorrhage between the dura and skull usually comes from a ruptured middle meningeal artery, and such cases are amongst the most successful in cerebral surgery. The bleeding which takes place beneath the arachnoid may be very extensive, and cause death rapidly. Such a case has recently occurred in this Hospital. The patient was knocked over by a cab, and sustained a longitudinal fracture of the vertex running from the occipital region to the ethmoidal plate. Death occurred in two hours, and *post mortem*

numerous hæmorrhages, both sub-dural and cortical, were found. In such cases nothing can be done by operation, but when the symptoms point to a localised bleeding, trephining and removal of the clot is often followed by a cure.

In connection with hæmorrhage I should like to refer to the pupil signs, which are of great importance in aiding a diagnosis. If the compressing agent be on one side, the effects are for a time felt only on that side. The third nerve is irritated, and the pupil contracts, but soon paralysis of the nerve sets in, and the pupil dilates, and finally remains widely dilated and immobile. As the pressure continues to rise, the pupil of the opposite side goes through the same changes, until finally both pupils are equal and widely dilated.

#### TUMOURS OF THE BRAIN.

It is impossible in a paper of this nature to do justice to such a subject as intra-cranial growths, and I must content myself with only touching on a few important points.

One of the first questions which occurs to one in this department is: What and how many tumours are amenable to operation? A question which is naturally associated with this, and which must be settled before we can answer the former one, is: What parts of the brain are accessible to the surgeon, or are proper fields for surgical work? To deal with the latter question first, we may, I think, say that the whole of the hemispheres and the greater part of the cerebellum are amenable to operation. The base of the brain, the basal ganglia, the pons, and the medulla, partly from their hidden position, and partly on account of their important functions, must at present be considered as beyond the limits of surgical attack. The statistics which have been collected to answer the first question vary so much that it is difficult to form a definite opinion, but it appears that only a small percentage of tumours are fitting ones for operation. In deciding this question from the results of *post-mortem* examinations only, as has been chiefly the case, we must remember that some tumours which would appear

to be readily removable were rendered during life inoperable by reason of the lack of sufficient localising signs. It is the old question of *ante-mortem* versus *post-mortem* diagnosis, and so long as the scales are unevenly balanced we may perhaps consider it as an argument in favour of more frequent exploratory measures.

To the surgeon the most important tumours are those which press upon or irritate the cortical motor centres, and produce attacks of Jacksonian epilepsy, or inhibit the function of those areas, and cause paralysis of the muscles that they enervate.

With regard to the epileptic attacks, it may be said that not only are they caused by growths of the cortex, but also by meningeal and sub-cortical ones. In the case of the cortical growths, loss of the sense of position in the parts affected is a marked symptom, but in sub-cortical and meningeal tumours this symptom is only a fleeting one. Hence when a patient is seen shortly after an attack of Jacksonian epilepsy, the first thing to do is to test the part which was first affected by the attack, and if the loss of the sense of position recovers in an hour or two the tumour is either meningeal or sub-cortical; if it does not the lesion is a cortical one.

Cephalic tenderness will also help us in this matter. If the tenderness be brought out only by hard pressure or percussion, the tumour is in the membranes, near the tender spot; if the tenderness is superficial it is in the brain substance, cerebral growths causing tenderness of the scalp, cerebellar ones causing tenderness of the face.

Affections of vision are of the greatest service in aiding a diagnosis; indeed, there are some cases in which the condition known as hemianopia is the only definite and unmistakable indication of brain disease. I will therefore, before closing this paper, say a few words on this subject.

It must be remembered that the similar halves of each retina are represented by cells in the cortex in the opposite occipital lobe. Thus the right half of each retina is in connection with the cells of the left occipital cortex. If these cortical cells be destroyed, the corresponding half of each

retina will be blind, that is to say, all objects in the left visual field will be invisible if each eye be tested singly. This is one of the conditions known as hemianopia. There are several forms of hemianopia, but the above is for our present purpose sufficient. The nerve fibres in their course from the retina to the occipital lobe pass through the optic nerves, the chiasma, the optic tracts, from which they pass into the brain substance, traversing the external geniculate body, and then spread out into the so-called optic radiation, to reach the cuneus of the occipital lobe. It is obvious that in this long course many variously situated tumours may press upon the fibres and produce hemianopia. We are, however, by means of the concomitant symptoms, to tell in which regions these growths arise. Thus, a tumour in the cuneus will produce hemianopia alone; one involving the optic radiation will, besides the hemianopia, cause hemianæsthesia. One pressing on the external geniculate body will cause hemianæsthesia, and some hemiplegia from pressure on the internal capsule, and usually some paralysis of the pupil of the same side from pressure on the third nerve.

A tumour of the base of the brain pressing on the optic tracts causes not only hemianopia but also the condition known as the hemianopic pupil. This is failure of the pupil to contract when a ray of light from the ophthalmoscopic mirror is thrown upon the blind half of the retina, and is due to the fact that the optic tracts contain certain fibres from the retina which run to the third nerve centre, and convey the impulse which starts the pupillary reflex. When this pathway is blocked the reflex cannot take place.

One word with regard to cerebellar tumours. These are usually tuberculous, and are generally situated in the middle lobe. Inco-ordination is usually a cardinal symptom in such cases. A lesion of the anterior part of the middle lobe causes a tendency for the patient to fall forwards, one of the posterior part a tendency to fall backwards. Weakness of the back muscles is also a symptom in tumours of this lobe, as is also nystagmus, which is most marked in a direction towards the side of the lesion.

I had hoped in this paper to have found time to deal with the surgical aspects of congenital mental defects, but time enough has been occupied in dealing with the other diseases. I would, however, refer to a case I operated upon. The child, a patient of Dr. Roberson Day, was a hopeless idiot, unable to talk or to do anything for itself. Periodical convulsions occurred on both sides of the body and limbs, which were usually maintained in a firmly flexed condition. As the convulsions were most marked on the right side, after a consultation it was decided to trephine over the left motor area, which was accordingly done. I found that the whole sub-arachnoid space was filled with œdematous fluid, which could be drawn off in considerable quantity with a hypodermic syringe. A drain was left in with a view to drawing off the excess of fluid, but unfortunately meningitis developed and the child died. The *post mortem* made by Mr. Johnstone showed that the œdematous condition was diffused over the hemisphere, so that the available space for brain growth must have been considerably limited.

The lesions met with in congenital idiocy are so numerous that it is almost impossible in any given case to diagnose the lesion, or to say how much good is likely to come of an operation. A few very hopeful cases have been reported, especially in microcephalic idiots, in which operation has vastly improved the patient's deplorable state; but at present this branch of treatment is in need of considerable development, and I believe that more good is likely to come of feeding with thyroid or pituitary gland extract in many cases than from surgical measures.

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Dr. E. B. Roche said the cases of the kind that occurred in private practice were comparatively few. He had lately under his care a case of Jacksonian epilepsy which had been diagnosed and treated by Dr. Hughlings Jackson himself. Previous treatment was without any benefit, but good results had been obtained by the persistent use of *ignatia* and *belladonna*. He also had under his care at the present time a case of meningitis which emphasised the remark that early evidence of retraction of the head probably indicated a non-tuberculous condition, and pointed to a hopeful prognosis. The case was that of a young man who

was gradually recovering under belladonna, ignatia, and some other remedies. There was marked spasm of the facial muscles and of the sterno-mastoid, and the retraction was marked. In country practice, where the advice and assistance of skilled surgeons could not always be obtained, it was for the general practitioner to pursue medical treatment as best he could, leaving the debatable points to be hammered out at the hospital, where the surgeon and physician would be in constant touch, and a surgical operation, in any apparently hopeless case, could be at once carried out. The results of operation in some cases, especially cases of abscess, where things seemed to be utterly hopeless, had been very encouraging ; and cases which in the country would probably die were saved. They could only hope that by-and-bye, when surgical procedure was more generally understood and more accepted by patients, country practitioners would be able to obtain the advantages which were now confined to the hospital. With regard to the middle ear disease, the results were very successful. He had now under his care a case of brain disease which was of great interest. A lady, well educated and able to speak in seven or eight languages, was seized with pain, difficulty of speech, loss of recognition of persons, and great sensitiveness of smell and hearing. The condition would pass off after a time with extreme headache, and after two or three days she would recover her ordinary condition. At first he was inclined to think it was a tumour of some kind, but there had been no paralytic symptoms, and he had not been able to localise anything. No fresh development had occurred. Medicines had relieved her again and again, and he thought that in many of the cases one must be content with relieving the pain and symptoms.

Mr. KNOX-SHAW said that the essential of correct treatment in this class of cases was an exact diagnosis ; and he ventured to think that, as in some other diseases where the surgeon and physician came together, the surgical treatment had outrun the diagnosis. When medical men came face to face with their patients they would find that the typical pictures of disease, as presented by the text-book, were not always found by the bedside. He illustrated the difficulty in diagnosis by mentioning the case of a man who had been admitted into the hospital a few weeks previously after being thrown off his horse. He was brought in on a Monday morning, unconscious, and from the symptoms a diagnosis of fractured base was made. His symptoms were most carefully noted ; and the conclusion arrived at that there was no definite symptom indicating surgical interference. For five days he went

on well, but on the Saturday he became suddenly and violently convulsed. The convulsions were continuous and general, and offered no localising indications. The man died in a few hours, and at the *post-mortem* there was discovered a left-side sub-dural hæmorrhage, due to the rupture of the middle meningeal artery, the rupture appearing to be of recent date. He thought surgery would do most in cases of intra-cranial suppuration. Dr. Goldsbrough had referred to the medicines suitable for collections of pus. In his (Mr. Knox-Shaw's) early surgical days he had some belief in medicines which controlled the formation of pus. He was sorry to say he had grown more sceptical. He did not think there were any medicines which were likely to do collections of pus in the skull any good; and he considered the greatest surgical field would be found in cases of meningeal hæmorrhage and intra-cranial suppuration. The question he wanted the pathologist to answer was: In what proportion of cases of meningitis did they get cerebral effusion? because it seemed to him that in many of those cases where, as Mr. Wright had pointed out, everybody said there must be cerebral effusion, an operation discovered next to nothing. Lumbar drainage was practical enough in cases of hydrocephalus, but in meningitis, unless they were quite sure there was a large amount of cerebral effusion, he did not see they were going to do very much good. In dealing with cerebral tumour there was always the question of cerebral syphilis. A question arose which he was anxious to have answered: Supposing, as was often the case, there was no direct evidence of syphilis, and yet on giving iodide of potash the patient got well, were they to believe that the man had made a mistake, or would iodide of potash cure a cerebral tumour that was not syphilitic? ("Certainly.")

Dr. GALLEY BLACKLEY said that in brain diseases, as in lesions of other parts of the body, the anatomical situation of the ailment had really very little to say in the matter of treatment, certainly so far as medical treatment was concerned. The essential nature of the lesion was the guide, not its seat. A lesion might be seated in a certain spot and be diagnosed to a nicety, but it might be a tumour, a syphilitic mass, an abscess, or a neuritis causing degeneration of the myeline; and the mere localisation of all these did not really help towards drug-treatment. The question they had to solve first of all was: What is the essential nature of the trouble? As, for instance, is it meningitis? And if so is it an inflammation of the fibrous capsule or of the serous envelope? In the case of encephalitis, is it cortical, and if cortical is it one

thing or the other thing, and so on? Those were the points upon which they ought to satisfy themselves before proceeding to treat brain disease. That, of course, accorded with one's experience in other parts of the body. They had remedies for pleurisy, for peritonitis, and why not for inflammation of the pia-mater, and so on? In the same way they had remedies for nerve troubles, for neuritis, and if they could diagnose a neuritis in the brain tissue itself the remedy was obviously the same. That was the lesson he had drawn for himself. With regard to abscesses of the brain, these they knew were often difficult of recognition. When recognised, if they were near the surface and could be readily got at, by all means give vent to the pus, but there seemed to him no reason why those abscesses should not retrocede, or at any rate undergo caseous and then calcareous degeneration. Why should not the anti-pyogenic serum be used to limit the area of the growth of the abscess—put a stop to the septic process and let the abscess become calcareous, if possible? With regard to the iodide of potassium treatment, he did not know—although some one had exclaimed “certainly”—what the cerebral tumours were which were curable by iodide of potassium, at any rate so readily as the syphilitic cases.

Dr. ROBERSON DAY said that he happened to have under observation at the present time a case of intra-cranial tumour in a boy about seven years old, which had steadily improved and was now sufficiently well to be at home. The only symptoms in the case were vomiting, staggering gait, and double optic neuritis. The optic neuritis had completely cleared up under treatment, the vomiting had ceased, and only a slight staggering gait now remained. The principal remedy employed was iodide of arsenic, under the most probable supposition that the case was one of tuberculous deposit, and from lack of other symptoms possibly situated in the cerebellum. He agreed with Mr. Knox-Shaw that it was impossible to place reliance upon the statements of patients as to syphilis, citing two cases in illustration thereof.

Mr. ASHLEY BIRD mentioned the case of a patient who was under his care for about four years. In the first instance there was a history of grippe; afterwards the patient became paralysed, with double optic neuritis. He partially recovered, however, and he (Mr. Bird) saw him about six months afterwards, when he was in a deplorable condition. He was semi-paralysed, and for a child of twelve was very fat, heavy and lethargic—in fact, he hardly moved at all, but was carried and taken about in a bath chair. The intellect seemed to be the brightest part of him. He was an



enormous eater. His reflexes were very poor, and both sensory and motor systems were very low. The head was very much enlarged, and he (Mr. Bird) was inclined to think that the child had been hydrocephalic from infancy, but could not get any definite history of that, but one of the child's photographs taken earlier in life seemed to show that this supposition was correct. The boy improved very rapidly under treatment, belladonna, apis and calcaria being given most of the time. He improved so much in general health that he could walk about very freely. He went to the Normal School for the Blind, and had been in that institution for a couple of years when he again came under Mr. Bird's hands. He got another attack of influenza which pulled him up very sharply, and signs of effusion appeared, but he recovered gradually from that. He used to suffer from very violent headaches and signs of brain pressure. The parents then left the district, but three months afterwards the child died. A *post mortem* was held, and the amount of fluid that burst out when the brain-pan was opened was astonishing. The dura mater was attached considerably, and when that was torn through, an enormous quantity of fluid gushed out—in fact, more than a pint was collected and a quantity was spilled on the floor. The head had enlarged enormously, and the skull was as thin as paper. He thought that this history very clearly showed the immense influence that could be obtained by homœopathic remedies upon such conditions as effusion.

Dr. BURFORD emphasised the very important suggestion Mr. Knox-Shaw had made with regard to surgery, in dealing with brain lesions, having over-shot diagnosis. Some years ago he was asked to go into the country to see a child, in consultation with a colleague. The child had chronic middle ear disease with a recently suppressed purulent discharge, and every symptom of incipient meningitis. He did what he supposed was a classic operation, incised deeply over the mastoid process; the dressings the next morning were saturated with pus, and the patient made a rapid recovery. The child was removed from the country to a public school, and some year or two afterwards he was told that the child had been under the treatment of the medical man in charge of this school, and had been seen by an eminent allopathic consultant who said that the patient had "epidemic cerebro-spinal meningitis." The child made no progress, and the consultant came again, and the same treatment was continued until about a couple of days before the child's death. It was ultimately found that the case was one of cerebral suppuration obviously secondary

to middle ear disease, the very condition that had been assigned and treated in the first instance, and altogether missed in the second. This case, the speaker had reason to believe, had formed the text of an important monograph issued in Germany as a "Festschrift" in celebration of Prof. Virchow's Jubilee.

Dr. MOLSON said that there were two cases, differing widely as to cause, which he should like to mention. One was an infant aged 11 months, who had suppressed measles. Wet packs and the ordinary remedies failed to bring out the eruption. When at the end of his resources, after three weeks of failure, he happened to see in Farrington's *Materia Medica* that zinc was capable of developing a hidden exanthem. Accordingly, he gave the patient this remedy in the form of zincum metallicum. The long absent eruption became fully exposed, and the child went on to a rapid recovery. Some years afterwards a girl aged 11 years had meningitis, presumably from heat stroke. Her shrieks were frequent and distressing. Dr. Day, who saw the child in consultation, suggested the use of apis. For a short time there was some improvement, and then the child relapsed. Remembering his success with zinc, Dr. Molson decided to try this remedy again, and gave zincum phosphidum 3x trituration. From the moment this remedy was used the patient improved, consciousness was regained, and continued progress ended in an early convalescence. In both instances he was satisfied that it was the zinc which touched the mischief. He strongly advocated the early employment of this remedy, either in the form of zincum metallicum 3x, or zincum phosphidum 3x.

Dr. BODMAN said there had been pointed out in how few cases of cerebral tumour it was possible to remove the tumour, but he believed that it had been found that in a certain number of cases decided relief could be obtained by removing a considerable area of the skull by trephining, although possibly that relief had been in most cases only temporary. The symptoms mainly relieved in that way had been severe headache, vomiting and optic neuritis. He happened to have seen one case in which that treatment had been adopted. It was a man with a cerebral tumour, who was fast losing his sight from progressive optic neuritis and consecutive atrophy. He was also suffering from very severe headache. The operation was performed, and a very considerable area of the vault of the skull removed by trephining, and from that time the headache ceased and the progressive loss of sight was arrested. He could not tell what was the sequel of the case, probably the tumour eventually proved fatal; but it was certain that for a time

very considerable palliation was secured by the operation, and he should like to ask Mr. Wright what was the present condition of medical opinion upon that kind of operation.

Mr. JOHNSTONE said that Dr. Goldsbrough had related a case of tuberculous meningitis upon which operation had been done without avail. At the *post mortem*, there was found a little nodule in the cerebellum. It looked like a tuberculous nodule. He examined scrapings of it, suitably stained, under the microscope, but failed to discover the presence of any tubercle bacilli. There were, however, nodules on the pleura which were undoubtedly tuberculous. That was only another instance of a well-known fact that they might have tuberculous nodules in which the presence of the bacilli could not be proved by staining. If a cultivation had been made of the nodules the probability was that the tubercle bacilli would have grown. The explanation was that in those particular nodules the bacilli might have lost their bacillary form and have taken on another not recognisable by the microscope. He was glad to note the importance which Dr. Goldsbrough gave to the subject of the pathological inferences which were to be drawn in brain cases. There was no doubt that to treat such cases upon mere symptomatology was quite out of the question. That procedure was no doubt very much in vogue in the earlier days of Homœopathy, but it was that kind of practice which in many cases had led Homœopathy into ridicule. He was pleased to know and to feel that a more scientific spirit was abroad among them. The discussion, especially the surgical aspect of it, was particularly interesting to him. For over 12 months he had been house-surgeon to Professor McEwen, in the Royal Infirmary of Glasgow, and curiously enough during that time had occurred many of the important cases cited in Professor McEwen's recent work on cranial surgery. The most interesting to him was a case of cerebellar abscess, for which Professor McEwen had trephined with absolute success. It was the first undoubted case of pus in the cerebellum which had been cured by operation. Such cases were rare, and it was almost hopeless for a surgeon with a limited surgical sphere to expect to meet with all the rarities of cranial surgery.

The PRESIDENT (Dr. E. A. Neatby) said it was very striking to those who came back to the subject after having left its consideration for a number of years to see the remarkable advances that had been made both in anatomical and pathological diagnosis. At the same time, it had been shown that evening that great care was still required, and that even now the matter was in its

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infancy, and that before brilliant results in the way of recoveries could be gained there was a great deal to learn. He emphasised Mr. Johnstone's remark that if they hoped to make any progress in medicinal treatment, although they might do it on homœopathic lines, they must not do it on pure symptomatology. As far as possible the pathology of the disease must be brought in, and as a corollary it was of the utmost importance that they should push ahead with their investigations of the pathological or pathogenetic effects of remedies. Their knowledge of pharmacodynamics had not advanced with their knowledge of pathology and therapeutics and other methods of treatment.

Dr. GOLDSBROUGH, in reply, said with regard to the use of medicines in abscess, he endeavoured to show in his paper that surgery was the first and primary consideration, and he thought that having decided on the surgical procedure, the use of medicines should be conjoined with it. He suggested that in the case of Jacksonian epilepsy, mentioned by Dr. Roche, the epilepsy was a symptom and not the actual disease. It would be interesting to hear from Dr. Roche what his view was as to the cause of the convulsions, that being, of course, the true pathological diagnosis in the case.

Dr. ROCHE said it was injury. The man dived into the water and damaged his head against the bottom.

Dr. GOLDSBROUGH said the pathological condition was probably a hæmorrhage. The lady referred to as having sensory disturbance and what was called mind blindness—loss of recollection of objects—might be a case very similar to those of hemi-crania, where the patient would lose sight temporarily prior to the onset of intense headache. Were not these cases instances of spasm in the blood-vessels causing anæmia, followed by paresis, causing the pain? The case cited by Dr. Roche seemed like one of paroxysmal functional disorder of this character rather than one of organic lesion. With regard to lumbar puncture, Mr. Wright's interesting description would make them think they had to do with the normal condition of circulation of the cerebro-spinal fluid in cases of meningitis. It would be a most exceptional case, however, if the channels were not blocked with inflammatory products, such as the engorgement of the capillary blood-vessels, exudation of lymph, and leucocytes, so that the possible transudation of fluid into the spinal canal would be a rather remote possibility.

Mr. DUDLEY WRIGHT also briefly replied. In answer to Dr. Bodman's question with regard to the trephining method for re-

lieving the symptoms of intra-cranial tumour, he said it was a thing which had been done, and he believed it was done solely on the principle of reducing intra-cranial tension, and thus relieving the headache—which was often excruciating. He thought that as a matter of fact intra-cranial abscess and suppuration were not uncommon, and he believed the members if they only looked out for such cases would find this to be true. Not a year passed without his having to deal with some intra-cranial complication of middle ear disease. It was extremely common for the results of middle ear disease to be overlooked. It would be found by the Registrar General's return of deaths in London that a very large percentage of deaths were due to the results of middle ear suppuration, and he was certain from what he had seen that cases got missed, and children died of what was called meningitis, when an examination of the ear would have shown that the origin of the trouble was there, and that the meningitis was secondary to ear disease, and possibly an operation might have saved life.

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## A DIGEST OF TEN YEARS' WORK AT THE CHILDREN'S SANATORIUM, SOUTHPORT.

BY WILLIAM MORRISON STORRAR, L.R.C.P., L.R.C.S.ED.

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As it is now over ten years since I came to Southport, and the whole of that time I have been on the medical staff of the North of England Children's Sanatorium, I have thought that an account of the institution and of a few of the experiences I have there gained might prove a matter of interest, and form a useful topic for discussion.

The Sanatorium, some of you may be aware, was founded in the year 1860, as a small home for the reception of sick children, chiefly through the initiative of the late Dr. Blumberg, supported by the vigour of a committee of influential and philanthropic ladies. For some years this

<sup>1</sup> Read before the Liverpool Branch, November 11, 1897.

#### THE CHILDREN'S SANATORIUM, SOUTHPORT

home was kept up in a very small way in a little back street, but when Dr. Blumberg left Southport, in 1864, the charity seemed almost in danger of flickering out. Under the fostering care, however, of Dr. Stokes (who had bought Dr. Blumberg's practice) and Dr. Harvey, supported always by the benevolence and spirit of the ladies, the institution gradually got established on a surer basis. A dwelling-house in Hawkshead Street, not far from the site of the present building, was obtained, and accommodation provided for thirty children.

Gradually this accommodation was found to be too limited, so in 1878 a special effort was made, larger subscriptions were called for from the public, and, still further assisted by a grant of £2,500 from the Cotton Districts Famine Fund Committee, the foundation stone of the present building was laid by Lady Crawford—a building capable of holding sixty-five beds. On two occasions since then new wings have been added, one in 1889, and another in 1892, sufficient accommodation being now provided for 100 children.

The institution is supported partly by endowments. There are at the present time seven endowed cots costing each £500.

There were last year six *appropriated cots*. These are cots secured by a donation of £15 15s. for one year only. This is becoming a very favourite way, with some kind people and with ministers of religion, who thus secure the right of nomination of sick children to their own particular cots for twelve months. A continuous interest in the place is thus kept up in a very practical sort of fashion.

The chief source of income, however, is from the patients. Each child has to pay 6s. per week, if recommended by a subscriber, or 7s. per week if admitted without a recommendation.

We keep each patient for a period of three weeks—never less—or six weeks, if their parents are agreeable, on the special intimation of the medical officer that such further stay is likely to prove beneficial. The income from this source is about £900 a year.

The next source of income is the public, from whom is collected, chiefly in the Southport district, by lady collectors, the sum of about £500 every year. The total cost of the Institution is about £2,000 a year. In recognition of the grant of £2,500 from the C. D. F. F. C. in 1878, that Committee is allowed to send in children to the Sanatorium at the subscribers' rate, viz., 6s. per week, instead of at the actual cost price rate, which is the custom they follow at their larger institutions in Buxton and on the Promenade at Southport, and, as the actual cost price per week of each child (the whole expenses of the Charity divided by the number of children admitted in the year) is about 13s. 5½d., this arrangement has proved to be rather an unfortunate one for us. We are actually 7s. 5½d. out of pocket every week by every child sent by that rich Committee. It was the eagerness of the Sanatorium Committee in 1878 to get the grant of £2,500 which led them to offer such too favourable terms.

As showing the far-reaching ramifications of the Institution, I should mention that the following hospitals and infirmaries have each one or more beds allotted to them, *i.e.*, they are always entitled to have the allotted number of beds for their own particular patients at any time when required.

The Children's Hospital, Pendlebury, has ten beds, but since the opening of a place at Lytham we do not get nearly so many children from this source. The Manchester Royal Infirmary has 10 beds. The following have one bed each:—Preston Infirmary, Wigan Infirmary, Blackburn Infirmary, Bolton Infirmary, Oldham Infirmary, the Royal Eye Infirmary (Manchester), Salford Royal Infirmary, Victoria Hospital (Burnley), Stockport Infirmary, the Clinical Hospital (Manchester), Ashton-under-Lyne Infirmary, Macclesfield Infirmary, Royal Lancaster Infirmary, Rochdale Infirmary, Warrington Infirmary, Ardwick and Ancoats Hospital, Bury Infirmary.

The parents of the children coming from these hospitals and infirmaries are many of them so poor that they cannot even afford to pay the 5s. for three weeks, which is the very

low charge made. The C.D.F.F.C. makes up the amount to 18s. for the three weeks, and practically guarantees that nothing less than 6s. per week—the ordinary subscribers' rate—shall ever be paid.

Since the foundation of the charity to the present date, 10,415 children have received the benefits of the Institution. Since I joined the medical staff, in 1887, 7,000 children have come under our care; 842 were admitted last year.

In the same decennial period both Drs. Harvey and Blumberg have passed away (Dr. Blumberg returned to Southport in 1876 after twelve years' absence, and took over his old practice from Dr. Stokes). Dr. Stokes has also passed away, but him I never knew. They all rendered invaluable services to the Institution. Dr. Harvey was a model of patience and devotion, and gave, most ungrudgingly, no end of his time and energy to the interests of the charity. I don't think his services were ever appreciated as they deserved to be. He never made any fuss or show, always went about his work very quietly and thoroughly, and for the 25 years he was connected with the Institution was always ready at a moment's notice, and always to be depended on. Dr. Stopford joined the medical staff in 1889, but resigned in 1893. Dr. Henry Blumberg was appointed in 1892, and is my colleague at the present time. We have also an honorary ophthalmic surgeon and an honorary dental surgeon.

It should be observed that all the children must be certified as convalescent before they can be received, *i.e.*, they must be considered fit to be out of bed, with benefit to themselves, three or four hours a day.

As a matter of fact, a very considerable proportion are very far from convalescent, although certified as such. Those of us who have been house-surgeons in public hospitals know why the present day house-surgeons are glad to get rid of unpromising cases, and foist them upon other institutions. If the cases are really moribund we won't admit them, but many very critical cases get in nevertheless. We must not complain, as it accounts for the facts of our experience.



Now, I propose briefly, in somewhat discursive fashion, to run over the lines of treatment I have generally found myself following in most cases. A very large proportion of the children, being the offspring of poor parents, living under somewhat squalid and depressing conditions, come in, as you may guess, suffering from the remains of diseases of the scrofulous diathesis. For this cachexia I think all authorities are agreed that the first essentials towards cure are fresh air and sunshine, good food and reasonable clothing, and absolute cleanliness.

We have always laid great stress, too, upon the value of the climate of Southport in helping children of the scrofulous type. The air is always pure and free of smoke. We get more sunshine than in Liverpool. Moreover, the temperature is very equable, and besides, we have sometimes the odour of brine from the ocean, carrying with it free ozone, and perhaps, in high dilutions, iodine, natrum muriaticum, and goodness knows what else, all of which have their influences working for good.

The sub-soil of the district being composed entirely of sand is very porous; water never lies in our streets, and damp is a thing unknown.

The front of our building faces almost due south; so our large sick ward and the play-room immediately below it, being on that side, get the benefit of sunshine on all possible occasions.

In the mornings on fine days the rather feeble ones and cripples are put into our donkey carriage and paraded about the town or promenade for about two hours. The stronger children, under the charge of one or two nurses, are walked off to the seashore—as near as they can get to it—and allowed to enjoy themselves as they please. There is a large area of sand just behind the house, where those who feel equal to it may swing, see-saw, dig mines, or build castles to their hearts' content. This is generally the fine afternoon's occupation. On wet or damp days the play-rooms are fully engaged, and occasionally lady visitors or members of the Committee come round to assist in their amusement. We are blessed in having a matron (Mrs. Kyle) who is a vigorous,

lively, and happy woman, with a heart full of affection for all the children, and I am happy to say that her genial influence seems to be caught up by all the nurses and domestics under her control. The consequence is that we almost never have a case of persistent home-sickness among our patients.

Having now given due credit to the influences not usually classed as medical, I pass on to medicinal treatment.

The remedy which I find myself prescribing most often, the one to which I think the condition of scrofulous children most frequently points, is *calcareæ phos.* The children are generally somewhat thin or flabby and dirty-coloured, with enlarged glands about the neck and elsewhere, and with enlarged tonsils, and often a laxness of the abdominal walls amounting to tubbiness. *Calcareæ carb.* often answers very well where there is marked fatness with the flabbiness, but *calcareæ phos.* for nearly all the manifestations of the diathesis is the remedy which, after generous diet and general hygiene, I have most confidence in. The 3x or 6x attenuations are the preparations I generally employ.

Frequently we have little outbreaks of follicular tonsillitis, to which, moreover, the nurses are particularly susceptible, the effect, I firmly believe, of their being too much or too long in the atmosphere of the sick, on which account I particularly insist that the nurses should spend as much of their off-duty time out of doors as possible. Some years ago these cases were constantly giving us a lot of trouble in spite of the best modern sanitary arrangements in the building; but since for this complaint I have taken to use Schüssler's *kali mur.*, 3x or 6x, we have had next to no trouble whatever. This is a remedy which with me ranks as practically a specific in follicular tonsillitis, or hospital sore throat, and those cases, which if not checked early, very often run into acute tonsillitis. In about three days these throat cases are generally quite well.

For *tabes mesenterica*, of which we have a large number of serious cases every year, my usual treatment is first of all careful feeding—generally milk only, then *calcareæ phos.*, 6x, twice or three times a day, and a hydropathic compress worn constantly round the abdomen, changed three or four

times in the 24 hours. Often I prescribe a weak solution of natrum mur. in the compress. This compress consists of one fold of very damp, not wet, linen round the abdomen, covered over with a piece of oiled silk or red jaconet, or other waterproof sheeting. This sort of compress keeps damp a very long time. I refer to this particularly because later on I shall have to refer to another kind of compress or pack. Where diarrhoea is a prominent feature, as it often is in these cases, I generally find acid phos. dil. meets the contingency very well. In any case, it very rarely happens that we do not send out these cases practically cured, although it may take six weeks to do it.

As a matter of course we have a great number of cases of adenitis, most frequently about the neck. Under calcarea phos., with the improvement in the general health, some measure of subsidence is frequently achieved. In the early stages where there is only some swelling and tenderness of the glands, with no central necrosis of the gland substance, kali mur. has answered admirably. Somewhat later, when the gland tissue is still intact silica has often started a disposition to subsidence of swelling which has gone on then to reduction to almost normal.

But where the swellings are large, and the centres of the glands caseous or purulent, I don't think our remedies touch the spot at all. It may be well to leave them alone sometimes, but when, as most frequently happens with these cachectic children, suppuration sets in and danger of bursting is imminent, I am strongly of opinion that surgical measures cannot too speedily be resorted to. A favourite method with me is the metallic seton, *i.e.*, a piece of wire threaded through the abscess and left *in situ* for a few days until it has discharged itself.

If this plan is resorted to early enough, before the skin has become adherent by inflammation to the capsule of the gland, no mark or pucker is left behind, a great improvement upon the usual plan of waiting until, if not opened, the abscess will burst of itself, continue discharging for an indefinite period, and certainly leave an ugly and indelible scar to advertise for ever the scrofulous habit of the individual.

We get, too, an enormous lot of hip cases, sometimes in the quiescent stage, often with lots of sinuses. I must say these cases are very well treated by our surgeons nowadays. The Thomas splint was the invention of a genius. I wonder Liverpool has never thought of honouring itself by raising a monument to him. This splint answers every possible way of securing rest to the diseased joint, and I am certain cures absolutely cases got hold of early enough. Here calcarea phos., silica and calcarea sulph. are the remedies I most frequently employ. Calcarea sulph., another of Schüssler's remedies, I find very efficacious in diminishing purulent discharge and ultimately drying it up. It seems to answer better, to penetrate somewhat more deeply than hepar sulph., which is its nearest analogue.

In cases of empyema—I see we had 19 last year—I recommend the nurse to use a dilute solution of calcarea sulph. as a lotion for flushing out the pleura. This solution has always proved useful, so much so, that we very rarely send away a case of empyema not quite cured. Of course I administer calcarea sulph. internally at the same time.

We get annually a great number of cases of chorea—52 last year—and I must say we are uniformly successful in their treatment. I don't recollect one case which has not improved so much as to be sent out in six weeks practically cured. One girl I recollect was so violent that she had to be held down in bed for two days—she was frightfully emaciated, covered with bed-sores, and generally speaking a deplorable sight, and for three weeks could not feed herself, yet she made a very good recovery. My usual prescription is agaricus mus., 6x, once a day, and alternate hot (95°) and cool (80°) spongings, with some friction, to the spine night and morning, or more frequently if the symptoms are very urgent.

I wonder if you have the same feeling I have about many of the cases we so often see and hear of nowadays, since McEwen, of Glasgow, began resecting deformed limbs. We have frequently of late had cases of young rickety children sent in with their legs in plaster casings after

having been broken : of course the bones unite in the new positions perfectly—but with enormous callus. I should very much like your opinion about the propriety of fracturing the limbs of children below adult age. I have the impression that to fracture the limbs of children before 8 or 12 years of age, *i.e.*, in order to set them straight, is not only a brutal but an unnecessary procedure. Could not these limbs be equally improved by rest in bed under the best hygienic surroundings, and with splints and extensions? Or is it that hospitals cannot spare beds and surgeons are in a hurry?

Before bringing this rather disjointed essay to a close I would like to draw your attention to the hydropathic pack as a most valuable adjunct to our *medical* treatment of disease. The pack consists simply of a piece of linen or a sheet sufficiently large to encircle the body—what is called the half-pack is a piece large enough only to encircle the trunk. This sheet must not be very wet—it should be well wrung out,—the reason for this being that the finely divided water of a damp sheet is more efficacious in carrying off superfluous heat quickly by evaporation than a wet one would be. And it is not essential that the pack should be wrung out of cold water—quite otherwise, no good purpose is secured by that at all, for not only may the patient be shocked and the congestion be driven inward instead of attracted outward, but the susceptibilities of all anxious onlookers are also saved from shock. The one single indication for the pack is pyrexia. I never hesitate to put it on if the temperature runs up quickly to about 103° or 104°, no matter from what cause. I have yet to learn what acute fever may not speedily be relieved by it. Take the case of a big girl of 15, attacked, from an excoriated nostril, with erysipelas of the face and scalp. Her temperature ran up quickly one morning to over 105°, she became delirious and wild. Aconite and belladonna would immediately suggest themselves here, but when called in, at 9 p.m., I immediately had her wrapped up in a large sheet well wrung out of water at 95°. In this case the sheet was renewed every two hours, or sooner if it became dry; or to save movement and disturbance of the patient, it

was simply sponged over with a very damp, not too full, sponge. In this case the temperature in three hours came down to  $101^{\circ}$ —next morning it was  $99.8^{\circ}$ —no higher at night, and the next day after it was normal.

Or take another case, seen with me in September by Dr. Nicholson, of Clifton, who was visiting in Southport at the time. This boy, 7 years old, came in with a little cough, convalescent from pleuro-pneumonia; he had been getting on very well, but one afternoon his temperature ran up to  $104^{\circ}$ , with very laboured breathing, and a very high pulse and general look of collapse. There were no physical signs on examination of the chest, but all the symptoms pointed to acute pneumonia. A half-pack was immediately put on, and renewed as soon as dry, till the temperature came down to  $101^{\circ}$ , which it did in three hours; then it was discontinued. The next morning his temperature was  $101^{\circ}$ , and in the evening  $99^{\circ}$ , and the next day quite normal. The next day after he was allowed up, and seemed little the worse for his narrow escape.

Both these cases in the ordinary course of events were bound to die, and that quickly. Our homœopathic remedies, valuable as we all know them to be, are not, in my opinion, quick enough in their action to cope with these cases in time; and it is time that is the most important factor, for I believe that pyrexia, *i.e.*, the vital reaction, is often a great deal more dangerous to life than the original exciting cause, be it pneumonia, erysipelas, or the acute exanthemata. Help the struggling system to throw off its exuberant caloric, and then probably the exciting cause will prove less formidable than at the onset it seemed.

I find on examination of the Annual Reports for this last ten years that the mortality in the Institution is only about 2.5 every year, while all but 3 per cent. (who are sent home "no better") get quite well, or are more or less considerably improved.

It may seem strange to you that we continue receiving children from nearly all the allopathic hospitals in the county, and stranger that no great outcry has arisen because of the heretical opinions of the medical officers. From the

very foundation of the institution only medical men with some practical knowledge of homœopathy, in *addition* to the usual medical lore of the schools, have been on the staff. That there has been no occasion for scandal, which, without doubt, would have arisen on the very slightest provocation, speaks volumes for the uniformly great success which has always attended our efforts as medical officers, and speaks volumes also for our modesty in refusing to too much obtrude our extra scientific attainments when such advertisement would have had a prejudicial effect upon the popularity of a very deserving charity. A few allopathic medical men sending children to the Sanatorium, who know we are practically acquainted with homœopathy, have said they don't care what 'pathy we profess; they only know the children come back looking very well. In my time only once was there a suspicion that a little trouble might arise through the intervention of a rather prejudiced medical man. Most of the profession in the county do not associate our Institution with homœopathy at all. We are not careful to take our light from under the bushel. Good work is being done; we are content.

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Dr. J. D. HAYWARD (Vice-President) thought the relation of the sanatorium to other non-homœopathic hospitals was very satisfactory but he wondered if there were any limitations to the post of medical officer as a homœopath. Touching on the treatment used he said as a rule he preferred calcarea iod. to calcarea phos. in scrofula. Dr. Storrar did not mention cod liver oil in this condition, but perhaps they were able to do without it. He then asked for some particulars respecting admission, and thought their own hospital should have a bed there.

Dr. THOMAS said he thought calcarea phos. more suited to rickets than scrofula, while this latter condition was met by calcarea carb., silica, iodium and others.

Dr. HAYWARD had always been impressed with the great homœopathic zeal of the founder—the late Dr. Blumberg. He agreed with the Vice-President that their hospital should have a bed there if it could afford the expenditure, but in the meantime it had a free convalescent home at West Derby. Sunlight in a ward was a very important thing and conducive to health. They were

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wise in making this provision. In reference to treatment, neither sulphur nor iodium had been mentioned, and both were very useful in the treatment of scrofula. He agreed with Dr. Thomas that calcarea phos. was more suited to rickets than struma. For tabes mesenterica, in his earlier days calcarea carb. 6 had given him every satisfaction. It was not, he thought, necessary to give acid phos. for the diarrhoea, for as the glandular condition improved so would this symptom. He was at one with Dr. Storrar in the pack treatment, it was more satisfactory and less risky than the cold bath. He did not understand, however, how evaporation took place when the patient was covered with a blanket. But he had seen reduction of temperature take place with homœopathic medicines alone.

Dr. MEEK thought that the term hyperpyrexia should be restricted to temperatures of 106°-107° or higher. He had seen ten cases when it had gone over 110°; only two of these were his own patients. Packs and sponging were tried but without avail. If homœopathy failed anywhere it was here. If the temperature was above 105° the pack was not sufficient. He mentioned a case where the temperature was 107° after an abortion. He scraped out the uterus and next day it was 99°. He had a case of typhoid where for six weeks, but without delirium, the temperature had been 104°-106°; he failed to reduce it by either sponging or packs, but eventually it gradually came down itself.

Dr. ELLIS remarked that cod liver oil was an expensive drug and this was a drawback to its use. Hydropathy was interesting; he used the hot pack in cases of high temperature and the result in bringing it down was marvellous. It saved time for the medicines to act. The heat caused dilatation of the blood vessels on the surface and so reduced the internal heat.

Dr. GORDON said that while no particular medicine could be prescribed for a given disease we may generalise and say which was the most useful. Calcarea phos. was valuable in struma, but a favourite of his was baryta iod., 3x: he had not used kali mur. for follicular tonsillitis, phytolacca having always given satisfaction. With regard to the treatment of high temperature, when over 105° the pack and sponging was waste of valuable time, and the patient should be put into a cold bath. He instanced a case in point where the patient was almost moribund, with a temperature of 108°, and this treatment brought about recovery.

The VICE-PRESIDENT endorsed Dr. Gordon's remarks. We must discriminate between the pack and the cold bath. The



former was only useful in temperatures below 105°. The heat or cold of the pack did not matter, it soon became the temperature of the body; the moisture was the essential thing. With regard to Dr. Hayward's remarks about sunshine in a ward, it was useful in a convalescent home, but in a hospital you could have too much. Everyone knew that it was a natural instinct for the sick, whether animal or human, to prefer the shade.

Dr. HAWKES said in strumous cases iodine could not be too much thought of. As to the rapidity of reducing temperatures, if we had a case of 105°, and when the first crepitations appeared gave phosphorus, how soon the temperature began to come down! In follicular tonsillitis he was most satisfied with ailanthus, kali bichrom. and mercurius cyanide, as indicated, and above all, one of the serpent venoms, if slow in going away. In chorea, if the movements were violent, we could not do better than give agaricus, and we need not be afraid of it, as Dr. Madden had taken two hundred drops of the mother tincture; when there were brain symptoms stramonium, and in more chronic cases cuprum or arsenic. Hyperpyrexia begins at 106°, and as it occurs suddenly, when the patient is already under homœopathic treatment we could not look to these medicines to reduce it. He preferred sponging with cold or ice-cold water, the patient placed on a mackintosh and sponged for ten minutes. He had used a pack in a uterine case when the temperature rose to 107° after syringing, and an abdominal compress reduced it. His own view was that, apart from the disease, 107° was sufficient to kill.

Dr. MOORE stated that the average amount of sunshine at Southport was very great, and he believed that sunshine alone had marked bactericidal properties. The hydropathic treatment was useful, but he had a compunction in using a pack where the heart was weak.

Dr. STORRAR, in reply, said that the Committee had been careful to elect new medical officers who were favourable to homœopathy. With regard to cod liver oil he thought he got good results without it. He agreed with Dr. John Hayward that in sickness shade was preferable to sunshine, but for the most part they had to do with convalescent cases. With regard to hyperpyrexia he agreed that it began at 106°. In the pack evaporation could proceed, for the patient was only lightly covered.

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**SOCIETY NEWS.**

At a meeting of the Society, held on Thursday, November 4th, 1897, Dr. Harold V. Munster, 3, Oldfield Road, Croydon, was elected a member.

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At a meeting of the Liverpool Branch of the Society, held on Thursday, November 11th, Dr. James Watson, 259, Smithdown Road, Liverpool, was elected a member of the Society and the Branch; and at the same meeting Dr. Douglas Moir, Dr. Percy Cox and Dr. Compston, members of the Society, were elected members of the Branch. Dr. Bertram Nankivell was elected an honorary member of the Branch.

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At the November meeting of the Society, the President announced, with sorrow, the death of Mr. Hugh Cameron, at the age of 87. Mr. Cameron was the sole survivor of the eight members who founded the Society in 1844, at the house of Dr. Quin. In appropriate terms the President moved that a vote of condolence be sent to Mrs. Cameron and the family. Dr. Dudgeon, who said he had been a friend of Mr. Cameron for over fifty years, seconded the motion. He paid a high tribute to the many virtues of his old friend, and mentioned the interesting fact that Mr. Cameron was probably the last surviving person in Great Britain who had been intimate with Hahnemann.

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At the December meeting of the Society the Secretary regretfully announced the death of Dr. Rhodes Reed, of King's Lynn, who had been a member for twenty-five years.

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SUMMARY OF PHARMACODYNAMICS AND  
THERAPEUTICS.

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"GATHER UP THE FRAGMENTS, THAT NOTHING BE LOST."

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AUGUST—NOVEMBER, 1897.

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PHARMACODYNAMICS.

**Acidum camphoricum.**—Hare and Stockman have verified, in America and Great Britain respectively, the Continental observations as to the value of camphoric acid in night-sweats. It seems to have no disagreeable effects, even when as many as sixty grains are given; but twenty are, as a rule, sufficient. As it is slowly absorbed, it should be given an hour or two before the time at which the sweat usually comes on.—*N. Am. Journ. of Hom.*, November, p. 725.

**Acidum hydrocyanicum.**—Dr. Ironside considers the symptom "liquids gurgle and roll audibly from œsophagus into bowels," hitherto associated with laurocerasus, a capital indication for the active element of that plant—hydrocyanic acid. He relates a case in verification.—*Hom. Physician*, November.

**Aconite.**—In an article on "Aconitum napellus in non-febrile diseases," Dr. Deschere has some valuable remarks on the applications of this drug. He indicates the nervous erethism which calls for it; urges its employment in cardiac affections where its characteristic numbness and tingling in the left fingers are present, in which case it will even relieve the paroxysms of angina pectoris; and praises it in pure nervous palpitation.—*Hahn. Monthly*, November, 1897.

**Antipyrin.**—Dr. Marc Jousset commences, in *L'Art Médical* for November, a collection of cases of poisoning with antipyrin, similar to those with which he has enriched our literature relative to chloral and thyroïdin.

**Antitoxin.**—Yet more statistics. Dr. Knight, of the *Medical Counselor*, some time ago sent out circulars to many homœopathic practitioners in the United States asking for reports upon cases of diphtheria treated by them. The figures furnished him give 1,030 cases, with 76 deaths—a percentage of only 7·8. No antitoxin was employed. In *Pædiatrics* for May a list of 1,972 cases is given, all treated with antitoxin. The death rate was 13·4; and, leaving out the moribund, it was still 10·3. In laryngeal cases antitoxin lost 44·1 per cent., homœopathy 36·3 per cent.—*N. Am. Journ. of Hom.*, August, p. 522.

“One of the strongest arguments against the antitoxin treatment of diphtheria is the attitude of those who are living in the hospitals and watching its results, who formerly were earnest advocates of the treatment, and who, after experience, have from conviction become opposed to it. Dr. W. M. Welch, of the Municipal Hospital of Philadelphia, who has injected over 300 patients, has stated that he would not have antitoxin used on himself if he had diphtheria; that if his children had it he would not allow them to be injected; and that, if left to act independently and from his own conviction, he would never inject another patient. Drs. Warmuth, Tyler, and Bemis, of the same hospital, were believers in antitoxin, and are now opposed to it. Dr. Hardin, of Washington, and Dr. Levy, of Richmond, came to the Willard Parker Hospital thorough believers in antitoxin, and are now equally adverse to it.”—*Homœopathic Physician*, August.

**Apis.**—Dr. Sulzer finds this the best medicine for assuaging the pain of furuncles and carbuncles, and securing a favourable course for them. He gives the 3x or 4x, two drops every two or three hours.—*Hom. Recorder*, September, p. 405.

One of the results of a bee-sting, in a case recorded in the *Homœopathic World* for September, was a short but severe attack of asthma (? dyspnoea). Urticaria was marked on the surface.

**Arbutus andrachne.**—Dr. Cooper contributes to the *Homœopathic World* of November some evidence that the arbutus andrachne has considerable powers (given, he would say, after his method) over arthritis deformans.

**Arnica.**—Dr. Ord has a high opinion of arnica in removing “the painful thromboses which occur in the course of a vein after a phlebitis.” He relates two cases in point. The 1x dil. was given.—*Monthly Hom. Review*, September.

**Arsenicum.**—Dr. C. E. Wheeler reports a case of psoriasis guttata rapidly cured by arsenicum 6; and states that he has done much better in psoriasis generally with this dilution than previously when he used the 3x trit. or Fowler's solution.—*Ibid.*, June.

**Arsenicum iodatum.**—Dr. Kruska, of Eisenach, was called to a woman who had recently had her left breast excised for cancer. He found her almost dying; the wounds from the operation were still suppurating; another tumour was far advanced in the right breast, and the skin of the trunk was studded with nodules. For six months there had been daily vomiting of food. Dr. Kruska first gave ant. tart. 3x, and after three powders the vomiting ceased. Arsenicum iodatum 3 was then substituted, and under this appetite returned and strength increased, till in a few months the patient was able to resume her ordinary life. A year later it is recorded:—"The tumour in the right breast has not increased, but rather diminished; the wounds have healed; the nodules in the skin have largely passed away."—*Hom. Recorder*, September.

**Baryta carbonica.**—Dr. Choudbury, of Calcutta, of whose extensive use of baryta carbonica we have given some instances in the case of malarial fever, writes:—"I have not been able to ascertain its better efficacy in old and in dwarfish subjects, and have not been able to make out its preference for any sex, age, stature or constitution."—*Ibid.*, October.

**Birch-leaves.**—"Dr. Winternitz's attention was called to birch-leaves by a female patient, whose dropsy, due to kidney disease, was cured by them after every other diuretic had been tried in vain. Twenty-four hours after the first dose the secretion of urine becomes very abundant, and continues so as long as the tea is taken. The albumin, epithelial cells, cylinders, &c., become less, and then disappear completely; and it is worthy of note that, though the increase in the urinary secretion is so enormous, no symptoms of irritation (of the renal parenchyma) have been noticed in a single case. Dr. W. recommends an infusion made by macerating three ounces of the leaves in about a pint of water for two hours, to be drunk in three portions during the day. The leaves must be gathered in spring, and dried in cool, airy rooms."—*Amer. Homœopathist*, August.

**Calcarea carbonica.**—Dr. Kiefer, of Nuremberg, urges the importance of giving unhealthy children the full benefit of their great remedy—Hahnemann's "calcarea ostrearum"; and relates several cases in point. It is interesting to notice that he seems to get excellent results from the 6th and 3rd (probably decimal) triturations.—*Hom. Recorder*, November.

**Calcarea fluorica.**—In an article on remedies for backache, in the *Medical Century* of August, Dr. Dewey states that "calcarea fluorica has quite a clinical reputation for curing backache, and especially the backache simulating spinal irritation." In cases apparently calling for rhus, but where this medicine fails us, it will often succeed.

**Calotropis.**—Dr. Edward A. Gramm writes in commendation of this drug in syphilis, where enough mercury has been taken for the present; and also in the early anæmia. He gives from one to five drop doses of the tincture. [Dr. Gramm says that he has "not been able to place his hand on the record" of Mr. Ivatt's proving of calotropis. He will find it in the "Cyclopædia of Drug Pathogenesy," vol. i., p. 683. Ed.]—*Minneapolis Hom. Magazine*, Aug.

**Cantharis.**—Dr. Jousset has been experimenting on rabbits, in the laboratory of the Hospital St. Jacques, with cantharides. From his own observations he concludes:—(1) Cantharides in strong doses produce an acute parenchymatous nephritis, of a special character, the urine being diminished in quantity and sometimes suppressed, while what is passed is of a reddish-black, and is moderately albuminous. (2) The above changes being constant, it is to be added that in one case priapism was observed; and once a sero-sanguinolent liquid was found in the pleura and pericardium. (3) From the doses used the temperature rose; it was only when they were much increased that it fell.—*L'Art Médical*, September:

**Cedron.**—Commenting upon Dr. Hayward's lecture on Tropical Fevers (which has been translated into French), Dr. Frichet, of Algiers, expresses his surprise that no mention is made of cedron among their remedies. His own experience and that of his colleague, Dr. Feuillot, are in entire accord with the reports of Teste<sup>1</sup> regarding, its value in intermittents.—*Revue Hom. Française*, October.

<sup>1</sup> We are glad to see that this venerable physician still lives. A banquet was offered to him by his colleagues on the sixtieth anniversary of his doctorat, and only his advanced age obliged him to decline the honour.—ED.

**China.**—A man of 40 contracted intermittent fever five years before consulting Dr. McNish. He was treated with quinine and other "tonics," but did not get well, and from that time forward was treated for divers "malarial" symptoms, varied at times by attacks of genuine ague. He was of about the colour of an old opium-eater, much emaciated, walking feebly; he had a constant constrictive headache, ringing in ears, temporary loss of sight, loaded tongue, rebellious stomach and constipated bowels; liver was somewhat enlarged and tender, and spleen more so; urine was less than normal and contained some bile. Dr. McNish gave him china in the 1st dilution, and got an aggravation of all the symptoms. Regarding this as a good sign, he changed to the 3rd dilution, and later to the 6th and 30th. "The patient recovered. He had no other remedy. This was four years ago. The patient is now one of the handsomest and healthiest men to be found. All his organs save the spleen seem to be normal. The spleen is somewhat hypertrophied."—*Amer. Homœopathist*, September 15.

A case of acute bullous dermatitis induced by two doses of 15 min. of tinct. cinch. co. is given in the *Homœopathic World* for October.

**Cocaine.**—"Da Costa has found that the local anæsthetic effect obtained with cocaine is more rapid, more intense, and more lasting if the solution is warm. The dangers of intoxication are thus much diminished, as the quantity of cocaine can be very much reduced. A solution of 0·5 or 0·4 per cent., heated, will produce a powerful effect."—*Med. Century*, September, p. 259.

**Damiana.**—This plant has a somewhat dubious repute in sexual troubles, but another use for it seems to have been found. In a series of more than twenty cases of megrim it has caused, after two doses of the 1x given within an hour, cessation of the headache and supervention of sleep.—*Hom. Recorder*, September, p. 410.

**Erysimum.**—An old-school physician is quoted in *L'Art Médical* for October as calling attention to erysimum as a remedy for hoarseness. [He does not say which species of the genus so-named he means. The best-known is the *E. cheiranthoides*, whose name of "worm-seed" suggests a different sphere of activity.—Ed.] Its repute here is such as to give it the name of "herbe aux chantres." In twenty cases of recent laryngeal

catarrh with hoarseness, Dr. Hermary has been surprised by the rapidity of its action. In simple chronic laryngitis, similar results may be obtained by about a fortnight's use of the plant; and a hoarseness due to the removal of a polypus from the larynx has yielded to it.

**Hyoscyamine.**—Dr. Delamater says that hydrobromate of hyoscyamine is a good remedy for controlling the tremor in cases of disseminated sclerosis. He uses the 4x made from Merck's hyoscyamine, and gets results from it which he does not obtain from any other preparations. If too much is used aggravation will follow.—*Med. Century*, August.

The same alkaloid is obtaining much credit in old-school circles for paralysis agitans itself, and in hardly larger doses. A drop of a solution of one grain to the ounce instilled into the eye is found to keep the patient quiet for some hours, and has no disagreeable effects of its own.—*Hahn. Monthly*, August, p. 553.

**Iodoform.**—A case of iodoform poisoning (through the uterus) is recorded, in which the cerebral symptoms became chronic, and ended in general paralysis of the insane, from which the patient died two years and a half later.—*L'Art Médical*, August.

**Iris.**—A fat boy, age 18 months, had for fifteen months an eruption all over the hairy scalp, which is covered with thick, greyish, rather hard crusts, under which the skin is red, shining, and covered with small vesicles or papules. In several spots the growth of the hair is quite destroyed. The ears are raw, and the secretion is so acrid that it irritates the skin; the cheeks are red and scaly; there are some pustules on the back and arms. Iris internally and externally in the form of an ointment made by mixing the fresh roots with butter. This cured the disease.—*Mossa, A. h. Z.*, cxxxv., 120.

**Jaborandi.**—The dry mouth of jaborandi has been set down to the profuse drain of fluid from the system by the skin and other emunctories. In a case of overdosing, however, the whole buccopharyngeal cavity became red and painful, as well as devoid of moisture; and it remained in this painful condition for nearly two months.—*L'Art Médical*, September, p. 233.

**Kali iodatum.**—Colombini and Gerulli find that in syphilitic subjects iodide of potassium causes an increase in the number of red corpuscles and the quantity of hæmoglobin. At the same



time there is a notable and constant augmentation of the body weight. In healthy subjects precisely the opposite series of phenomena occurred. There was constant diminution of hæmoglobin and of red corpuscles, and decrease of body weight.—*Monthly Hom. Review*, September.

**Lachesis.**—The older testimonies to the power of lachesis over gangrene have been reinforced by Dr. Lambrechts *fiis* in the *Journal Belge d'Homœopathie* of July-August. He relates four cases illustrative of its action. In the first the penis was the seat of the mischief (in a case of typhoid); the second was one of *post-mortem* wound; the third of erysipelas of the hands in a pregnant woman; the fourth of stomatitis in a child. The 6th dil. was that employed.

**Magnesia phosphorica.**—A man of 60, nineteen years before coming under Dr. McNish's care, strained his back while digging. The effects soon passed off, and he believed himself well, when he was suddenly seized with a cramp in the lower dorsal and upper lumbar region, which twisted him round until he "faced to the rear." The spasm, which was very painful, was repeated several times. After an interval of some weeks he had another attack, and from that time forward they had increased in frequency, until he had one or more daily. Electric massage, continued for four years, had increased the intervals to a week or two, but the attacks had not diminished in intensity.

Magn. phos., 6x trit., was given four times daily for a month; and for eighteen months thereafter, when the report was made, they had not recurred.—*Amer. Homœopathist*, October 15.

**Myrica.**—Mr. Frederick Kopp begins in the *Homœopathic World* for September an account of a proving of myrica, in which ten minims of the mother tincture were taken every hour for a fortnight. Decided symptoms of jaundice were induced.

**Naphthalin.**—Dr. Louis Hartman communicates his experience with this drug to the *North American Journal of Homœopathy* for October. In asthma he finds it to relieve promptly when paroxysms of coughing follow each other in such rapid succession that the patient is unable to get his breath. In whooping-cough he esteems it the best remedy, and finds drosera (when required) to act much better after it than before. For the cough of phthisis, and to some extent for the associated diarrhoea and night-sweats, he esteems it highly. He gives the 1st trit.

**Oils.**—In the *Hahnemannian Monthly* for August, Dr. E. M. Hale has a paper on “The Medicinal and Therapeutic Effects of the Vegetable Oils.” It contains nothing new, but its wide range and its method of classification make it very instructive, and it should be noted for study.

**Oleander.**—Dr. Goullon has brought to light a fresh observation as to the effects of oleander, the nightly exhalation from the leaves alone seeming capable of inducing morbid symptoms. A young man suffered from vertigo and muscular weakness, and from a headache, diminishing every evening but returning the following morning on waking. Therewith was pallor, white tongue, and slow pulse. The cause was found in some oleanders (not in bloom) which stood in his bedroom. His physician remembered a similar experience of his own when a student—heavy head on waking, great weariness before rising, and a vertigo on doing so, being his symptoms.—*Hom. Recorder*, Sept.

**Phellandrium.**—Reviving an ancient usage, Dr. Gandy propounds the value of the water-hemlock in chronic pulmonary affections, and relates two cases in point, with promise of more to follow.—*Journ. Belge d'Homœopathie*, July-August.<sup>1</sup>

The promise is redeemed in the number for September-October, and Dr. Gandy's whole experience with the drug is worthy of attention.

**Phosphorus.**—In an interesting article on “The Elective Affinity of Drugs,” Dr. Deschere gives an account of the old-school use of phosphorus in rachitis, and claims it for homœopathy. [Stating Kassowitz's dose as half a milligramme, Dr. Deschere writes: “This is conformed to our third decimal trituration.” Should it not be “second decimal,”— $\frac{1}{2}$  milligr. = gr.  $\frac{1}{130}$ ?—ED.]—*N. Amer. Journ. of Hom.*, November.

Dr. Chakravarti, of Serampur, in India, communicates a case which he calls “cirrhosis of the liver,” and which, indeed, had the ascites and other symptoms of that disease, but in which the organ was only slightly if at all contracted. Phosphorus 6 to 30 effected a speedy cure.—*Ibid.*

Aufrecht maintains that cirrhosis of the liver is the result, not of interstitial inflammation, but of that process in the glandular cells of the acini (peripheral portion), and that the cirrhosis of slow phosphorus poisoning is of identical pathology.—*Monthly Hom. Review*, October.

<sup>1</sup> See also *L'Homœopathie Militante*, ii., 384.

**Polymnia uvedalia.**—This plant, indigenous to North America, the “bears'-foot” or “leaf-cup” of popular nomenclature, is a domestic remedy for the “ague-cake” of malarious regions. Dr. Boger has proved it (his results are given, he says, in the *Proceedings of the International Homœopathic Association* for 1897), and finds it to act specially on the spleen, sciatic nerve, and rectum. It has an evening aggravation, and the patient prefers the cool air, while the symptoms of ceanothus are worse from cold. The splenic pains almost invariably ascend the back to the scapulæ, neck, or even the head. It seems to prefer the left side. Guided by these indications, Dr. Boger reports much success from the remedy, which he seems to give in the 2x dil.—*Medical Era*, October.

**Ptelea.**—This extensively proved drug has found little therapeutic employment as yet, but Dr. H. K. Leonard reports to the *North American Journal of Homœopathy* for November a case of chronic enlargement of the liver, with emaciation, sallow pallor, and other symptoms of impaired health, where three doses of the mother tincture daily effected a marvellous change.

**Pulsatilla.**—Dr. B. G. Clarke calls attention to the frequency with which pulsatilla is indicated where rhus is given preference, specifying the back-ache of diphtheria, influenza, and other febrile toxæmiæ. He also relates two cases of glandular enlargement subsiding under its use.—*Amer. Homœopathist*, August 1.

**Quinine.**—The controversy about quinine in ague, raised by Dr. Allison Clokey,<sup>1</sup> continues to rage. In the October number of the *North American Journal of Homœopathy*, Dr. Bliem, of Texas, writes in support of him. *Apropos* of its homœopathicity, he cites an old-school physician as acknowledging that he had repeatedly seen typical chills and fever resulting from overdosage with it, and says that he himself had a similar experience. As regards dosage, he quotes Osler's statement that in many cases grain doses three times a day will prevent the paroxysms, which does not look like germicidal action.

**Rhus.**—In his “Revision of the Materia Medica,” Dr. Jousset in *L'Art Médical* for October handles rhus. He is unable to recognise any distinction between the “toxicodendron” and the “radicans” species; and he considers that neither the patho-

<sup>1</sup> See vol. v., p. 290.

genesis of the drug nor its clinical action warrants its being ranked as an anti-typhoid. His article has an additional interest in that it shows how large has been the use of rhus in the old school—chiefly in paralysis, in cutaneous eruptions, and in strumous ophthalmia.

**Scopolamine.**—This mydriatic, which has been widely used in place of atropine, appears capable of inducing similar disagreeable effects. Two girls of ten had a 1·5 per cent. solution instilled into the eye. In fifteen minutes the faces became flushed, and in the case of the one who had had the drug twice applied the lips, cheeks and chin became slightly cyanotic. The children lost control of their limbs, and could not stand alone; the pupils became widely dilated, the lips dry and cracked, pulse 150. Acute mania set in, with visual hallucinations; they jumped, laughed, cried, and babbled inarticulately. The acme of the intoxication was reached in two and a half hours, when the flushing and cyanosis began to decrease.—*Hahn. Monthly*, November.

**Sentellaria.**—Dr. Royal has given us a study of this little used medicine which should bring it into larger play. It is of course a “nervine,” but may often do good work in nervous conditions where ignatia, stramonium, &c., will effect nothing. In the only case he relates, he gave the drug in ten-drop doses of the tincture.—*Amer. Homœopathist*, September 1.

**Senecio.**—Dr. Talcott relates a case of puerperal mania admitted to the Middletown Asylum. It had lasted three months without improvement, when, as the lochia had subsided suddenly, and the catamenia had not returned since child-birth, senecio 3x was given on September 15th. In less than three days improvement set in and progressed; in October she menstruated, and by the 20th of that month was free from delusions and well-balanced in mind. A later relapse yielded, after only partial improvement under belladonna, to the same remedy.—*N. Am. Journ. of Hom.*

Dr. Fothergill considers senecio a trustworthy emmenagogue. Even in healthy women (as regards this function), he finds its use anticipate (and shorten) the period—an effect sometimes much to be desired when an operation on the pelvic organs is necessary.—*Hom. Recorder*, November.

**Strophantus.**—Some provings of this plant were reported at last year's meeting of the Homœopathic Central Verein, and the results obtained are summarised by Dr. Mossa in the *Homœopathic Recorder* for November.

**Thyroidin.**—The dependence of Graves' disease on over-activity of the thyroid has never been better illustrated than in a case cited in the *Homœopathic Recorder* of October. It was one of catalepsy, of three years' standing, which was treated with increasing doses of thyroid extract till 75 grains a day was reached. Symptoms of exophthalmic goitre (minus the thyroid enlargement) then set in, and obliged the discontinuance of the remedy. After a few days the catalepsy returned, and the treatment was again taken up with the same results—disappearance of the cataleptic symptoms, but re-appearance of those of exophthalmic goitre.

**Tuberculinum.**—Dr. Jousset, getting no results (in animals) from the use of any of the tuberculins now employed, has tested a pure culture of the tubercle bacillus, made on potatoes, raising it by trituration first to the third then to the ninth potency. The former showed no power of retarding death in tuberculised guinea-pigs, and seemed rather to increase their fever. Much better results have followed the use of the ninth trit., and two cases seem actually recovering under its action.—*L'Art Médical*, November.

**Veratrum viride.**—Dr. Cartier communicates to *L'Art Médical* for November an original article on veratrum viride. Confirming the opinion of those who regard it as especially suitable in puerperal fever and inflammation, he points to marked oscillations of temperature as the indication for it here and elsewhere.

**Vinegar.**—Dr. Elias C. Price writes:—"Immediately after the removal of the placenta, give the patient a teaspoonful of good cider vinegar in about two ounces of water. It will produce a cannon-ball-like contraction of the uterus, in from one to two minutes after it reaches the stomach." He recommends the same remedy, in repeated doses, for after-pains.—*Hom. Journal of Obstetrics, &c.*, November.

**Vipera.**—Dr. Jousset relates in great detail a difficult case of cardiac dropsy, in which twice, after all other remedies had failed, vipera was effectual in setting up diuresis and producing general relief. He was led to this snake-poison by observations of M. Calmette, at the Pasteur Institute, which showed the poison of the viper to have a special action on the kidneys and to induce hæmaturia. He gave the second and third trits. by subcutaneous injection.—*L'Art Médical*, August.

**THERAPEUTICS.**

**Arteries, Disease of.**—Dr. Arnulphy gives an interesting lecture in *The Clinique* for August on “chronic aortitis, atheroma, and arterio-sclerosis.” He esteems plumbum, in high dilution, as very helpful in checking the progress of atheroma, with oxalic acid to combat the painful sensations incident to it. In arterio-sclerosis he thinks strontium iodatum preferable.

**Chlorosis.**—Dr. Van den Berghe has the highest opinion of bryonia in this condition. He relates a case where nourishing diet and ferruginous medication had accomplished nothing, while bryonia 30 and more moderate nourishment cured in a fortnight, though the malady had lasted for months. In stout subjects he finds calcarea a useful ally.—*Journ. Belge d'Homœopathie*, July-August.

**Chorea.**—Dr. Halbert reports, in the *Clinique* of September, three interesting cases of chorea. The first occurred in a man of 27, from strain of the nervous system, and affected chiefly the abdominal muscles. Agaricus, and then its alkaloid, agaricine, effected a gradual but definitive cure. The former was given in the 3x, the latter in the 1x dil. In the second case, after treatment directed to improvement of general health, actæa, in various potencies (there being a rheumatic history), was prescribed with curative effect. The patient was a girl of 15. The third, a boy of 14, had a neurasthenic inheritance, and some disorder of sensibility. He was cured with tarantula, given in the 3x potency, in which Dr. Halbert esteems it most effective.

**Diphtheria.**—Dr. George K. Peck summarises a number of reports received from homœopathic practitioners, as to their treatment of this disease. He concludes with three sets of results from epidemics. In the first 23 cases occurred (three requiring intubation), with but one death. In the second, 40 cases, and in the third 36, were all brought to a successful termination. This was without antitoxin.—*Hahn. Monthly*, November.

**Gastralgia.**—A married woman, aged 66, looking very ill and much emaciated. She had formerly suffered frequently from pains in the stomach, but the last nine months the pain has been constant, in the pit of the stomach, burning and shooting, ameliorated immediately after eating. She has much empty eructation, is very thirsty, and after rising in the morning has headache, which is relieved by cold compresses. Bowels formerly generally loose, now normal. On the legs, especially the left knee and posterior surface of the right thigh, and on the top

of the head, red scabby spots. The painful part of the stomach very sensitive to pressure. The head of the pancreas was somewhat enlarged. As she had formerly had frequent cutaneous eruptions, which had generally been removed by sulphur ointment and sulphur soap, I gave her arsenicum 30. After fourteen days she reported that the stomach pains were better and her appetite improved. The red spots had cast off their scales and were now become ulcers, which were very painful at night. I now gave mercurius, under which the ulcers dried up, but for the next three weeks she had increasing discomfort in the bowels. I now gave antim. crud. 30, twice a day. Three weeks after this she had no more stomach pains, and a feeling of emptiness in the stomach which she had often felt was gone. No new spots had appeared except on the knee. The vesicles with a red basis which had appeared were very small, but they were very sensitive, and the burning pain was considerable. On the forehead at the border of the hair there were some red stripes which exuded. I continued the antim. crud., and according to the reports furnished to me on the 75th and 100th days after commencement of this treatment she was much better than she had been during the last years. No more eruption, only a few scabs on the scalp. There appeared a greasy secretion deep in the navel. I now gave sulphur, a dose twice a week, and this completed the cure.—*Archiv. f. Hom.*, vi., p. 207.

**Gonorrhœa.**—In a valuable article on this disease in the *Medical Century* for October, Dr. Fisher narrates an instructive case. “A medical friend had gonorrhœa in early life. It ran the usual course, subsiding under constitutional treatment in due season, and for years there seemed not to be any effects traceable to it. Finally, locomotor ataxia symptoms began to show themselves. I suspected that the old gonorrhœa might, perhaps, be responsible. Acting upon this hypothesis, I prescribed a few doses of thuja, and after two weeks of treatment there began to be evidences of urethral moisture, and within a week more he was showing a plentiful discharge of thick creamy pus. With the appearance of this his nervous symptoms began to improve, and in the course of a few weeks he was apparently well, neurologically speaking, but was draining like a sugar tree. Any sudden suppression of the urethral discharge would be followed by increase of nervous symptoms, while, on the contrary, he felt well physically and nervously so long as the flow continued. For more than six months this lasted, the patient improving steadily, until finally, under thuja, sulphur, and psorinum, administered

almost if not altogether empirically, though always in higher attenuation, the discharge gradually subsided, the patient remaining well."

**Hydrophobia (?)**.—Three cases are related in the *American Homœopathist* of June 15 in which acute nervous symptoms supervened upon the bite of a dog or cat. These were controlled by gelsemium and veratrum viride, fractional doses of the mother tincture every half-hour alternately; and with the aid of other remedies later on good convalescence ensued. [The reporter asks, "Were these cases hydrophobic"? As the symptoms occurred, in the first case three years, in the two others nine days, after the bite, we should answer in the negative. They were sufficiently serious, however, and the action of the medicines was everything that could be desired.—ED.]

**Leucorrhœa**.—Dr. Wilson Smith reports a case of leucorrhœa of two years' standing, which, after divers treatments had been tried in vain, was cured by five powders of borax—strength not specified. Examination had found a red inflamed vaginal mucous membrane, partly covered with a secretion resembling the white of an egg. She said that it made her sore, and that she was worse just before and after the menstrual flux. It was accompanied with a sensation as of a hot fluid running down the thighs; and she complained of a sticking pain in the clitoris at night. The latter was the "guiding symptom" for borax—why, is not said.—*Med. Century*, October.

**Locomotor ataxy**.—Dr. Delamater reports a case apparently of this disease, of two years' standing, with a probable syphilitic history, in which under a course of merc. corr. 3x, with one fortnight of secale 1x, a complete cure was effected in six months.—*Medical Era*, October.

**Menière's disease**.—Dr. Gilles de la Tourette considers that the treatment of labyrinthine vertigo is summed up in the judicious use either of quinine or of salicylate of soda. He prefers the former in most cases, and thinks it must be given in doses sufficient to excite a marked aggravation. "The results are marvellous." (Nothing is said about the obvious homœopathicity of such treatment.<sup>1</sup>—ED.)—*L'Art Médical*, September, p. 223.

**Nephritis**.—Dr. Ella Tuttle relates a case in which nephritis, only discovered a few days before labour, persisted after it. Be-

<sup>1</sup> The same number of *L'Art Médical* contains old-school observations as to the value of cantharides in nephritis and of Dover's powder in the sweats of phthisis.



sides the usual symptoms, amblyopia was present to a high degree. Phosphorus 4 was given with gratifying results. "In twenty-four hours the eyesight began to improve (though she complained of a red halo round the lamp), the headache had disappeared, and the albumen had sensibly diminished. From this time the case went on to an uneventful recovery."—*Hom. Physician*, October.

**Nightmare.**—Dr. Van den Neucker relates a case of nightmare of fifteen years standing in a nun. Tracing the affliction to her meagre diet, he put her on china (30th), and the attacks ceased at once.—*Journ. Belge d'Homœopathie*, July, August.

**Prolapsus ani.**—Dr. Schmey, having observed that children affected with prolapse of the rectum generally showed signs of rickets, was led to treat them with small doses of phosphorus, and has in all cases obtained therefrom a definitive cure.—*L'Art Medical*, September, p. 230.

**Pyelitis.**—Dr. Wilson Peterson relates a case in which suppurative nephritis yielded completely to the use of peroxide of hydrogen—albumen, pus and blood having disappeared at the end of three weeks, and the patient considering herself a "well woman." Marchand's "glycozone" seems to have acted as well as the usual solution of the peroxide.—*N. Amer. Journ of Hom.*, September.

**Raynaud's Disease.**—Dr. Halbert, in a full article on Raynaud's disease, relates a case in which, though at first amputation of fingers and toes seemed inevitable, cure set in and progressed under the steady administration of ferrum phosphoricum, 6x trit.—*The Clinique*, November.

**Tinnitus Aurium.**—A man, aged 32, complained that he could not work because his head was so confused by perpetual noises in his ears that he did not know what to do. The noise was like a waterfall, continuous and very tiresome. He was very sensitive to any change of weather, easily caught cold, and speaking fatigued him greatly. I gave graphites 30 every other day. Three weeks later he reported that for a fortnight his hearing had improved, the noises considerably less, but having taken a chill he had an aggravation. He observed that the coryza which used to occur every morning no longer troubled him, and that he was now not affected by trifling changes of temperature. I directed him to take the medicine every fourth day, and after two months he reported that his hearing was now quite good and the noises in the ear gone.—*Archiv. f. Hom.*, vi., 208.

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THE SURGICAL TREATMENT OF DIPHTHERIA,  
WITH SPECIAL REFERENCE TO THE  
METHODS AND ANATOMICAL RELATIONS  
OF TRACHEOTOMY.<sup>1</sup>

BY E. B. ROCHE, M.R.C.S., L.R.C.P.

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It was a surprise to me to find myself called upon to read a paper on "*Tracheotomy*" on this occasion, as my desire had been rather to discuss the *site* of operation than to deal with the general question. Moreover, I feel that there are others so much more competent, by knowledge and experience, to lay this subject before you, that I must ask your consideration while I occupy the fifteen minutes allotted to me as profitably as I can.

More than twenty-five years ago I read a paper before the Medical Society of King's College on this subject, and

<sup>1</sup> Presented to the Section of Surgery and Gynæcology, Dec. 2, 1897.

the chief point which occupied attention then was the question of "high" and "low" operation. In those days there were staunch adherents of each, and it was constantly discussed; but after so long a time, finding that this question still claimed attention, I proposed again to take the matter up.

In a few sentences let us recall the anatomy of the area involved. Beneath the skin on either side of the median line are the anterior jugular veins. Their size and exact position vary; at the lower part they diverge and are frequently connected by a transverse communicating branch. Next comes the cervical fascia enclosing the muscles, extending from above downwards in front of the trachea. Beneath these the isthmus of the thyroid crosses the second, third, and fourth rings of the trachea. Eight rings are usually seen above the sternal notch. Above the isthmus a transverse branch between the superior thyroid veins is found. Over the isthmus is a venous plexus, from which the inferior thyroid veins arise, while below the isthmus these veins lie in front of the trachea, with the thyroidea ima artery, if it exists. The inferior thyroid veins may be in single trunks, or form a plexus. The thymus gland extends upward in *young* children to a variable distance, and the innominate artery and vein cross the trachea about the seventh and eighth rings, or even higher in some cases. The isthmus of the thyroid is the crux of the question of "high" and "low," the tube being placed in the trachea above or below that structure. Above, the first two rings of the trachea give little room, and bring the tube very close to the larynx. Below the isthmus the dissection has to be carried much more deeply to reach the fifth and sixth rings. In *young children* the depth of the trachea below, the short fat neck, the presence of the thymus, specially *contraindicate* a low incision, while above, the high crossing of the isthmus necessitates the division of the cricoid, and still closer approach to the larynx.

In former days it was considered that to cut the isthmus was dangerous, while above it and below it an insufficient area presented itself. Accepting the importance of the

isthmus, and the danger of serious bleeding, observing also the transverse vein above and the plexus below, the possible presence of the thyroidea ima, and the great desirability of a larger and clearer area for opening the trachea, namely, the third, fourth and fifth rings, I proposed to avoid the contest as to "high" and "low," and secure the best area in the following manner:—An incision of  $1\frac{1}{2}$  to 2 inches being made from the cricoid downwards, the fascia divided, the muscles separated, and the isthmus reached, an aneurism needle threaded with a silk ligature is insinuated beneath it from above, and carried on for half to three-quarters of an inch along the surface of the trachea, the point then brought forward, and the ligature divided, each ligature slightly drawn to its respective side and firmly tied. The band of tissue between the ligatures is then divided by scissors, and the lobes of the thyroid and the vessels connected with each slightly drawn to each side, leaving the second, third, fourth, and fifth rings clear. The ends of the ligatures are laid on each side for the time being. The rings most to be desired are now in view, and there is no necessity to approach the larynx too closely, or divide the cricoid, or to work in a dangerous and difficult spot below.

To keep exactly in the middle line is the guiding rule of tracheotomy, and when the trachea is bared this holds good in the highest degree. The trachea must be incised in *the middle line*, and the incision must be exactly *vertical*, and sufficiently free.

On this depends the prompt insertion of the tube, and its comfortable fitting afterwards. If the incision be to one side or diagonal, the tube cannot be properly located, and there is sure to be trouble, while if the incision be too small the operation is gravely complicated. The trachea is divided by the scalpel from below upwards. Entering with a puncture so as to carry the point into the calibre of the trachea, through the mucous membrane, and any exudative layer (if such there be), the rings are sufficiently divided. If the *handle* of the scalpel be instantly made to follow the incision of the *blade*, and then turned on its own axis, and pushed upwards, the trachea is at once fixed, the incision

opened in triangular form, and the handle forms an infallible director along which the tube is carried into the trachea. The importance of thus clearing the surface of the trachea, and *seeing* the rings, is emphasised when from our own experience or that of others we recall incisions misplaced even to the extent of missing the trachea altogether, wounding the œsophagus or carotid artery, or even placing incisions on the surface of the vertebræ. In performing this operation it is very important to have the patient on a table sufficiently high, as otherwise the operator will find himself greatly hindered. The patient should be well wrapped round so as to control the arms; and in most cases an anæsthetic is to be used, the neck made prominent by a supporting roll, the head thrown back, the line of the body well preserved and the middle line well defined.

The cricoid cartilage is the guide and starting point. As a matter of fact the thyroid isthmus does not bleed so very much if incised in the middle line, and if the fascia is properly divided it can be pushed down a good deal, but to obviate all risks from it or any related vessels, and to free the trachea to a comfortable extent so that eye and finger can carefully locate the incision to the greatest advantage, I proposed and still advise the use of the ligature. If owing to the congestion of parts caused by difficulty of breathing there is any considerable amount of oozing hæmorrhage it is best checked by at once making the tracheal incision, and the insertion of the tube. The use of the tracheal hook I have not found necessary, the scalpel handle, used as described, fixing and raising the trachea and ensuring the placing of the tube. The triangular opening of the tracheal slit gives free passage to the air at once and allows the expulsion of mucus or membrane prior to the placing of the tube. No tracheal hook, dilator, or pilot, is needed, and thus three special instruments are eliminated. Retractors are in most cases unnecessary, and where the work is single-handed impossible. The end of one of the ligatures passed behind the neck and gently tied to that of the opposite side may be helpful in this case to keep the lips of the wound open. The absolute certainty of the tube being placed in

the trachea is a most important matter, as it is common knowledge that the tube has again and again been pushed down in front of the trachea, where a low operation, a scanty tracheal incision, and the absence of a certain guide contributed to this most mortifying conclusion.

Comfortable fitting of the tube, and the tube so shaped that the lower end shall not press against the tracheal wall, either anteriorly or posteriorly, are of vital importance. Ingenuity has found expression in the bivalve of Fuller, the angular tube of Parker, and the fish-tail of Durham, which are the principal types of an extended and minutely varying armamentarium. Ulceration into the œsophagus and innominate artery are recorded results of ill-devised or ill-adjusted tubes.

The after treatment is all important. The tube, which should be ready provided with tapes, should be at once tied in; a little shield of protective overlaid with gauze should be slipped under the collar of the tube, a dust of boracic acid being useful as these are replaced from time to time. A piece of gauze laid over the mouth of the tube will protect it, and intercept coughed-up mucus. The importance of good nursing and management of the tube cannot be overstated, being more than half the battle. It may be necessary to clear the tube every hour at first. For cleansing the tube, as well as for spraying in case of dryness, a solution of bicarbonate of soda gr. x. ad  $\zeta$ i. is very useful. Sudden obstruction of the tube is more often due to inspissated mucus, and the use of the alkaline spray helps very much to mitigate this. If there is evident obstruction in the trachea, feathers moistened with the soda solution may be passed through the tube, and twisted round to free it. There should, however, be no needless meddling. Generally, with good management and care, the little patient can swallow nourishment. If, however, as is sometimes the case after this operation, food cannot be taken, owing to its invasion of the larynx, it will be necessary to pass a small indiarubber tube, or flexible silk catheter, through the nostril, into the œsophagus, and administer liquid nourishment through it. Be sure the tube is in the œsophagus. The tracheotomy

tube should be got rid of as soon as possible, as the longer it is in place the more difficult, or even impossible, it may be to dispense with it. Where there is need for delay an india-rubber tube of reliable make may be substituted for the metal one with advantage, and this can be curtailed from time to time till little more than the shield is left. The act of breathing through the larynx having fallen into abeyance, this is the most frequent cause of difficulty, but there may be granulations, contractions, or adhesions, which will have to be dealt with from the tracheal opening before the removal of the tube can be accomplished. MacEwan's & Stœrk's tubes may be helpful in these difficult cases, and much patience and ingenuity are required to meet the spasm, fear, and temper which are all elements in the difficulty experienced in getting rid of the tube.

The success of tracheotomy depends very much on the point in the case at which the operation is performed. If it be looked upon as a last resort, and the condition of the patient is very serious before it is proposed, few recoveries can be expected. The first distinct symptom of extension to the larynx, though the constitutional symptoms may be slight, should determine the time and need for tracheotomy. The operation is required to obviate the conditions of spasm and obstruction of the larynx, and not in any sense to cure the disease. Its use is to preserve the patient from asphyxia and death, and thus secure time, in which treatment and the course of the disease may work out a successful issue. The new treatment by antitoxin serum is on its proof and trial, and if used early, and acting with the success claimed by many, will doubtless reduce largely the need for operation. In cases, however, in which the disease has made some progress, with early laryngeal symptoms, the operation is called for, while the treatment of the disease is continued either by the serum or ordinary and various medicinal agents. In any case where the patient is not manifestly moribund by reason of the lethal constitutional effects, and where the laryngeal obstruction is prominent, it is merciful to give the patient relief if possible from the painful death by strangulation, and save the friends from witnessing so

distressing a termination. It must always be remembered, too, that to gain time, with possibility of treatment, and mitigation of symptoms, is our duty, and therefore not to be neglected, through taking a hopeless or gloomy view of the patient's condition. The case of an experienced surgeon who, being called into the country to perform tracheotomy, declined to operate because the case was hopeless, and yet the child recovered, should remind us that none of us are infallible, and that while there is life there is hope.

There are many other points of practical interest, and matters of detail, connected with the operation and after treatment, which as matters of opinion would afford material for discussion, did time permit. The points which I personally wish in closing to emphasise are, that an effort should be made to simplify the operation in every way as regards instruments, and the necessity for assistance; and that, abandoning all question of an operation, "high" or "low," we should free ourselves of this needless and embarrassing limitation, and so act as shall enable us safely to place our incision and insert our tube at the point we may judge to be the best.

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## THE SERUM TREATMENT OF DIPHTHERIA.<sup>1</sup>

BY J. ROBERSON DAY, M.D.

*Physician for Diseases of Children to the London Homœopathic Hospital.*

At the present day, when serum-therapy has been so largely occupying the mind of the medical profession, an evening which has been devoted to the consideration of Diphtheria in all its aspects would be incomplete without some reference to the antitoxin serum treatment—as well might we witness the play of "Hamlet" with the Prince of Denmark left out!

<sup>1</sup> Presented to the Section of Surgery and Gynæcology, Dec. 2, 1897.



The honour of contributing to this portion of the subject has fallen to my lot, and I shall endeavour briefly to describe the use of serum in treating diphtheria.

With Mr. Johnstone's exhaustive paper fresh in our memories, it is needless for me to allude in any way to the methods and various steps which are now employed in the preparation of the serum. I refer you for this to the November number of the *Monthly Homœopathic Review*, where the whole subject is clearly set forth. Nor is it necessary to speculate on the nature of the serum or its mode of action: this was discussed at the meeting of the Congress at Clifton.

I shall confine myself to the therapeutic application of the serum, illustrating my remarks from cases under my own observation, and then bring before you statistics based on our own hospital cases; and secondly, statistics compiled from allopathic sources.

CASE I.—My first case occurred in February, 1896. M. W., girl aged 6½, was perfectly well on the morning of February 8, 1896; at 7 p.m. the same day she complained of sore throat, and the temperature was taken and found normal. She passed a very restless night, with frequent empty retching. Next day, February 9, I found temperature 104° F., both tonsils enlarged and covered with patches of exudation, and also some patches on the pharynx. The glands at the angle of the jaw were enlarged and tender. Scarlatina was suspected but no rash was found on the chest. I gave belladonna 3 and aconite 3x alternate hours. Quoting from my notes made at the time, I read:—

*February 10.*—Very delirious last night, but better this morning, and temperature 102·6°, pulse 132. The cervical glands on the left side much enlarged and tender; tonsils swollen and covered with exudation membrane, like acute tonsillitis. There was no rash on the body anywhere. She was feeling better and taking nourishment well. At 10 p.m., temperature was 99·6°, with delirium at times and fœtid breath. Tonsils covered with a suspiciously diphtheritic membrane; glands on the left side very much swollen and tender. Medicine changed to mercurius bin-iod. 3x gr. i. every two hours, also a gargle of weak permanganate of potash, and hot fomentations and a steam kettle ordered. Diet: milk and Vichy water only.

*February 11.*—Passed a restless night, but was less delirious,

and is brighter and has taken more nourishment. To-day is quite rational. Throat is now covered with membrane on both tonsils, which meet. This was the third day of the disease. At 1 p.m. I injected 14 c.cm. of antitoxin serum into the loin, but continued the merc. bin. 3x, and also sprayed the throat with peroxide of hydrogen. Diet: in addition to milk and Vichy water, Valentine's meat juice ʒj. ter die, and brandy ʒj. in twenty-four hours, as the pulse was weak and 126. At 8 p.m. the throat was examined and a piece of membrane stripped off (which caused free bleeding) and sent to be examined.

I may here say that all my cases have been submitted to the bacteriological test, which in doubtful cases has proved of greatest value.

There was to-day a thin offensive discharge from the nose, showing the membrane had extended into the posterior nares.

*February 12.*—Decidedly better—slept at one time one and a-half hours' quiet sleep. Is brighter, and had no delirium last night. Throat less red, glands less swollen. Nose still discharging, foetor less. 10 c.cm. again injected, merc. bin. 3x continued. At 5.30 p.m., swallows more easily, membrane not extending; urine, opalescent with albumen on boiling.

*February 13.*—Passed better night, some good sleep; temperature normal; membrane looks to be detaching itself, and at 6 p.m. was clearing from the throat. Asked for and ate some bread and butter.

*February 14.*—Very much better this evening. Coughed up a large piece of membrane.

*February 15.*—Improvement continues. Breathes through the nose. No membrane can be seen in the throat. A measly rash appeared about the elbows and buttocks. Progress now continued steady, and on February 19, china 1x was substituted for biniodide of mercury.

*February 24.*—A slight nasal twang was noticed in her voice; this continued, but the paralysis never caused regurgitation of fluids through the nose.

*March 6.*—Had slight sudden pallor, and again on March 9, when the knee-jerks were found absent.

*March 10.*—Heart's beat irregular, and strychn. phosph.  $\frac{1}{300}$ , ℥iii. ter die, was substituted for the china.

*March 16.*—Eyesight noticed defective, and on March 20 there was marked strabismus from paralysis of right external rectus, with diplopia; all things looked double. Shortly after she left for Exmoor, and on her return the squint had disappeared, but

the knee-jerks were still absent. This, I have before observed, is a most persistent symptom.

I have given the notes of this case at some length because it was my first case treated with serum, and the type was severe, paralytic sequelæ were marked and varied, and, what was most satisfactory, complete recovery followed.

CASE II.—My second case was also one of severe type, in a lady aged 58, and but for the serum I believe she would have lost her life. I saw her first on July 2, 1896. She had been ailing some days, and two days before I saw her felt the throat sore. The temperature was normal, but had been 101°. Has had headache and no sleep. The right tonsil was found enlarged, inflamed, and ulcerated. The lymphatic glands were enlarged. I gave *mercurius bin-iod.* 3x and *belladonna* 3 in alternation.

*July 3.*—Throat less swollen, and temperature normal, pulse 98. Tonsils meet, and the inner side of each and the uvula are covered with exudation.

*July 4.*—Had no sleep last night, and membrane now has assumed the typical appearance of diphtheria. Swallowing very painful; speaks with difficulty. Ten c.cm. of serum injected, and medicines continued as before, and in addition a spray of peroxide of hydrogen. At 9.30 p.m. the membrane had extended forwards to the soft palate. A further injection of 10 c.cm. of serum was given.

*July 5.*—Next day, patient decidedly better, slept more than three hours; swallows with less pain, and voice has somewhat returned. The membrane has not extended, and appears to be detaching itself, portions of it have been coughed up.

*July 6.*—Slept four hours last night. Decidedly better.

*July 9.*—Much better. Membrane clearing away; only slight streaks can be seen on the uvula and tonsils.

*July 10.*—Slept ten hours; better in every way; still aphonic, and fluids regurgitate through the nose at times. Paralysis of the legs followed; convalescence was hastened by change of air; ultimately the recovery was complete, and in every way satisfactory. This case gave great anxiety, from the evident extension of the membrane down into the larynx and trachea, and at one time it seemed that tracheotomy would become necessary.

These two successful cases convinced me of the undoubted value of the serum, and I determined to use it earlier in my next case.

CASE III.—Teddie B., aged 7, on July 30, 1896, had a temperature  $103.2^{\circ}$ , and there were two typical patches of diphtheritic membrane on the tonsils, and his breath was foetid. Within an hour I injected 8 c.cm. of antitoxin serum, giving still the biniodide of mercury. The day before he first complained of his throat, so that the injection was given on the second day of the disease.

July 31.—Membrane on each tonsil disappearing; only little spots were left on the side of the patches, which were so marked the day before. At 8.30 p.m. all traces of the membrane had disappeared.

August 1.—Pharynx normal, and seems quite well! *Cured in two days.*

CASE IV.—The last case which I intend to quote is very similar, only the patient, a little girl aged 4, was a very delicate child, the victim of enlarged tonsils and post-nasal adenoids, and just such a case which would have done badly under the influence of diphtheria. I was fortunate in seeing this case also on the second day of the disease, November 18, 1896. The temperature was  $100.6^{\circ}$ , and there were patches of membrane on each tonsil. At 6 p.m. I injected 10 c.cm. of serum. Next day, Nov. 19, the membrane had almost gone, and on Nov. 20 completely gone, and the child taking food well. Thus both these cases were *cured in two days!*

Thus far I have only selected cases from my private practice. Let us now turn our attention to the use of the serum in the London Homœopathic Hospital.

The homœopathic treatment of diphtheria having always been so much more successful than the treatment of the old school, it was only natural that the physicians of this hospital should be somewhat loth to relinquish a tried and proved method of treatment for something which was new and untried. And hence it was that the serum treatment was not used in this hospital until *November 22, 1896*, when I sent in Ellen Wheeler, aged 21, under Dr. Moir's care, having the previous day seen her and injected the antitoxin serum. It was a remarkable case, the membrane being in the larynx and trachea, and the fauces entirely free. At a meeting of this Society, some of you may remember I showed some portions of this membrane which the patient coughed up.

When I first saw her she was in a most critical state, cyanosed, and coughing up long pieces of membrane, which to the naked eye resembled portions of tape-worm, at the imminent risk of suffocation. Improvement began with the use of the serum, and recovery was complete.

From this time the serum has been used in the hospital, although not entirely; and the following facts supplied by Dr. Hervey Bodman, who was house physician at the time, enable us to compare the results of treatment with serum and with homœopathic medication only.

During the year October, 1896, to October, 1897, thirty cases were treated in this Hospital, with three deaths. Of these thirty, seventeen had antitoxin, and only one died, a mortality of 5·8 per cent.; and thirteen had no antitoxin, and two died, a mortality of 15·3 per cent. If we now turn to the statistics of the old school the results are even more striking. The most valuable paper on the subject has recently been published in the *British Medical Journal* (for October 23), by Mr. Charles Clubbe, who has charge of the diphtheria branch of the Sydney Children's Hospital. He has drawn his statistics from 600 cases of diphtheria, all of which were under his own care, and it is this fact which makes them so valuable. Three hundred cases were treated without serum and 300 with serum, the former with a death-rate of 52·7 per cent., the latter with a death-rate of 20 per cent.

An article on "The Treatment of Diphtheria," by Dr. George Peck, in the November number of the *Hahnemannian Monthly*, deserves a brief notice. A series of questions were sent to the American homœopaths as to how they treated diphtheria. *Have you ever used antitoxin?* was one, and to this over 50 per cent. replied they had never used the serum; and of those who had only a very few appear to have been impressed with its value. It may be the serum used was defective or its virtue destroyed by the hot climate.

Within the last fortnight I was called to see a bad case of diphtheria in a child aged 7, in consultation with Dr. Searson. On my first visit, on November 18, the treatment

which Dr. Searson had employed appeared to have mastered the disease ; and as there seemed no immediate danger, although it was a severe case, involving the naso-pharynx, we decided not to use the serum, but persevere with the local treatment, swabbing the fauces with a solution of perchloride of mercury, 1 in 4,000, and giving internally the biniodide of mercury 3x.

On November 21, I was again asked to see the child. The membrane had not disappeared from the fauces, but would reappear some time after the swabbing had been left off. The child's condition was distinctly worse, and it was decided to use antitoxin. Six c.cm. (1,500 units) were injected. This was the sixth day of the disease. The nasal discharge soon ceased after this, and the breath became less offensive ; the membrane persisted on the throat for two days longer, and then disappeared. A slight papular rash followed, and some aching in the joints. The patient is now, I believe, convalescing.

I have endeavoured to set forth my experience of the use of the antitoxin serum, and since I have used it I have not lost a single case, although some have been of a severe type, like the first two cases I quoted, and Dr. Searson's case.

The statistics drawn from our own hospital cases, and those of the Sydney Children's Hospital, are most convincing.

In Cases III. and IV., in which I injected on the second day of the disease, the patients were practically cured in two days. Even if the serum is injected in a case which is not diphthéria, no harm results. In one case of severe tonsillitis, with membranous exudation, I injected the serum, regarding the case to be diphtheria. A bacteriological examination, made from a portion of membrane taken at the time, revealed no Klebs-Löffler bacilli.

The difficulty of diagnosis in diphtheria should always prompt us to avail ourselves of this bacteriological test. In another case, of a child aged  $4\frac{1}{2}$ , admitted under my care in Barton Ward, the pseudo-bacilli were found, causing a non-virulent form of disease, but one which in another person might produce serious symptoms.

All the cases I have cited were proved to be true diphtheria by the bacteriological test.

These are the conclusions which I have come to from my experience with the serum, and I believe all who approach the subject with an unbiassed mind will become as firm believers in its efficacy as I am myself.

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## ON THE GENERAL MEDICAL TREATMENT OF DIPHTHERIA.<sup>1</sup>

BY BYRES MOIR, M.D.

*Physician to the London Homœopathic Hospital.*

It is interesting to notice the steady increase that has taken place in the number of cases of diphtheria treated in this hospital. When I was house surgeon, seventeen years ago, not more than one or two cases a year were admitted, while in the twelve months just finished thirty cases have been under treatment. Diphtheria and typhoid fever have changed places, for when I was resident we saw plenty of typhoid, whereas we now get only a few cases in the year.

Dr. Bodman has been drawing up tables for a paper for the next number of the *Hospital Reports*, and has kindly allowed me to make use of them. His figures show the same thing with regard to frequency of admission. He has taken 120 cases, and for this has had to go back to 1886. In dividing these into four series of thirty cases, the first series of thirty were from 1886—1891, a period of five years, while the next series were in two years, 1892—1894, and the last thirty were during the twelve months of his residence in the hospital.

Along with the increase of the total number of cases during the last ten years, it is satisfactory to notice a con-

<sup>1</sup> Presented to the Section of Surgery and Gynæcology, Dec. 2, 1897.

tinued diminution in the percentage of deaths—even before the use of antitoxin. The mortality in the Metropolitan Asylums Board Hospital has been steadily falling, from 59 per cent. in 1888 to 29·6 in 1894.

Our own cases are too few to draw any definite conclusions from, but in the first series of thirty cases the death-rate was 33·3 per cent. ; in the second, 30 ; and in the third, 26·6 ; while in the last thirty cases treated in the hospital, thirteen without antitoxin, and seventeen with, there have been only three deaths, two of the cases being moribund on admission, thus giving the death-rate at 10 per cent.

In the hospital cases, which have been under Drs. Blackley, Clarke, Epps, and myself, the treatment has varied greatly, but a large proportion have received mercury in one form or the other, principally the cyanide or bin-iodide. The cyanide of mercury has a great reputation among homœopaths. In Dr. Arnold's interesting paper on the "Therapeutics of Diphtheria,"<sup>1</sup> read before this Society in May last year, he gave very striking figures of the success met with by different observers in the use of the cyanide. Dr. Villers was one of the first to report on its successful use, having used it in over 100 cases, with no deaths. Dr. Sellden, of Sweden, reported that in his district the mortality which in four years, 1879—1882, had been 92·7, was reduced by the use of cyanide, internally and also as a gargle, so that 1,400 cases gave a mortality of 4·9 per cent.

We have not met with the same success, whether it is due to having a different class of cases or not I cannot say. Nearly all our cases have been under ten years of age, and in nearly all the fatal ones the nasal and laryngeal regions have been attacked before admission. I have no doubt in my own mind of the great value of the mercury salts, especially when the treatment is begun early, but I cannot look upon them as specific.

For mild cases, where the septic condition is not well marked, we have good remedies in kali bichromicum, phytolacca, bromine, and ammonia, but they do not meet the blood-poisoning ; and we naturally turn to lachesis, crocotalus,

<sup>1</sup> JOURNAL OF THE SOCIETY, vol. iv., p. 375.



and apis, all of which have rendered me good service. They are of the nature of toxins, and I think much light has been thrown upon their action by Dr. Johnstone's paper on "Serum-therapy;"<sup>1</sup> and I do not think we have been making the best use of them that we might. When there is present the marked blood-poisoning which we so often see, it must be difficult to stimulate the vital powers to react against the diphtheria poison, and I think a more rapid and better action would be obtained by administering them hypodermically. In Dr. Hayward's monograph on "Crotalus," he brings forward several cases of malignant scarlet fever, where little or no action was obtained by administering crotalus by the mouth, but immediate benefit was obtained by applying it to a blistered surface; and I think we are to be blamed for not having followed the lead which he gave us.

Dr. Day has dealt with the subject of antitoxin, so I will only add that from my own observation of the cases which have been treated with it, it gives far better results than we can get with any of the other drugs I have mentioned, and I have been struck with its action even when given in a late stage. The first case in which I saw it used, was a boy who was admitted with laryngeal diphtheria, and Dr. Bodman had to do tracheotomy at once; the patient went on fairly for a day or two, and then the wound became covered with membrane, and almost as a last hope antitoxin was administered, though I did not think it a fair test on account of the stage of the illness—but in twenty-four hours he showed decided improvement, and made a steady recovery.

The question of local treatment is a very important one, and I consider that even with antitoxin it should be persevered with steadily. I used to have no fear of cases when we got them at an early stage and could apply local treatment to the parts affected, as a rule they all did well; but it was quite a different thing in cases where the nasal fossæ were implicated, and fatal cases nearly always came from these. In children it is impossible to

<sup>1</sup> *Monthly Homœopathic Review*, 1897.

properly irrigate the nose, and the danger is a steady progress in the toxæmic condition.

The fœtor of the breath is a very important sign with regard to the progress of the case, and I always feel easy as soon as it is overcome.

The local applications can be roughly divided into two classes—as disinfectants, or from their action as solvents on the membrane.

Among the first I must put most reliance on insufflation of flowers of sulphur and gargling with Condy's fluid. Each person has his own favourites, and there are plenty to choose from—alcohol, petroleum, chlorate of potash, corrosive sublimate, &c., &c.

As solvents of the membrane I have certainly seen benefit from papain, and lime water, either painted on with a brush or as a spray.

As soon as there are signs of decided interference with the respiration tracheotomy should be done without delay, the success of the operation depending very much upon its being done early and not waiting for serious symptoms; our results in the hospital have been very satisfactory. On the Continent and in America since the use of antitoxin, intubation seems to have come greatly into favour; but so far we have not used it, except in one case of mine where Mr. Wright tried it.

After the direct dangers from the membrane are over, many cases are fatal from the sequelæ, and here I think our homœopathic treatment gives us great advantage.

The sequelæ usually met with are:—nephritis, pneumonia or broncho-pneumonia, and the different forms of paralysis.

In the nephritis we have sheet anchors in cantharis, terebinth, apis and arsenicum; in the pneumonia, kali bichrom., phosphorus and antimonium tart.; while for paralysis, gelsemium, causticum, belladonna, and nux vomica.

I would wish particularly to draw attention to the use of belladonna in the paralysis of the respiration and heart.

Failure of the heart is met with in two conditions; first, in the early stage of the disease, when the heart itself

seems to fail ; and second, in the later stages when it is due to changes in the nerves, and it is in this condition that belladonna given in one or two drop doses of the  $\phi$  tincture is of great value.

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DISCUSSION ON THE PAPERS OF DRs. ROCHE, DAY, AND MOIR.

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Mr. DUDLEY WRIGHT believed that to perform tracheotomy three cuts were sufficient: first, a longitudinal incision made deep down exposed the isthmus of the thyroid, and then a second transverse incision just above it divided the layer of fascia binding down the isthmus, and enabled the operator to push the isthmus of the thyroid down and reach the trachea; then a third cut in the trachea finished the operation. He thought one almost always began by making too small an incision, and, blood welling up, the field of operation was hidden. When the trachea was opened there was no need to be in a hurry to put in the tube. It was essential to incise the trachea in the mid-line; by steadying it with the two fingers one could manage to hit it off fairly easily. As to feeding there was often a difficulty, and his experience was that children did not like to have the feeding tube passed through the nose, and he only did it as a last resource. He had found very great value from oxygen inhalations in the after treatment. Mr. Dudley Wright then described the instruments used for intubation. He did not recommend anæsthetising, as the amount of mucus which flowed when that was done was enormous. Opinions had changed very much in relation to this treatment since the introduction of antitoxin. Before that time the necessity of leaving the intubation tube in for several days, and other circumstances, militated against the convenience of the use of the tube, and, as a consequence, it was only used with success in those cases which were the most hopeless for tracheotomy, namely, very young children. Nowadays there was no question whatever that the antitoxin treatment had altered the form of operative treatment very considerably, and they might possibly look forward to an era of greater usefulness for the instrument he had described.

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The most suitable cases for that condition were those of the ordinary type, which were only moderately severe. Dr. Klein, who had had very considerable experience in Berlin in the Kaiser Kinderkrankenhaus, had treated a large number of cases of diphtheria since 1893. In that year the antitoxin was not used, and he had had thirty-seven cases intubated, nine of which were cured—24 per cent. In 1894 he intubated, without serum, eighty-seven cases, and with serum, sixty-eight. The percentage of cures for the intubation without serum was 20 per cent., not so good as the previous year; but with antitoxin it was 54 per cent., much more than double the percentage of cures without its use. In 1895 the percentage went up still higher. All his cases were treated with serum; they were all intubated, and 65 per cent. were cured. He thought that was a very good percentage indeed, as compared with ordinary tracheotomy. Dr. Klein also remarked that since the introduction of serum the number of cases requiring surgical treatment had been much less, either tracheotomy or intubation; and again, that in the earlier cases before the antitoxin treatment, tracheotomy was very often needed after intubation as a secondary operation, but since the introduction of the antitoxin treatment, he had had very few such cases. It was always advisable, however, to have tracheotomy instruments ready when performing intubation.

Dr. MADDEN said it was interesting to note that the first reference to diphtheria in homœopathic literature was in a paper by Dr. Francis Black, written for the *British Journal of Homœopathy* in 1858. At that time it was a new disease in this country. It had apparently only been introduced some two years before, and was known by the name of Boulogne throat. Dr. Black had given reports of cases which had been treated by himself and his colleagues, and it would be found that the lines of treatment and the medicines used were very much the same as at the present day—a striking proof of the continuity of ideas in homœopathic practice. At that time, however, the cyanide of mercury was not known. The first knowledge of it was gained from Dr. Beck in 1864. He, as the result of experiments, without any idea of its being used from the homœopathic standpoint, found that it produced an exact simillimum of the whole disease of diphtheria. It produced congestion, ulceration of the tonsils and pharynx, and, indeed, a very fair imitation of the diphtheritic membrane, besides its general toxæmia. They had also the striking results of treatment both by Dr. Villers, of St. Petersburg, who treated all his cases with high dilutions, and by Dr. Sellden, of Sweden, who

treated his cases allopathically with material doses. Dr. Villers treated one hundred cases with a mortality of *nil*; Dr. Selden and his colleagues treated fourteen hundred cases with a mortality of under 5 per cent. They could not expect anything better than that from such a virulent disease as diphtheria. Although the iodides of mercury produced inflammation and ulceration of the throat, they did not produce nearly such a picture of diphtheria as the cyanide. It was a curious thing, which he should like to hear explained, that the greatest successes had been found by those who used it in high dilutions and material doses. Those who used it in the medium doses did not meet with the same success as those at either end. Dr. Stonham had written a paper in the *Monthly Homeopathic Review* in 1889, in which he reported five or six cases rapidly cured with the 30th. Dr. Goldsbrough, somewhere about 1884, had read a paper in which he brought forward exactly the same result. Dr. Goldsbrough had been disappointed with the results of 3x and the 3rd, but in the 6th and the highest he had good results. All the good results he (Dr. Madden) had obtained had been from the 6th and the highest. It was most peculiar and unaccountable how various were the statistics of the different treatments. They had been told of the treatment from an allopathic source with an average of about 50 per cent. of deaths, or higher, where they had not used serum. Many years ago they had accounts of the use of perchloride of iron as the local application, with a mortality of 1 in 73. There were also statistics—he was quoting from Dr. Arnold's most interesting paper—of the local application of paraffin, where there were 122 cases, with two deaths. Dr. Martin had written to the *Lancet* with regard to the use of sulphate of magnesia, which he had employed in over fifty cases with a mortality of *nil*. Why was it, if those experimenters could get such splendid results from simple local applications, that men of the greatest experience, having everything at their command for the application of those methods, could produce nothing approaching it? He could not understand it, except on the supposition that the epidemics were of a totally different class of the complaint—that the one set of cases were malignant and the other simple. They could not accuse those men of mistaking the milder forms of sore throat for diphtheria. With reference to the local applications he would ask Dr. Blackley if he still used the preparation which he spoke very highly of some eight or nine years ago, viz., bromoform, as an inhalation. Dr. Blackley had then spoken very hopefully of its use, and had quoted one or two cases where

it had been successful. Everybody seemed to admit that the serum was an additional help, and however good results they might be able to obtain with homœopathy, unless they could produce the result of a complete cure in every case, he thought it was not only permissible but right that they should adopt serum as well as the homœopathic treatment.

Dr. HUGHES thought that if homœopathic treatment were carried out with the biniodide of mercury, homœopathy was not done justice to. The mercurial action in this compound was very small in comparison with that of the iodine, and iodine in ordinary diphtheria had no action whatever. He knew it was traditional, and he wished to speak with all respect of those who used it; but he ventured to think that if they would reconsider it and watch its action they would see that it was utterly futile in real diphtheria. With regard to the Sydney statistics, which Dr. Day had made great use of, he would call attention to the enormous mortality in cases not treated with serum. When they put 20 per cent. side by side with 52 per cent. it did look like a grand gain. But how came the 52 per cent.? Must there not have been some injurious treatment in those cases? And might it not have been the leaving off of that treatment which had a great deal to do with the fall in mortality? He would illustrate that by reminding them of Mr. Lennox Browne's statistics. Just as, in the present instance, 300 cases had been taken before serum and 300 after, Mr. Lennox Browne took 100 cases before serum and 100 after, and found that the mortality was nearly identical. But what was that mortality? Fifty-two? Twenty? No; it was twenty-six; so that the Sydney man lost double the number of his cases treated without antitoxin as compared with the cases treated in the London hospital from which Mr. Lennox Browne got his statistics. He thought if this point (and there were many more statistics pointing the same way) were taken into consideration, it would be found that they had not gained so very much by the use of antitoxin as was sometimes supposed.

Dr. GALLEY BLACKLEY said he occasionally used bromoform as an inhalation in laryngeal cases; but in the pharyngeal form of diphtheria, especially in fœtid diphtheria, he had come to the conclusion that it was not a sufficiently powerful parasiticide or antiseptic. It did not destroy the fœtor and did not prevent the growth of membrane. In some laryngeal cases he still used it and thought it was an excellent inhalation. It was an anæsthetic, and the children were quieted by it. He generally used 20 or 30

drops every three or four hours, and after tracheotomy he had found it very useful. He did not look upon the statistics brought forward by Mr. Lennox Browne as so infallibly correct as Dr. Hughes did. He thought there could be no resisting the enormous mass of evidence now existing in favour of the decreased death-rate under antitoxin treatment, even to homœopaths who had had an opportunity of treating large numbers of cases by cyanide of mercury, the bin-iodide, and the serpent poisons. He had had nothing like the success of those gentlemen in Sweden who had 1,400 cases with almost no deaths at all. He had seen a few cases treated by antitoxin, all were very severe cases and all got well. With reference to the local treatment, he had been recently treating a case of putrid sore throat of a very severe form, and he had used formalin as an application in a diluted form. It was not a pleasant application, but was most efficacious and cleaned the throat up in a wonderfully short time. He was going to use the powder of formalin in gelatine as an insufflation in the next suitable case.

Dr. CARFRÆ considered that they had never tested the use of the animal poisons by injection as they ought to do, and thought they would turn out to be extremely valuable by being subcutaneously injected instead of being given through the mouth.

Dr. DYCE BROWN said, with regard to Dr. Day's cases, it was a pity they had the two treatments mixed, as they could not judge what part each treatment played. In the last few years he had seen very few cases of diphtheria, but the medicines he had found most useful were the cyanide and bin-iodide of mercury, chiefly the former.

Dr. EPPS said that some of the cases quoted in the statistics had been under his care. When the serum treatment was begun in the hospital he was opposed to it, but they had had three or four most severe cases which had got well by it, as well as, if not better than, by other modes of treatment. At his (Dr. Epps') suggestion the serum method had been tried alone, without homœopathic treatment, and had proved most successful. With regard to the homœopathic treatment there was no remedy equal to cyanide of mercury in the sixth and higher dilutions.

Dr. SEARSON said that one of the difficulties of judging of the comparative value of the antitoxin treatment was that of having no fixed factor to go by in the treatment of bygone days. Some practitioners had been in the habit of using local applications and some had not. Some had used one method of medical treatment and some another. He thought the only fair way to judge

the antitoxin treatment would be to compare it with some other fixed method of treatment. Apart from the fact that the antitoxin treatment seemed a somewhat filthy curative agent, it was to be remembered that while they were conscious of the proximate benefits, the remote results had yet to be ascertained. Again, from the standpoint of the general practitioner, there was a difficulty, as anything injurious which might take place afterwards would be attributed by the parents of the children to the new, and to some of them unknown, treatment. In the cases of diphtheria which he had had to treat during the past five or six years, his custom was to swab the throat thoroughly with a solution of perchloride of mercury, first at a strength of 1 in 500, and afterwards at a weaker strength indicated by circumstances. He was glad to say he had not lost a single case. The point he wished to emphasize was that antitoxin was still on its trial and had not been fairly compared with other successful methods of treatment. At the same time he would consider its use indicated where the membrane had invaded the larynx, also in the cases of young and nervous children; in all cases, in short, where local treatment was either difficult or impossible.

Dr. BODMAN emphasized the importance of performing the operation of tracheotomy early, that is, as soon as the retraction of the lower part of the chest becomes well-marked and persistent. The crucial point in the operation was how to deal with the isthmus of the thyroid. His experience was that each case must be judged on its merits. As to the use of the tracheal dilators, a very useful instrument was Parker's. Directly the trachea was opened the dilator was inserted. There was no need to be in a hurry to put in the tube. The first thing to do was to see if there was any loose membrane in the trachea, and if so, remove it. As to the tube used, Parker's tube in his opinion excelled all others, being specially designed so as to conform to the anatomical condition of the parts, and therefore more comfortable to the patient. With reference to intubation, one difficulty was that the tube might be coughed out, and therefore in private practice where there was no skilled assistant at hand to replace it the child might die before relief was afforded; therefore its practice was almost limited to hospitals where medical aid could be summoned at once. There was more difficulty in feeding after intubation. When the antitoxin was injected early the membrane separated very rapidly, and therefore, if one got a case early and injected the antitoxin, intubation would probably be sufficient. With respect to the results of



antitoxin treatment in the hospital during the past year, there were 17 cases treated with it with one death, a mortality of 5·8 per cent., and 13 cases treated without, with a mortality of two, or 15 per cent. There were certain facts connected with those cases which greatly emphasized the impression which they gave at first; in the first place the number of severe cases was very much greater in the group treated by antitoxin, than in that in which it was not used. Secondly, the average age of the patients in the cases treated by antitoxin was very much less. Thirdly, the treatment with antitoxin was begun much later on the average than that of the cases where it was not used. Therefore, the antitoxin gave a mortality of little more than a third of that in cases not treated with it, although the cases were more severe, the patients younger, and the treatment was begun later. It was those accessory facts which gave the importance of the figures. No case which had antitoxin treatment subsequently required tracheotomy. Nothing was so convincing as to watch a malignant case of diphtheria recover after the injection of antitoxin. He had given about twenty-five injections of antitoxin, and had seen no bad effects, except the occurrence of a rash in about two cases. That was certainly not a sufficient reason for giving up the treatment.

Dr. GOLDSBROUGH said it seemed to him that as homœopathic practitioners they had in the antitoxin a first aid in the treatment of diphtheria, and they ought to consider in every case whether it should be administered or not. The objections to its use would no doubt be got over by and by, when a greater knowledge of its after effects were known.

Mr. JOHNSTONE said that Dr. Searson had mentioned one of the common objections to the use of antitoxic serum, viz., that it was an unnatural thing to inject an animal substance into a human being. He would meet that by reminding them that they ate and drank serum in the form of meat and meat juice, and he did not see that there was much difference in injecting it under the skin. Moreover, the very latest ideas prevalent among the pioneers in serum-therapy were that the immediate effect of the injection of the antitoxic serum is not due to the antitoxin contained in it, but that there was introduced into the child a certain amount of serum, containing albuminoids and other matter, which acted as stimulant and nourishment, and gave the patient a temporary fillip over a dangerous crisis; that only after a little time did antitoxin begin to take effect, by neutralising the toxic poison in the blood. With regard to the after effects, such as rashes and

nephritis, it was found that ordinary serum from an ox, sheep, or other animal would have almost the same effect; that in reality the injurious effects were probably not so much due to the antitoxin substance itself as to the materials normally contained in the serum. It might be that at some future time the chemist would be able to separate the true *antitoxin* from the serum, and produce the curative material in its pure state. Of its curative effects he did not think any one would have any doubt whatever, if they looked carefully into all that has been written on the subject, or watched the results in practice, and so arrived at an unbiassed conclusion. He thought the statistics were most convincing that the antitoxin treatment of diphtheria was at present better than any other treatment in use, and that when combined with homœopathic treatment the mortality was still lower.

Dr. STONHAM said allusion had been made to the cases which he had published some time ago, treated by cyanide of mercury in the thirtieth dilution. There were nine successive cases occurring in two houses, and all had quickly recovered. The cyanide of mercury had also been very valuable in other cases, but it stopped short when the larynx was attacked. Directly the larynx was attacked it was of no further use. The only thing he did find of any use for the larynx in drug treatment was the vapour of acetic acid. He had seen really marked effects from the child inhaling vinegar vapour. All those cases had been treated before the days of antitoxin serum.

Mr. KNOX-SHAW thought that every one had his own particular weakness with regard to the tube used in tracheotomy. He liked to have a tube which he could hold, and preferred Hilton's tubes to any other. The point he wished to emphasize to physicians was this. It seemed to him that in diphtheria they were endeavouring to carry their patient through a most serious condition of blood-poisoning. There was the toxin of diphtheria in the blood, and if they could bring the patient's blood into such a condition that it could resist and neutralise that toxin they would probably get him over his difficulty. The more he saw of bacteriological work in surgery the more he was convinced of this, that the greater the injury to the part, caused either by a severe operation or by bruising, the greater play the bacteria had in doing their deadly work. In diphtheria he thought they had the same thing going on as in ordinary surgery. If they got the slightest laryngeal obstruction, enough to keep the proper amount of oxygen from the blood, they were diminishing the resistance of the patient to the disease most enormously. On

those grounds he should like to support Dr. Bodman's plea for an early operation. He knew the difficulty met with from the friends of the patient, but he believed most strongly that the success in the tracheotomies which Dr. Moir showed in his paper in the last number of the *Hospital Reports* was due to his great insistence on the point that if they were going to operate at all, it should be done long before the necessity becomes apparent to the friends of the patient, because at that period the operation was generally far too late.

Dr. ROBERSON DAY, in reply, said he had had more experience with the bin-iodide than with the cyanide, but in future he would bear in mind Dr. Madden's advocacy of the latter. There was no doubt that the types of disease changed in succeeding ages, and it was never quite fair to draw comparisons between statistics based on an epidemic in former years with one at present raging. That was why he placed such great reliance upon the statistics he quoted of the Sydney Children's Hospital. Dr. Dyce Brown objected to mixing the treatment, but he (Dr. Day) had great confidence in homœopathy and also in antitoxin, and therefore combined the two.

Dr. ROCHE, in reply, wished to emphasize the use of sulphur, which he had used with glycerine. He found it was difficult to get sulphur well over the throat when the child struggled, but if glycerine were used with it one could be pretty sure one had gone over the whole surface.

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## SUDDEN DEATH AND PREMATURE BURIAL.<sup>1</sup>

BY C. THEODORE GREEN, M.R.C.S., L.R.C.P.

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IN the course of our professional experience we are usually brought in contact with the living, but we have, not infrequently, to stand face to face with the dead, sometimes under very startling circumstances. Let us, then, consider some of the causes of sudden death, and also the signs of death, that we may not fall into error, and perhaps be the

<sup>1</sup> Presented to the Liverpool Branch, December 9, 1897.

unconscious means of consigning a living person to the horrors of a premature burial. By sudden death I do not here refer to that which may occur in the course of a known disease, but that which suddenly terminates the existence of persons hitherto supposed to be in good health.

I wish to express my great indebtedness to the book, "Death and Sudden Death," by Dr. Brouardel, director of the Morgue, or rather to its very able translation by Dr. Benham. The position of director of the Morgue for so many years gives its holder an experience second to none in the world, and therefore entitles him to speak with authority on these matters.

"No one dies suddenly, apart from the effects of violence, as long as all the organs are sound; but there are some diseases which develop slowly and secretly, without the attention of the patients having been called to them by any pain or by any feeling of illness, and without a physician having been ever called in, and which terminate naturally by a rapid death. Among these diseases I will mention diabetes and arterio-sclerosis accompanied by atrophy of the kidneys."<sup>1</sup>

An autopsy should always be made when practicable, and no stereotyped cause as "heart disease" given unless we have a true reason for our opinion. Yet there appear to be some cases in which it is impossible to assign a cause of death, even after a most careful autopsy made before putrefaction has begun. At any rate, we can try to avoid cloaking our ignorance of the cause of death by ascribing it to the "Visitation of God," the which phrase is relit from the time when anything unusual or unknown was put down to the agency of "Spirits."

#### LESIONS OF THE CIRCULATORY SYSTEM.

In fatty overgrowth and fatty degeneration of the heart, death may be due to a shock like that from a cold bath.

Fibroid degeneration of the heart may lead to rupture from violent emotion.

<sup>1</sup> "Death and Sudden Death," p. 122.

Arterio-sclerosis of the coronary arteries and angina pectoris lead to degeneration of the cardiac muscle, and hence a liability to sudden death.

Adherent pericardium may cause sudden death from dyspnoea after violent exertion.

Valvular incompetence may exist without noticeable pre-existing symptoms and cause death in the same way.

Endocarditis, apparently recovered from, may give rise to fatal embolism when the patient is going about again.

Occasionally neoplasms of the ventricles, as cancer and hydatids, may cause a sudden death.

Arterial sclerosis makes these vessels brittle, and any of them may rupture, or this condition may give rise to an aneurism which may burst and so cause a fatal termination.

Although rare, a fatal rupture of big veins, as the pulmonary and vena cava, has been known to cause death. Death owing to embolism of the pulmonary artery from thromboses, varicose veins, or in phlegmasia alba dolens, is not infrequent. When air enters the veins it kills by forming bubbles which block the capillaries just like emboli, and also fills the heart with froth, thus stopping its action.

Miliary aneurisms of brain or spinal cord may cause a fatal hæmorrhage.

An individual may die from anæmia or congestion resulting from a considerable disturbance of the general or local circulation; *e.g.*: any sudden hæmorrhage that may withdraw blood too quickly from the brain, as rupture of varices, paracentesis abdominis when done too rapidly. Here the abdominal vessels dilate and take up a large quantity of blood now that pressure is suddenly removed.

“We have all sometimes felt dizzy on jumping out of bed in the morning due to anæmia of the brain produced by sudden congestion of the lower limbs. It is obvious that these phenomena will be much more pronounced in convalescents and lying-in women, and may even be sufficient to cause fatal syncope.”<sup>1</sup>

<sup>1</sup> “Death and Sudden Death,” p. 159.

## LESIONS OF THE CEREBRO-SPINAL SYSTEM.

Latent suppurative or even tuberculous meningitis does exist, and its existence is only discovered *post mortem*.

Cerebral abscess or tumour may develop and yet show no symptom till within a few hours of death.

In tubercle of the spine just below the skull, the odontoid process may suddenly break off, compressing the cord and causing instant death.

A person may die during an epileptic fit, and yet an autopsy will show very little that is pathognomonic.

Inhibition.—“Insignificant injuries, even the slightest blows, may bring about sudden, even instantaneous death.” There are certain regions which present this susceptibility: the epigastrium is the chief; other regions are the hypogastrium, the larynx, mouth and nose and the genitals. “What happens in such a case? It used to be said that death took place from syncope by reflex action upon the heart. Nowadays, since the works of Brown-Séquard have been published, we call it death by ‘inhibition.’ Instead of a reflex movement, there is produced, on the contrary, an arrest of one of the functions which was in action at the time the violence was suffered . . . those of circulation and respiration; and these are the ones which are arrested.”<sup>1</sup>

## LESIONS OF THE RESPIRATORY SYSTEM.

Blows on the larynx or laryngismus stridulus may result in sudden death.

Fatal asphyxia may result from the introduction into the trachea of food, the contents of a pulmonary cavity, or of a lumbricus which has contrived to ascend into the pharynx and enter the glottis.

Bronchial spasm may be induced suddenly from pressure of a thyroid enlargement or caseous bronchial glands.

Pulmonary congestion may cause sudden death, but the autopsy will usually show some morbid cause for this congestion. Pneumonia may run its course in a latent manner and terminate fatally with suddenness.

<sup>1</sup> “Death and Sudden Death,” p. 172.

Capillary bronchitis in adults sometimes kills suddenly. The autopsy shows the bronchi filled with froth, the product of bronchial over-secretion. Such cases are likely to be met with in persons who are much exhausted and have been exposed to intense cold.

Cold applied internally may result in the same way, as when an over-heated person drinks cold water. The cold causes it by reflex action on the lungs by means of the vagus.

Tuberculous phthisis may run its course without manifesting any symptom till at the last death ensues with startling suddenness.

Of all pulmonary affections, pleurisy causes the greatest number of sudden and unforeseen deaths.<sup>1</sup> Sometimes this is due to extensive exudation. Embolism of the pulmonary artery has been mentioned. Supposing one lung to be already useless through disease, it will then not require much obstruction in the healthy one to cause death. Complications, as fatty heart or adherent pericardium, increase the chance of a sudden death.

Paracentesis thoracis done too rapidly may cause fatal syncope in precisely the same way as in paracentesis abdominis; *i.e.*, in proportion as the pleuritic fluid escapes there is a rush of blood towards the lungs and syncope follows from cerebral anæmia. Therefore it is wise to leave a little fluid behind in the pleural cavity, but as the amount of fluid cannot be known exactly, it is easy to make a mistake.

A fatal rupture of the diaphragm may occur, but this accident is extremely rare.

#### MODIFICATIONS OF VASCULAR TENSION.

Under the action of great heat the capillaries dilate, which lowers the vascular tension. When this is considerable and the heart is weakened by exertion or aortic incompetence fatal syncope may ensue.

<sup>1</sup> "Death and Sudden Death," p. 172.

The action of cold shows itself in a contrary way. The capillaries contract, intra-vascular tension is increased, and if any vessel be weakened it will burst. In both cases heat and cold only act as auxiliaries to some pre-existing cause.

But in a certain number of cases heat or cold may be the sole factors of death.

Heat.—There is no great difference between sunstroke and heatstroke. In New York more people die from sunstroke than in any other city in the world.

In heatstroke it is not the solar radiation that kills. People are found dead under a tent, or in the shade of trees, while the thermometer registers 97° Fah. in the shade. The heat is a moist one.

In sunstroke the symptoms resemble those of meningitis. At Aldershot I noticed two effects of the heat. In the first set of cases, during a fatiguing march in great heat the men fell out and appeared as in a faint, with pale face and feeble pulse; these required stimulant. In the second series the men fell out in the same way, but had purple blotchy faces and full pulse; these cases of heat apoplexy ought not to have stimulants but amyl-nitrite. The men of the Liverpool battalions dressed in black or scarlet uniforms fell out from the heat more frequently than the men of the 1st Cheshire, whose uniform is grey. There were no fatalities. The lesions found *post mortem* are those of pulmonary congestion.

Death from cold is more common than that from heat. In Russia the cold kills about 700 persons every year. Alcohol, which dilates the capillaries, promotes the action of cold by causing a free radiation of the body heat. It is a singular thing that lunatics do not complain of cold, and they resist it better than their attendants.

#### LESIONS OF THE DIGESTIVE SYSTEM.

It is a startling fact that sudden death may supervene in the course of simple pharyngitis or erythematous sore throat. An autopsy throws no light on these very puzzling cases, and as the redness disappears after death, we are not



entitled to conclude that no sore throat has existed. Death in these cases is probably due to inhibition, as in those of slight blows on the larynx.

Choking while eating is not an uncommon accident among general paralytics.

Ulceration or dilatation of the œsophagus is known to cause sudden death.

Death from syncope may result after a full meal in persons convalescent from enteric fever or the subjects of some renal affection.

Dyspeptic Coma, Kussmaul's group of symptoms, or Acetonæmia.—It has been thought that this is due to auto-intoxication by acetone liberated by intestinal fermentation; but Dr. Brouardel thinks that the cause of death should be sought in one of the conditions in which Kussmaul's group of symptoms are found, as in pernicious anæmia, diseases of the liver and kidneys, chronic catarrh of the bladder, certain eruptive diseases, chronic alcoholism, &c.

Ulcer of the stomach is a very common cause of sudden death. Generally the person dies of perforation of the stomach with symptoms of peritonitis, but not always; he may become collapsed and present symptoms of cholera.

“A distinguishing feature of simple ulcer of the duodenum is that its existence is quite unknown both to the patient and to those around him. In ulcer of the stomach there are pain, vomiting and hæmorrhage; ulcer of the duodenum gives rise to no symptoms. Moreover, sudden death in the medico-legal sense is comparatively more frequent in the latter than in the former.”<sup>1</sup>

Intestinal ulceration may be caused by enteric fever, tuberculosis or cancer. All these ulcers may give rise to intestinal hæmorrhage which may produce fatal syncope. Embolism of the mesenteric artery may also give rise to intestinal ulceration and hæmorrhage (Lancereaux).

Finally, we sometimes meet with persons who have died of intestinal hæmorrhage, although it is impossible to discover the vessel that has given way (Gendrin, Trousseau).

<sup>1</sup> “Death and Sudden Death,” p. 215.

Appendicular ulceration and perforation may also be mentioned. Intestinal obstruction in one of its varieties is a common cause of sudden death.

Dr. Brouardel here utters a word of timely warning:—  
“Never in your practice pronounce the word ‘poisoning’ unless you are sure of your diagnosis; if it has once escaped your lips and reached the ears of the patient’s relatives, they will not be able to think of anything else. Before uttering a word of suspicion, think over all the phenomena of perforation.”<sup>1</sup>

#### LESIONS OF THE LIVER.

Acute yellow atrophy; gall stones; in the latter fatal syncope, though rare, does occur. Death is due to stoppage of the heart, determined by reflex inhibition due to excitation of the pneumogastric filaments distributed over the liver.

Rupture of the gall bladder and biliary ducts, or of a hydatid cyst, may occur.

#### LESIONS OF THE SPLEEN.

The spleen, being a brittle organ, does not need very great violence to rupture it, especially if the subject has had malaria, which enlarges it and renders it more brittle.

#### LESIONS OF THE FEMALE GENITALS.

Sudden death has occurred after a single vaginal examination where there has been disease of the uterus or appendages, and after ordinary injections in gonorrhœa. “Superficial lesions sometimes suffice to bring on palpitation or intermission of the pulse even in robust though very nervous women, without there being any lesion of the heart; cauterisation of a small ulcer on the cervix uteri will make this palpitation and intermission cease. Is that not a proof of the intimate relation that exists between the innervation of the genital organs and that of the heart?”<sup>2</sup> Among other lesions of the female genitals that may cause

<sup>1</sup> “Death and Sudden Death,” p. 217.

<sup>2</sup> *Ibid.*, p. 228.

sudden death are: extra-uterine gestation; hæmorrhage into the peritoneal cavity ("hæmatocele," Bernutz) even apart from pregnancy; rupture of the gravid uterus: rupture of vulvo-vaginal varices, and syncope just after delivery—this is more frequent when the patient has endeavoured to keep her condition secret.

Sudden death in fevers may occur in pernicious forms of intermittent fever; in hæmorrhagic forms of variola and scarlatina, especially in pregnant women.

Complications in fevers or during convalescence therefrom, such as myocarditis, endocarditis, thrombosis, embolism, syncope, &c., may aid in causing a sudden fatal issue to the fever.

The subjects of hæmophilia are always liable to more or less sudden death from slight wounds, the bleeding from which cannot be stopped.

Diabetes is the disease of all others which may run the longest course without its subject being aware of it, whatever may be the quantity of sugar voided in twenty-four hours. The patient may go on for years in apparent general health up to the time he suddenly becomes comatose and dies. The autopsy will reveal little. The bladder is most often empty, and if the autopsy be much delayed, what sugar may have been present in the urine will have disappeared. Other forms of sudden death in diabetes have been described as due to syncope, atrophy or fatty degeneration of the heart.

#### LESIONS OF THE KIDNEYS.

"Death due to the kidneys is the most frequent form of sudden death, but the renal lesion is not always the only factor. Death supervenes when poisons manufactured in the system, or unwholesome food that has been ingested, can no longer be adequately removed by the diseased kidneys. The individual is therefore poisoned either by his food or by poisons which are generated within his own body, *i.e.*, auto-intoxication.<sup>1</sup> An individual who has suffered from damaged kidneys, although all signs of the mischief have disappeared

<sup>1</sup> "Death and Sudden Death," p. 244.

for a long time, is exposed to grave dangers if he catch any infective or eruptive fever." Toxic alkaloids such as are contained in stale meat may kill a subject of granular kidney, although the same meat may prove comparatively innocuous to those whose kidneys are able to eliminate the poison.

Why does the kidney suddenly cease to perform its excretory functions? Because the organ is irritated and congested, and consequently there is less urine secreted. Therefore, when we have to prescribe a diuretic, we should choose one which is free from irritating properties.

Uræmic cases may terminate fatally in several ways: as in the bronchitic form; gastro-intestinal form; comatose form; convulsive form; and the fulminating form which kills within an hour.

Death in uræmia is caused by the non-elimination of urea chiefly, but also of ptomaines and leucomaines. In cases of sudden death from gout, Dr. Brouardel has generally found some renal lesion present. The gouty person also has often "sclerosis of the arteries and heart or lesions of the liver. If some disturbance of the circulation should supervene, his condition immediately becomes grave. As long as the kidneys are working properly, his health is good; but as soon as the functions of the liver are checked, whether by atrophy or congestion, he is in danger."<sup>1</sup>

Alcoholism.—When death occurs after a single excess, it is by the body becoming cold. There is peripheral vasomotor paralysis, consequently the individual radiates a large amount of heat. This is one reason. Another is that the blood corpuscles no longer retain their full amount of oxygen, therefore they cannot distribute to the various parts of the body the gas which maintains combustion and regularity of respiration.

In delirium tremens the subject may die suddenly during a paroxysm of excitement.

Chronic alcoholism "has the power of making acute diseases run their course in a latent manner. This applies

<sup>1</sup> "Death and Sudden Death," p. 254.

to cases of pneumonia, meningitis, &c. Alcoholism also creates lesions in every organ, and the subject of it is thus exposed to the danger of sudden death in every form which may in fact result from lesions of these organs."<sup>1</sup>

Sudden death in children is usually due to one of five principal causes, viz., syncope; convulsions; asphyxia; pulmonary congestion; and intestinal troubles.

Syncope may be due to a violent pain, reflex action or inhibition.

Convulsions are a frequent cause of death in congenital syphilis, which may produce vascular lesions, simulating hæmorrhage or meningitis.

Meningeal hæmorrhage is chiefly met with at the period of dentition.

Children are strongly predisposed to suffer from convulsions when their alimentary canal is out of order, as in indigestion, constipation, diarrhœa, or a collection of worms in the intestines.

Asphyxia or inward convulsions usually implies spasm of the glottis, due to laryngeal irritation or laryngismus stridulus. An enlarged thymus may partially compress the trachea, setting up a slight degree of spasm which rapidly causes death.

Pertussis may end fatally with broncho-pneumonia, or by laryngeal spasm.

When a child suffering from indigestion is lying on its back food may regurgitate into the respiratory passages and choke it.

Pulmonary congestion or suffocative catarrh in children under six months commonly causes death by a choking-up of the bronchioles with froth.

Vibert has three times made an autopsy on children under one year of age who have died of enteric fever. In none of them was the child suspected to be suffering from enteric fever. The autopsy showed hypertrophy of Peyer's patches, but the immediate cause of death in each case was pulmonary congestion.

Intestinal hæmorrhage has been noticed by Bouchut to

<sup>1</sup> "Death and Sudden Death," p. 257.

frequently cause death in children where it is impossible to assign any definite cause for it.

#### SIGNS AND PHENOMENA OF DEATH.

We will now pass on to the consideration of the signs and phenomena of death itself. It is not my purpose at this time to deal with the medico-legal aspects, either of sudden death or of the signs of death. That would form a most interesting subject for a separate paper.

Does anyone think that the fact of death is so obvious that it were waste of time to consider its signs? No doubt in the majority of cases there is no room for doubt. But many times it is not so until some period of time has elapsed. And sometimes it is possible to restore to life those apparently dead. A careless examination of a supposed corpse may result in our being responsible for a premature interment. "Activity does not entirely cease at the instant of death. Vital phenomena are replaced by cadaveric phenomena."<sup>1</sup>

The moment of death is said to be that in which the individual, in popular parlance, "draws his last breath." That is an error, for the heart may go on beating for some time later, and artificial respiration or electrical or other stimulation is sometimes successful in restoring the respiration. We may, therefore, say that a person is dead when his heart has ceased to beat, and not merely when we fail to observe its beating. Drs. Regnard and Paul Loye found the heart beating one hour after its owner had been decapitated.<sup>2</sup>

"At present then, gentlemen, we have no absolute criterion at all to determine the precise moment of death."

Apparent death.—When an individual is in this condition we ought always to consider whether he could not return to life, even if we fail to observe the movements of the respiration and of the heart, whether the suspension of life is temporary or absolute, for the reason that as a result of inhibition the blood retains its vital properties for a fairly long time.

<sup>1</sup> "Death and Sudden Death," p. 17.

<sup>2</sup> *Ibid.*, p. 20.

An individual does not die in every part at once. This is due to the independence of the functions and of the tissues. In hibernating animals we are familiar with the suspension of the organic functions during life, and human beings resemble hibernating animals at times. Among hysterical subjects are some whose nutrition and excretion are reduced to the minimum ; life is almost latent. In cases of lethargy and catalepsy life is entirely latent.

Trance.—In Quain's "Dictionary of Medicine," Dr. Gowers says, "The mental functions seem in most cases to be in complete abeyance. No manifestation of consciousness can be observed or elicited by the most powerful cutaneous stimulation, and on recovery no recollection of the state is preserved. But in some cases volition only is lost, and the patient is aware of all that passes, although unable to give the slightest evidence of consciousness. Persons have been buried in this state. . . . The duration of trance has varied from a few hours or days to several weeks, months, or even a year."

And of catalepsy in the same work he says, "Like trance, it has often been mistaken for death and its subjects buried alive. The limbs remain in the position they occupied at the onset, as if petrified. The whole or part of the muscles pass into a state of rigidity. In profound conditions, sensibility is lost to touch, pain and electricity."

M. Josat gives the result of his own observations in 162 cases in which apparent death lasted :—

In	7	from	36	to	42	hours.
"	20	"	20	"	36	"
"	47	"	15	"	20	"
"	58	"	8	"	15	"
"	30	"	2	"	8	"

The order of frequency in which these occurred was as follows :—

Asphyxia, hysteria, apoplexy, narcotism, concussion of the brain.

Signs of death.—"There is no more any pathognomonic sign to determine the moment of death, than there is to

establish the diagnosis of enteric fever."<sup>1</sup> It is a collection of signs which gives the physician absolute certainty, and he alone can estimate their value.

(1) Cardiac failure: here the stethoscope may fail us, or even a needle stuck through into the pericardium. Moreover science has yet to prove that a heart once stopped may not be made to go on again.

Other signs, quoted at times, merely prove cessation of circulation, such as:—

(a) Blood does not escape on making a wound.

(b) A ligature tied round a limb does not cause the distal end to swell.

(c) The ophthalmoscope shows emptiness of the central artery of the retina.

(d) The eyeball loses its normal tension, except in those drowned.

(e) Although a blister may form after a burn, yet in a dead body this is not surrounded by an areola of inflammation.

(f) Absence of red blush of the skin after subcutaneous injection of ammonia (Monteverdi's test), or other irritant.

(g) Emptiness of the temporal or other artery.

(2) Respiratory failure: one of the most fallacious of tests (Brouardel).

(3) Insensibility. (a) Hearing: The old custom of "Waking the dead," may be cited. (b) Of smell: strong-scented substances induce no reaction. (c) Of touch: even in cataleptic cases, sensibility may be lost to touch, pain, and electricity.

(4) Reduction of the body temperature to 22° C.

(5) Cadaveric sugillations are liable to be mistaken for ecchymosis. In persons bled to death they appear late and are very slightly marked. They may appear before death in cholera, uræmia and asphyxia.

(6) Non-coagulability of the blood when drawn from a blood-vessel. In certain diseases, as scurvy, the blood drawn from a vein will not coagulate for days.

<sup>1</sup> "Death and Sudden Death," p. 50.



(7) The diaphanous test, *i.e.*, absence of red colour in semi-transparent parts under the influence of a powerful stream of light. Quite unreliable, for this red colour has been noted in dead persons.

(8) Absence of signs of oxidation of a bright steel needle when plunged into the tissues.

(9) Rigidity, which occurs well marked in catalepsy or tetanus. Rigor mortis is a nearly constant phenomenon in adults, but it may be so slightly marked in certain cases as to escape the notice of the most painstaking observer.<sup>1</sup> Niederkorn found that in 103 corpses observed by him, it appeared two hours after death in two cases.

From	2 to	4 hours	after	death	in	45	cases.
„	4	„	6	„	„	24	„
„	6	„	8	„	„	18	„
„	8	„	10	„	„	11	„
„	10	„	13	„	„	3	„

I have omitted many other tests recommended by various authors, probably to increase their lists of tests, as being too fallacious to require discussion, or too impracticable.

(10) Putrefaction, when well established, is the only reliable test of death. Its first external sign is a greenish discoloration of the abdomen. The less compact tissues putrefy first; the fibrous tissues resist longer, and the uterus longest of all; finally, the skeleton is exposed and gradually falls to pieces. Putrefaction is sometimes much delayed. Dr. Hartmann quotes the following case from Kempner: "The wife of Prof. R., at Rostock, was not buried until three weeks after her death, because before that time no signs of putrefaction appeared upon her corpse."

#### PREMATURE BURIAL.

This question is a grave one, not to be lightly pooh-poohed by anyone who may think either that it never occurs, or that the number of persons buried alive form such a minute fraction of the whole number of interments as to be practically negligible.

<sup>1</sup> "Death and Sudden Death," p. 71.

Predisposing causes of premature burial.—I have considered the causes of sudden death because it is asserted that premature burial is more likely to happen to persons dying suddenly. We have seen what a number of these causes there are, and are perhaps led to wonder that any of us manage to live at all. Premature burial is more likely to happen to women and children than men. Wasting diseases, such as cholera, enteric fever, influenza, fits of various kinds, drowning, suffocation by gases, hanging, shock by lightning, and alcoholism, are also among predisposing causes. Dr. Brouardel evidently believes that premature burial is very rare.<sup>1</sup> He says he has found that nearly all cases quoted from various sources had not been previously seen by a medical man, and are therefore, apparently, to be discredited. I do not follow his reasoning, but it seems obvious that persons whose bodies have not been examined by a doctor are more likely to be buried alive than those who have been.

The following cases have been selected from (1) "Premature Burial," by Dr. Frantz Hartmann; (2) "Premature Burial," by Messrs. Tebb and Vollum.

*Dr. Hartmann's Cases.*

CASE VI.—In the city of Salzburg there died, some thirty years ago, the wife of the most prominent merchant of the town, a Mr. Zeller, and she was buried on the third day. The body was deposited in the grave with a costly finger ring, which the lady had prized very much during her life. During the night after the funeral the undertaker's servant, having observed the costly ring, made up his mind to rob the body of it. Armed with the required tools, he went to the grave at midnight and opened it. As he removed the coffin lid the current of fresh air entering awoke the lady from her state of unconsciousness, and she sat up in her coffin. The grave robber ran away, and the woman, climbing out of her grave, walked back in her shroud to her residence, where she rang the bell and created no little consternation among her family on being admitted.

CASE VIII.—In Kronstadt, in 1866, a strong young man named Orrendo had a fit and died. He was put into a coffin and

<sup>1</sup> "Death and Sudden Death," p. 49.

deposited in the family vault in a church. Fourteen years after, in 1880, the same vault was opened again to admit another corpse, A horrible sight met those who entered. Orrendo's coffin was empty, and his skeleton lying upon the floor. But the rest of the coffins were also broken and emptied of their contents. It seemed to show that the man, after awakening, had burst his coffin open, and becoming insane, had smashed the others, after which he had been starved to death.

CASE X.—An hotel waiter at Vienna died at the hospital, and was, with some other corpses, deposited in the chamber for the dead, where after some hours he recovered, having been conscious all the time of what was taking place, but unable to give a sign of life.

CASE XIX.—In the year 1831 an Englishman died of typhoid fever, and was buried in a grave. On the fourth day after the burial his body was exhumed and brought into the anatomical museum, for the purpose of being dissected. There it was put upon a marble slab, and the Professor, after making some experiments upon the body, took his knife and made an incision into the breast. At that moment the supposed corpse cried out, and rising up, grasped the Professor's arm. The man's life had returned, and he lived for many years afterwards. He had been conscious the whole time after his supposed death, though unable to give a sign of life.

CASE XXI.—Dr. Honigberger relates an account of the Indian fakir Harridas, who permitted his body to be buried alive. In the presence of a rajah, this fakir filled his ears and nostrils with wax, and entered into a state of death-like trance, in which no heart-beat and no spark of life could be discovered. In the presence of the rajah and his court the apparent corpse was then sewed into a linen bag, and this was closed with the rajah's own seal, after which the bag, with the corpse, was put into a box and locked. This box was then buried in a garden. Barley was sown in the ground above, the whole enclosed by a wall and military guards posted by night and day. On the fortieth day after the burial the box was exhumed in the presence of the rajah, his ministers, General Ventura, and some Englishmen. They found the fakir lying therein, stark and stiff like a corpse, in the same condition as when he was buried. Warmth was then applied to his head, the wax removed, and air blown into his mouth, after which the body revived, nothing the worse.

CASE XXXIV.—A lawyer at Vesoul was subject to fits of fainting, but he kept the matter secret so that the knowledge of it might not spread and interfere with his prospects of marriage. He only spoke of it confidentially to one of his friends. The marriage took place, and he lived for some time in good health, then suddenly fell into one of his fits, and his wife and the doctors, believing him dead, had him placed in a coffin and got everything ready for the funeral. His friend was absent, but fortunately returned just in time to prevent the burial. The lawyer recovered and lived for sixteen years after this event.

CASE LIV.—In the year 1579, a certain Hans Fourtel apparently died and was laid out in a coffin. Five hours afterwards he awoke, and seeing the undertaker at his side he said to him, "My friend, will you be so kind as to present my respects to the parson and offer him my excuse for the disappointment I have caused him in making so bold as to revive again."

CASE LXXIII.—In 1842, a remarkable affair occupied the court at the city of Nantes. A man apparently died, and his death was certified to by the attending physicians and the inspector; he was put into a coffin and the religious ceremonies were performed in good style. At the end of the funeral service and as he was about to be buried, he awoke from his trance. The clergy and the undertaker sent in their accounts for the funeral expenses, but he refused to pay them, giving as his reason that he had not ordered them, whereupon he was sued for the money.

CASE LXXXI.—In May, 1864, a man died very suddenly at a hospital in the State of New York, and as the doctors could not explain the cause of death they resolved upon a *post-mortem* examination, but when they made the first cut with the knife, the supposed dead man sat up and grasped the doctor's throat. The doctor was terrified and died of apoplexy on the spot, but the dead man recovered fully.

Messrs. Tebb and Vollum also recite very numerous cases, many of which had been found to have turned in their coffins, bitten their fingers or arms, &c.

All the cases of premature burial quoted by our three authors (and they give reference to their source of information in each instance) have been discovered accidentally, as by the bodies being exhumed for examination, or by grave robbers, or from the opening of a vault to receive

other bodies, or from the removal of graveyards out of towns, &c. This naturally leads to the question—how many are there who have been buried alive, and yet who have not been discovered?

Dr. Hartmann quotes Professor Froriep, as saying that in 1829, in New York, among 1,200 persons buried, six came to life again in the grave. This would make one half per cent. of the whole number. Some years ago a graveyard in a town in Holland was removed to another place, and over one-half per cent. of the corpses examined gave indications of having been buried alive, and having awakened in their coffins. According to Bruhier's calculations, among 30,992 persons who apparently died in one year, there were 154 buried alive.

The length of time a person may live in the grave will depend on many conditions, but all things considered, a person buried while in a state of trance, catalepsy, asphyxia, narcotism, nervous shock, &c., and in any of the other states that cause apparent death without passing through a course of disease, and that occur during his or her usual health, will have a longer struggle before life becomes extinct than one whose strength has been exhausted by an attack of sickness. Estimates of the duration of such a struggle differ considerably. Some writers believe that however intense it must be short-lived. Dr. Lenormand observes, "It is a mistake to think that a living person enclosed in a narrow box and covered with several feet of earth would succumb to immediate asphyxiation." Dr. Londe remarks; "It has been calculated that after one quarter of the atmospheric air contained in the coffin, approximately estimated at 120 litres, was exhausted, death would set in; therefore, it is quite certain that if the shroud is thick and the coffin well closed, and the grave impenetrable to the atmosphere, life could not last more than from forty to sixty minutes after inhumation." But is not that a century of torture?<sup>1</sup> Dr. Brouardel thinks a man might live for twenty minutes, and says his calculation is based on the average respiratory activity;

<sup>1</sup> Tebb & Vollum, p. 120.

in persons whose nutrition is conducted more slowly than in others, such as the hysterical subject of whom we have spoken, survival might be much longer.<sup>1</sup>

M. Bernard, a skilful surgeon of Paris, certified "that in the parish of Riol, he himself and several other bystanders saw a monk of the Order of S. Francis, who had been buried for three or four days, taken from his grave breathing and alive with his arms lacerated near the swathes employed to secure them ; but he died immediately after his releasement."

At Stadamahof, in 1785, "a young healthy girl, on the way to a wedding, had an apoplectic fit, as it was thought, and fell as if dead. The following day she was buried. The grave-digger who was occupied near her grave that night heard noises in it, and, being superstitious, ran home in fright. The following morning he returned to finish the grave he was digging, and heard the whining again from the girl's grave. He called for help, the grave was opened, when they found the girl turned over, her face scratched and bloody, her fingers bitten and her mouth full of blood. She was dead, with evidences of most dreadful suffering." In France Madame Lacour died after a long sickness, and was buried in the vault of a church with all her jewels on. Her maid and the sexton opened the coffin-lid the following night to steal the jewellery, when some hot wax from the candle they were using fell on the woman's face and woke her up. The robbers fled in fright and the woman went back to her home. She lived many years afterwards and had a son who became a priest, who in turn—inheriting his mother's nature—underwent a fate similar to her own.

*The Spectator*, October 11, 1895, "published particulars of a recent case of recovery after three days' interment in Ireland."

*The Lancet*, September 12, 1896, records the following from its Cork correspondent, as having happened at Little Island, Ireland. "A child of four years contracted typhoid

<sup>1</sup> "Sudden Death," p. 49.

fever, and to all ordinary appearances died. The time of the funeral was appointed, and friends were actually on their way to attend it. When the supposed corpse was about to be removed from the bed to the coffin, signs of animation were exhibited. The services of the medical man were again requisitioned, and the child, opportunely rescued from such a terrible death, is progressing favourably."

In Appendix C Messrs. Tebb and Vollum give numerous cases of the recovery of the apparently drowned, some of whom had been submerged for many minutes. "On August 13, 1895, Samuel Lawrence, aged 5, while playing on the back of a disused clay pit at South Bank, Yorkshire, fell into the water and sank. Two of his companions dived into the water and brought him up, after a submersion of from seven to ten minutes, in an unconscious state. Two working-men commenced artificial respiration, and Dr. Steele continued it for ten hours before the boy showed signs of returning sensibility, and his complete recovery." "On August 6, 1895, at Bradford, Yorkshire, Rudolf Pratt, a clerk with the Midland Railway Company, was bathing, and sank in deep water. A bystander, by diving, brought him up, after a submersion of five minutes, unconscious, and not breathing. Dr. Oldham restored respiration by Sylvester's method, after one and a-half hours' treatment." In 1829 a young man was taken out of the Seine in Paris, after Dr. Bourgeois had witnessed the search for the body for fully twenty minutes. No pulsation, no respiration was perceptible. Amid the derision of onlookers, the doctor proceeded to resuscitation. The body recovered life after several hours' treatment. "What would have happened if Dr. B. had not persistently . . . continued treatment? The unfortunate man would have been laid in the grave, although capable of restoration to life." To this case, Dr. B., in *Archives de Médecine*, adds others in which individuals remained under water as long as six hours, and were recalled to life by efforts which a weaker conviction than his own would have refrained from making. These facts lead Dr. Londe to the conclusion that every day drowned individuals are buried who with greater perseverance might be

restored to life. *The Casket* of Rochester, N.Y., U.S.A., March 2, 1896, narrates recent discoveries made by T. M. Montgomery in the removal of Fort Randall Cemetery, and says: "We found among these remains two that bore every evidence of being buried alive. The first case was that of a soldier who had been struck by lightning. Upon opening the lid of the coffin we found that the legs and arms had drawn up as far as the confines of the coffin would permit. The other was a case of death resulting from alcoholism. The body was slightly turned, the legs were drawn up a trifle, and the hands were clutching the clothing. In the coffin was found a large whisky flask, showing that those who buried him were not his friends, or else that they too were afflicted with the disease that had cut short the life of their companion." The same journal comments, September, 1896, on the dangers of hasty embalming, *i.e.*, injecting the arteries with poisonous preservative fluids, and of packing the bodies with ice soon after death, which would effectually prevent any chance of recovery.

Appendix E gives a summary of the ordinances, &c., relating to the inspection of corpses and of interments in various countries.

Waiting mortuaries are the remedy. Such are already established with the best results in Munich, Frankfort-on-the-Main, Weimar, Stuttgart, and other towns.

*The Medical Times*, September 11, 1847, gives the following suggestions by Mr. R. Brandon:—"The building should be large enough to provide means for resuscitation, and have room enough for the deposition of bodies during epidemics. There should be hot baths, for these are often alone enough to recall the vital spark, and a kitchen to prepare nourishment for those who are recovered, and for the porter and other officers who would live in the building. The room for the deposit of the bodies should communicate with the porter's room by means of a glass door, and every body should have a wire fixed by means of a ring to the feet and hands in communication with a bell, which must ring in the porter's room, in order to warn him should there be any motion in those thought to be dead. There should be men and women on the premises.



to use friction, a galvanic machine, and the implements necessary for transfusion and artificial respiration." He goes on to say that none should be buried until decomposition has unequivocally set in, and that means should be taken to give the supposed dead every chance of coming back to life, especially by having the mortuary chamber heated to 84° Fah., as suggested by the late Sir B. W. Richardson in the "Asclepiad," and by keeping the bodies well covered by blankets, &c.

I look forward to the time when it shall be customary, if not compulsory, for all dead bodies to be removed from private and other houses to the waiting mortuaries. This would do away with all danger to the public health and to morals, and would be a great public convenience. The coroner would also have rooms here, and this would do away with the very undesirable practice of holding inquests in hotels or private houses. That any autopsies ordered by the coroner or done by private request, would be more expeditiously done with suitable tables and other needful appliances at hand, surely needs no demonstration. Such a custom as this would also conduce to the public security from crime, and the ignorances and negligences of both professional and non-professional persons.

Messrs. Tebb and Vollum give details of the various mortuaries in London and elsewhere, but none of these fulfil the requirements given above. These authors also discuss and compare the various Continental ones.

As examples of the utility of waiting mortuaries, I quote the following from Tebb and Vollum :—"In the middle of the night the bell of the vestibule rang violently. The caretaker, who had only entered on his duties within a few days, much startled, ran towards the mortuary. As soon as he opened the door he found himself confronted with one of the corpses enveloped in his shroud, who had quitted his bier and was making his way out. He was a soldier of the guard, believed to be dead, and he was able to join his regiment five days later."

Herr Schmill, director of the mortuary at Frankfort-on-the-Main, relates a case of apparent death, which occurred

under his own eye. "In the year 1840 a girl of 19 years died of acute pleuro-pneumonia. Her body, during very hot weather, was exposed in the mortuary for a period of eight days, in a state of perfect preservation. Her face retained its colour, the limbs were supple, and the substance of the cornea transparent, whereas in ordinary cases decomposition shows itself on the third day. The parents could not reconcile themselves to have their daughter buried, and found themselves much troubled. Finally, on the ninth day, the supposed dead suddenly awoke without any premonitory indications of life."

In conclusion, it may be said that it is not claimed that all persons buried alive while entranced, &c., recover consciousness in the grave. No doubt many do not, but I think enough has been said to prove that many do so, and that they have lived long enough within the grave to suffer indescribable torment. A vast number of authentic cases of premature burial are recorded, but there must be many more that are known, but which have escaped publicity owing to the natural reluctance of the friends, undertakers, and medical attendants of the deceased to have made public such terrible mistakes.

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Dr. HAWKES, after referring to a case of premature burial which was well authenticated, said with reference to the first part of the paper, he had seen sudden death follow embolism in cardiac disease and perforation in gastric ulcer. He quite agreed that pleurisy is an alarming cause of sudden death, but in these days, with the use of the aspirator, quite inexcusable.

Dr. SIMPSON remarked that one of the signs of death was pressure of the finger not being followed by pallor and then return of colour. He had seen two cases of hæmophilia, but was happy to say both had rallied under phosphorus.

Dr. GORDON mentioned as an unusual cause of sudden death rupture of a small aneurism into the pericardium. A case of this had been narrated to him by a colleague. He was reminded in the paper of Mark Twain's message to enquiring friends who had heard a false report of his demise—"Reports of death greatly exaggerated."

Dr. WATSON said that Dr. Green's paper opened up the question as to what life really is. He referred to a patient in an asylum whom he had seen in a state of stupor which might well have been mistaken for death. Mania always preceded this condition, however.

Dr. HAYWARD mentioned mastoid disease in children as a cause of sudden death. Had Dr. Green ever known of catheterism in the male being a cause of sudden death? He was disappointed that Dr. Green had not dealt with cremation.

Dr. GREEN, in reply, remarked that self-inhumation seemed to be well authenticated. The cremation question was an interesting one, but unfortunately time did not permit him to deal with it in his paper.

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## ON THE THERAPEUTIC USE OF NOSODES.<sup>1</sup>

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As the line proposed for me to take in the discussion of this subject is to advance some remarks in favour of the therapeutic use of nosodes, I will commence by some quotations from Hahnemann's writings which explain, as I understand, the nature of a nosode, and prove his adherence to their use. He says in the fourth American edition of the "Organon," p. 22, note, "a fourth mode of employing medicines in diseases has been attempted to be created by means of isopathy, as it is called—that is to say, a method of curing a given disease by the same contagious principle that produces it. But even granting this could be done, which would certainly be a most valuable discovery, yet, after all, seeing that the miasm is given to the patient highly dynamized, and thereby, consequently, to a certain degree,

<sup>1</sup> Presented to the Section of Materia Medica and Therapeutics, January 6, 1898.

in an altered condition, the cure is effected only by opposing a *simillimum* to a *simillimum*." Again, in vol. i. "Chronic Diseases" (American edition, 1845), on p. 195 are the words:—"In the subsequent list of antipsoric remedies no isopathic remedies are mentioned for the reason that their effects upon the healthy organism have not been sufficiently ascertained; even the itch miasm (psorin), in its various degrees of potency, comes under this objection." "I call psorin a homœopathic antipsoric, because if the preparations of psorin did not alter its nature to that of a homœopathic remedy, it never could have any effect upon an organism tainted with that same identical virus. The psoric virus, by undergoing the processes of trituration and shaking, becomes just as much altered in its nature as gold does, the homœopathic preparations of which are not inert substances in the animal economy, but powerfully acting agents. Psorin is a *simillimum* of the itch virus. There is no intermediate degree between *idem* and *simillimum*; in other words, the thinking man sees that *simillimum* is the medium between *simile* and *idem*. The only definite meaning which the terms 'isopathic' and 'equale' can convey is that of *simillimum*; they are not *idem* (*ταυτον*)."

As to Hahnemann's own thoughts of the meaning of the word psora, we must bear in mind that he used it in a very much more extended sense than the modern word itch conveys. Thus he says, in p. 19 of the same work:—"This primitive disease evidently owed its existence to some chronic miasm." Again, p. 21:—"This internal enemy I shall designate by the general term psora. It is an internal disease—a sort of internal itch—and may exist either with or without an eruption upon the skin. . . . I find that thousands of tedious ailments which we find enumerated in our pathological works under distinct names originate, with a few exceptions, in this widely ramified psora."

Now I submit that the above extracts imply distinctly that Hahnemann accepted, as proved science, four things:—(1) The law of similarity; (2) *The law* (I emphasise purposely) *of potentisation*; (3) The use of nosodes; (4) The origin of

chronic disease in miasm ; and consequently that those who are seeking to carry out these four things, in the use of nosodes, therapeutically, that is to say on the same lines of provings on the healthy subject as the foundation of their knowledge, are only following to their logical conclusion the great thoughts taught and originated for us by the master mind of the pioneer of scientific therapeutic medicine, Samuel Hahnemann ; and on the other hand, that those who reject this line of enquiry and advance, are consequently rejecting a most valuable corollary to the great laws of similarity and potentisation.

I will now define what I understand to be the use of nosodes, therapeutically ; namely, the administration to the sick of the secretions of diseased animals, or of the pus or other morbid products of diseased conditions ; examples of the first kind would be hydrophobinum, glanderinum, vaccininum, and of the second, anthracinum, tuberculinum, medorrhinum, syphilinum. With regard to the use of the viruses (potentised) of animals in health, the extensive use of lachesis, croctalus, apis, tarentula, and many others, is practically unchallenged, so that our enquiry is reduced to the question of the use of the virus of diseased animals or the products of diseased conditions.

The almost universal acceptance of vaccination in the allopathic ranks is surely sufficient proof that they cannot with any consistency reject the principle of the introduction of the morbid products of disease for curative purposes ; and the modern furore for the use of thyroidin, pancreatin, cerebrin and many others, equally silences all consistent opposition to the use of the products of healthy secretions.

Amongst ourselves the only difficulty roused seems to have been to the use of the nosodes, of not only the viruses derived from the three chronic miasms of psora, syphilis and sycosis, pointed out by Hahnemann, but also to those of tuberculinum, scirrhinum, anthracinum and many more proposed since. What are the objections raised ? In the *Homœopathic Physician*, September, 1884, the late Edward Bayard argues against the use of nosodes (pp. 246-247). (1) It proceeds upon the erroneous assumption

that cure is wrought by identicals, not similars. (2) Even if it could be done theoretically, practically the nosode would contain the seeds of hereditary evils, which had no visible exponent in the disease expressed, and while antidoting one disease you might inoculate with the virus of many others. In the same periodical (July, 1890, p. 305) the late Dr. Fellger argues, it was absurd to claim that any disease could be cured by its nosode; we cannot be satisfied that it is in the same condition as when first taken from the diseased individual. These are the only objections to the therapeutic use of nosodes which I have been able to discover, and their refutation seems to me simplicity itself, if the remarks of Hahnemann above referred to be duly weighed; for, as to Bayard's first, potentiation alters the nosode from idem to simillimum, and as to his second objection, if that is to hold, we should never use any animal or even vegetable product whatever, for in the use of apis, *e.g.*, who is to guarantee to us that the apparently healthy bee from which our virus was derived had not latently any disease whatever from which bees may suffer. Dr. Fellger, however, takes the opposite ground in saying we cannot be satisfied that it (the nosode) is in the same condition as when first taken from the diseased individual, which is exactly what we want and which potentiation gives us, that is, similarity instead of identity; and another objection which he states to the effect that primary syphilis in any one person will make a different set of symptoms from syphilis in another person, and therefore, we must have a potentiation of each one of these kinds of syphilis, would apply with equal force and logic to every single drug in the materia medica, for every prover stamps his individuality on every drug he proves, and the very shades of difference resulting are the glories and successes of the careful and conscientious prescriber. No one using nosodes on the lines indicated by Hahnemann in speaking of psorin, could possibly object to nosodes prepared at different stages of the disease, *e.g.*, in syphilis the pus from a primary sore, that from a bubo later on, secretion of any

kind from ulcers, matter of any sort from eruptions, all duly proved and labelled, and to be administered in corresponding stages of the disease. I return now to the four points previously mentioned, namely: (1) The law of similarity. (2) The law of potentiation. (3) The therapeutic use of nosodes. (4) The origin of chronic disease in chronic miasm.

With regard to the first, as every member of this Society has openly avowed his adhesion to that, I need not detain you over this, beyond saying that Hahnemann certainly maintained it to be a natural law as truly as those of physics, chemistry, optics, or any other science, and not a mere rule of practice; and also to say that our confidence in it will vary immensely, according as we look at it materially or dynamically in its action. I pass on to potentiation, as to which it seems only necessary to say that Hahnemann not only expressed it as a law but as a discovery, and that this discovery, and not that of the law of similars, was what the world owed to him in this particular, his second discovery being that of the origin of chronic disease in chronic miasm. These two thoughts of potentiation and dynamic origin of disease, as proved truths, so permeate either directly or indirectly, one may say, every page both of the "Organon," the "Chronic Diseases," and the "Materia Medica Pura," that one can only marvel how any one professing to have studied these works can have a moment's hesitation in admitting that their author treated them in this way, and that in this way only can treatment by nosodes be understood or practised scientifically, according to him. He says, as already quoted, that a method of curing a given disease by the same contagious principle that produces it would be a most valuable discovery, yet not isopathy, because the miasm being given highly dynamised, consequently in a certain degree in an altered condition, the cure is effected only by opposing a simillimum to a simillimum. Now, here it will be observed, there is no difficulty raised about the origin of the virus as a diseased product, but simply that dynamisation has removed its action from that of identity to that of similarity, the degree of the latter of course varying with every

degree of potency. The whole difficulty of those who have a difficulty in the use of nosodes appears to lie in this direction, thinking it to be a form of isopathy, instead of homœopathy; but here collateral proof, such as the familiar instances of similar heat to a burn, snow to frostbite, and many others with which even the public are familiar, will surely justify, from analogy, the trial whether the law is available in the above-mentioned way—always of course guarding ourselves from routine and empiricism by carefully noting the characteristic symptoms present, and if something be found which characteristically has such, more distinctly than the nosodes, then that is the medicine for that case. If the thinking man sees that there is no intermediate degree between idem and simillimum, but that simillimum is the medium between simile and idem, what an invaluable field of therapeutic lore is thus opened up to us. How often has one proved the truth of this statement, in giving—when a medicine, though acting beneficially, is causing some untoward symptoms—but one dose of the same medicine of a higher potency with most satisfactory results, and what is this but proving that simillimum is the medium between simile and idem? Here, however, as always, let the caution be given that the symptoms requiring to be met are most like those of the drug being administered—more like them than like those of any other known medicament—the simillimum in fact. Further, our author says no isopathic remedies are mentioned among the antipsorics because their effects upon the healthy organism have not been sufficiently ascertained; here we shall all agree, but it cannot be said now that their effects have not been ascertained. Allen's "Materia Medica" gives twelve pages of symptoms obtained from psorinum, with authorities, and in several cases the potencies; and in the *Medical Advance* of October, 1886, page 352, is a proving of medorrhinum, reported by Berridge, to which are added clinical symptoms, and on page 584, corrections, with the additional information that the proving is to be credited to Dr. Swan; also in the *Advance*, vol. xxi., p. 123, is a detailed proving of syphilinum, with symptoms distinguished by marks according as the symptom



was taken from some case of disease, and clinically verified in some other patient suffering from the same or some other disease, or symptoms of the disease cured by the corresponding nosode, or symptoms taken from cases of disease; the authorities are forty-four in number. I am aware that some have an objection to clinical symptoms being made use of in practice, even when distinguished from what may in this sense be called pure symptoms, so on this point will quote from the preface to the first volume of the "*Materia Medica Pura.*" "Among the symptoms which have been furnished to me by other physicians, and which will be mentioned together with my own, there are some which have been observed upon sick persons. However, inasmuch as these persons were chronic patients, and their morbid symptoms had been well ascertained, at any rate by Greeding, care has been taken to distinguish these standing symptoms from the symptoms produced by the medicine. Symptoms discovered upon such patients are therefore not without some value, and may, at any rate, serve to confirm analogous or the same symptoms when found upon healthy persons."

There has, then, been a commencement, and on Hahnemannian lines, to fill up the hiatus existing in our knowledge of the use of nosodes as pointed out by Hahnemann; and let those who object to the mode presented institute, on themselves or others, further and more rigidly scientific provings, and doubtless the effect will be, as was with the celebrated Austrian reprovng of nat. mur., a confirmation of truth already discovered, and an enlarging of the boundary of a scientific *materia medica*.

As to the clinical use that has already been made of many of these nosodes, both acute and chronic, instances will be found scattered up and down in the pages of the *Homœopathic Physician* and the *Advance*, and of "*Glanderinum* and *Syphilitinum*," in Dr. Skinner's "*Organon*" of 3 vols., as doubtless in other places; and I will venture here to mention a case, which seemed to me a very pretty one, in which to a young lady calling on me one day, and being unable to make out any particular symptoms, and knowing that she was very susceptible to the sound of falling water, I

administered a few doses of hydrophobinum, without, of course, giving her the least clue as to its nature and my object, and was much gratified some weeks afterwards on hearing her one day telling some friends with great animation that having been into North Wales, she greatly enjoyed the scenery (she had artistic talent) and, "do you know," she added, "what never happened to me before, I could stand near a waterfall and enjoy it." I do not here go into the practice beyond saying that the same rules, whether as to potency or repetition, must guide us as are necessary in the administration of every medicine to every disease, judgment being here, as everywhere else, judgment founded on knowledge and experience.

My object now is simply to show that the scientific use of nosodes is strictly a fair inference from the teachings of Hahnemann and a real advance in both the science and the practice of our art. To bring the subject down to date, what are Pasteurism, Listerism, and Kochism, but crude imitations, mechanical blunderings into the arcana of the mighty laws introduced to us by the genius of Hahnemann? and what were the fearful mortality at first under Koch and the many failures under Pasteur, but proofs of both the absurdity and the danger of mixing things that differ into an unknown compound, not of the multifarious drugs of polypharmacy, but of the laws of similarity and potentiation sought to be carried out on material lines? What is the thought that every case of hydrophobia could be cured by the crudity of inoculation but a gross defiance of that stern individuality of disease which true science alone claims, and which is an absolute *sine qua non* to successful cure? Let us go further. Is not the whole of bacteriological science as taught and practised in the present day, only on a large scale an admission, though a most gross recrudescence, of these same laws which come in so clearly in the scientifically therapeutic use of nosodes? What is the admission of the almost infinite power of something hitherto inappreciable by any of our senses and now only by one, because microscopes have been brought to an excellence hitherto unattained, but an admission that there are powers in nature which can both

kill and cure in myriads, and yet to four of our senses they are still *non sunt*? In a word, what real therapeutic advance is there in this year of grace, 1898, that is not in its germ to be discovered in the "Organon," the "Chronic Diseases," and the prefatory and other remarks in the "Materia Medica Pura," and in those two directions of similarity and potentisation?

In conclusion, I cannot forbear throwing out a hint as to the use of disinfectants, scientifically. Is not the most similar remedy at the moment the truest disinfectant for that particular case and that particular epidemic? Should not we, on principle, raise a unanimous protest against the crudity of Listerism and all powerfully offensive odours, and besides the carefully chosen remedy, trust implicitly to the powerful virtues of absolute cleanliness and fresh air?

This is a large subject, and I only refer to it, as it seems to me a fair deduction in principle from the subject before us.

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## ON THE USE OF NOSODES IN HOMŒOPATHIC PRACTICE.<sup>1</sup>

BY RICHARD HUGHES, M.D.

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SOME little time ago, the Section of Materia Medica and Therapeutics had to present before the Society at one of its meetings a paper by Dr. Pullar on the use of hippozænine and psorinum, and herein of other nosodes, in homœopathic practice. The Secretary to the Section having informed me (then, as now, its Chairman) that Dr. Pullar's paper

<sup>1</sup> Presented to the Section of Materia Medica and Therapeutics, January 8, 1898.

would hardly afford sufficient material for the discussion of the subject, I prepared some remarks of my own upon it—taking up primarily the two nosodes he had mentioned, and then considering such substances in general and tuberculine in particular. As it turned out, the evening was advanced before Dr. Pullar had finished his communication, and I asked that mine might be taken as read. It would doubtless have been printed ere now with his and the discussion which ensued; but Dr. Pullar having expressed a strong wish that his paper should not appear in the *JOURNAL* of the Society, it has been thought best to refrain from publishing the remarks, whether written or verbal, to which it gave rise: and my essay has been returned to me. Now that Mr. Mahony has again broached the question of nosodes and their employment in our hands, I think that I also may return to the charge; and my hearers will pardon me if what I shall read before them bears traces of the previous occasion for which it was prepared.

The mention by Dr. Pullar of hippozænine as one of the remedies whose action he proposed to bring before us, must have recalled to readers of the *British Journal of Homœopathy* an ancient passage of arms. The combatants were no less doughty knights than Dr. Garth Wilkinson and Dr. Drysdale—the former of whom we are glad still to have with us, though the latter has gone to his rest. The lists were pitched in 1854, and the account of the jousts is contained in the volume of the *Journal* (xii.) for that year.

I say it is glanderine which recalls this discussion of past days, for this was the nosode from whose use Dr. Wilkinson predicted so much good, and with which he subsequently in some measure fulfilled his prophecy. His paper, however, was called “Some Deductions from the Principle involved in Vaccination.” As may be supposed, prophylaxis was the main purpose to which the inoculation or ingestion of other such substances was to be turned; but the writer seems to have assumed, without arguing the point, that what was preventive would also be curative. He maintained also that the phenomena of idiopathic glanders constitute a true, and indeed the best, proving of the virus

upon the healthy ; and that we may infer therefrom, on the homœopathic principle, its suitability to ozæna, tuberculosis, and several other forms of disease.

Dr. Drysdale, commenting on Dr. Wilkinson's paper, says that he had been led by similar reasoning to like hopes with him ; but had met with complete disappointment in practice. Thinking out the causes of this, he was inclined to set them down as three in number.

(1) That some of the poisons used as nosodes are not of stable and fixed character.

(2) That many of them seem to act only when inoculated, not when taken into the stomach ; hence no inference can be drawn from their effects, when disease occurs from contagion, which shall guide to their use by ingestion as ordinary medicines.

(3) That the attenuation of self-multiplying viruses is no parallel process to that of vegetable or mineral poisons. "Dilution must either be so great as to deprive the virus of the power of reproduction, or else we give the complete disease ;" and as we certainly do not effect the latter, we must suppose our attenuations of glanderine and the like to be inert.

Looked at in the light of present-day knowledge, we may pass by the first objection as inapplicable to most of the viruses used as nosodes ; and of the second may say, *solvitur ambulando*. The analogy of serpent-venom and bee-virus, which was thought to support it, now makes all the other way. The Drysdale who wrote in 1854 : "We have no right to expect that the cured symptoms should accord at all with the bite symptoms," came in later times to be the supporter of crotalus and the introducer of sepsin as internal remedies in blood-poisoning ; and no one now doubts that the effects of a bee-sting are our best guide to the exhibition of apis. The third difficulty, which seemed decisive, has cleared away since we have learned to distinguish between bacteria and their toxins. The former are the "self-multiplying," "self-reproducing" elements of the *contagium*, but it is the toxin they secrete which causes the symptoms of the disease. The bacteria will

soon perish and vanish as attenuation goes on ; their product—a fairly stable chemical composition—remains, and will be available for medicinal use as long as any other substance can be. It is this which we employ when we give nosodes as medicines.

There was really, then, no theoretical reason why glanderine should not be tried as a remedy for conditions resembling those present in idiopathic glanders (and farcy). Three years later, Dr. Wilkinson came forward in the same journal (vol. xv.) to state the results of his experience with the medicine—which he now calls “hippozænine.” He had come to regard it as “little short of a specific in the worst forms of bronchitis ; especially in elderly persons, where suffocation from excessive secretion is imminent.” It is also valuable, he finds, in smouldering, persistent cases, which are apt to leave bronchial asthma behind. In severe nasal catarrh, and even where diphtheria invades the nostrils, he can praise it, and has “given it in one case of ozæna with marked success.” In phthisis, however, where he expected so much from it, it storms the outworks, but has not yet shown its power of carrying the citadel.

I know of no other recorded experience with this nosode, and am unaware whether it has ever been tried isopathically, *i.e.*, in glanders itself. If Dr. Pullar had allowed his experience with it to appear in print, this might have started it afresh as a remedy.

His mention of psorinum carries us back to yet more ancient history—to the doings recorded in the sixth of Dr. Dudgeon’s invaluable *Lectures on Homœopathy*. Into the general considerations there adduced I will enter later ; but with regard to psorinum the information given is not very encouraging. The pathogenesis of this nosode, as we find it in Allen, shows that four out of the five provings ascribed to it were made (by Gross) with “psora sicca,” which (the editor tells us) is the epidermoid efflorescence of pityriasis. They are quite out of court, then, for any genuine employment of the drug, and we can only hope that the “psorinum” supplied by homœopathic chemists is not derived from this source. The remaining proving

is Hahnemann's own, and is unexceptionable as regards the origin of the substance proved; though what can be expected from the "30th potency, once-repeated doses," may remain an open question. Is our "psorinum" derived from his? or do Americans (who are almost its exclusive employers) obtain it from the more indigenous source opened by Hering? His matter was got (Dr. Dudgeon informs us) "from some full, large, yellow pustules, on the fingers, hands, and forearms of a young and otherwise healthy negro, in whom these pustules had been produced by handling some stuff from Germany." He is unable to state whether the characteristic acari were present or not. "It is very improbable," our author goes on, "that the disease of this negro was true itch, for as far as we know, itch is always propagated by contact with an itchy person; and its eruption, when not altered by art, is a small vesicular, not a large pustular one." I hardly think Dr. Dudgeon would now maintain the non-transmissibility of itch by fomites; but his second objection seems unimpeachable.

There is thus a considerable uncertainty as to what it is that is being used under the name of "psorinum," and a few years ago I should have said the same as to there being any reality in the substance at all, even when derived from the genuine itch-vesicle. I mean, that there seemed no evidence that the contents of this had any specific properties. The analogy, however, of bacteria and their toxins suggests that the *acarus scabiei* itself may generate similar products; and Dr. Gailliard would carry us further still in this direction. Our Brussels colleague, now also a corresponding member of this Society, sent a paper to the International Congress of 1891, entitled "The Psoric Origin of many Chronic Diseases."<sup>1</sup> He there reminds us that the *acarus* of itch is a member of the family *arachnida*; and states that, like others of the group, it secretes a venom by means of a special glandular apparatus situated within its mandibles. The analogy of other venoms would suggest

<sup>1</sup> See its Transactions, p. 414.

that this of the sarcoptes hominis has an albuminoid active principle, which he would call "psorine" (as that of crotalus-venom is crotaline). To its absorption into the blood he traces the secondary disorders which he follows Hahnemann in laying to the charge of scabies. These are a simple papulous eruption presenting all the characters of prurigo, which, according to Hardy, is missing only once in a hundred patients; unbearable itching, commonly setting in at night and promoted by the warmth of the bed; and an abnormal smell of the sweat, *sui generis*, but reminding of sulphuretted hydrogen. This is not much in comparison with Hahnemann's list of "psoric" disorders; but it is sufficient to show that the itch-vesicle, like the chancre, has its secondaries, and that the Master was not so far wrong in propounding it as the starting-point of at least some chronic disease.

As Dr. Pullar promised us an examination of the provings and clinical symptoms of psorinum, I contented myself with the foregoing remarks upon it. If I remember rightly, however, he hardly came up to expectation here; and I can but hope that Mr. Mahony will do what he left undone. I would myself only observe that here also we have heard nothing—at any rate of late years—of its isopathic use. Hering, in 1833, extolled it as "the most important remedy in every form of scabies, and as a prophylactic against infection with itch. He found a globule of the 30th dilution the best dose to give" (Dudgeon). The Hahnemannians (so-called), who recently in their organ the *Homœopathic Physician* raised such despairing cries as to the futility of internal treatment for recent itch, would not (I imagine) find this medication of Hering's much help in their need.

The general question of the use of nosodes is discussed in the lecture of Dr. Dudgeon, already referred to, in a masterly manner; and I think we must all agree with most of his conclusions. He would limit the term and the practice to the proved virulent products of specific disease, thereby excluding such preparations as thyroidin ("sarco-codes," as Dr. Clarke would call them), which occupy a



place of their own, and sweeping away the manifold nastinesses of secretions and such-like with which morbid fancies have tried to load our Pharmacopœia. Within these limits he would not deny the efficacy of nosodes, and would not reject isopathic indications for their use. And here a word upon this term. By some, including Hahnemann himself, it has been objected to; and the "potentiation" of the nosode has been considered to make it no longer *ἴσον, æquale*, but *ὅμοιον, simile*. Whatever theory may say, however, in practice there is an obvious difference between giving hippozœnine for glanders itself and for bronchitis, psorine for scabies and for prurigo. Dr. Dudgeon maintains that the *modus operandi* is the same in either case, adopting (as he does or did) Fletcher's theory of this; and he cites his own and Trinks's experience of variolin in small-pox as supporting his argument. Still the practice belongs to a separate category and should have a distinctive name.

The mention of small-pox takes us back to one of the most important of nosodes—vaccine lymph, or (as it may be called) vaccinine. Upon this I should have liked to have said a few words to-day, but the vistas it opens are so many and so long that no adequate justice could be done to the subject in the time at my disposal. I pass, therefore, to the other substance of this kind mentioned in the synopsis of my paper—tuberculine.

While vaccinine is one of the oldest of nosodes, tuberculine is among the newest. We all remember its introduction by Koch in 1890, and the claims he made for it, on the strength of some experiments on animals, as curative in phthisis. We can recall what occurred in consequence—the mad rush of doctors and patients to Berlin, the high hopes raised, the State aid and honours given to the supposed discoverer; then the disappointment, the disasters, and finally the relegation of the new treatment to the limbo—already too full—of medical illusions. Homœopathy, however, has sought, by its better methods, to evoke the "soul of goodness in things evil" which may exist here as elsewhere. Even an old-school practitioner has seen that insufficient

reduction of dosage—far as it went in Koch's case—might be the cause of failure. Dr. Sinclair Coghill, of the Ventnor Consumptive Hospital, has obtained arrest of disease in eight cases of phthisis, six of whom, four years later, were enjoying excellent health; and he "mainly attributes the exceptional success of the treatment in his hands to his adapting the amount of tuberculine so as to obtain merely an indication of reaction," Koch being not content unless this was quite pronounced.<sup>1</sup> By the disciples of Hahnemann it was at once perceived that a substance which, introduced into the healthy organism, caused fever and cough, and which in the ordinary dosage set up in phthisical cases fresh inflammation and softening, might (whatever its source) be of the nature of a *simile* to the bacillus tuberculosis, and should do something, its virulence being subdued by our processes of attenuation, to control the ravages of that microbe.

Dr. Clarke, in this country, and Dr. Bernard Arnulphy, in the United States, have taken a leading part in so arguing and acting. The contributions of the former, are they not written in the *Homœopathic World*? and those of the latter have been summarised as from time to time they have appeared in the JOURNAL of our Society. Dr. Arnulphy's results are most satisfactory and encouraging, and there can be no doubt of the competence of the observer, whose acquaintance I had the pleasure of making at Nice in 1880. They, like Dr. Clarke's, were due to Koch's initiative, and were obtained with his preparation, which seems to be a pure solution of the toxine generated by the bacillus which bears his name, the microbes themselves being filtered out of it. Long before his time, however, the isopathic idea had led the late Dr. Swan to prepare and use a "tuberculine" as a remedy for phthisis—with what success I know not. About the end of 1890 appeared a little *brochure* by Dr. Burnett, entitled "Five Years' Experience in the New Cure of Consumption by its own Virus, illustrated by Fifty-four Cases." Of his preparation, which he calls "bacillinum," I will speak immediately. With it, he states, he had since 1885 been treating every pronounced tuberculous case that came under his

<sup>1</sup> *Lancet*, Nov. 16, 1895.

care, and with a very large measure of success. Dr. Burnett writes *ad populum* rather than *ad clerum*, and his cases often fail to bear close analysis. Physical examination of the chest is rarely noted, microscopical investigation of the sputa never, and there is no record of temperature, pulse, and respiration. He confesses (pp. 114, 184) that he has written *currente calamo*, and the book bears too strong evidence of it. Nevertheless, it is impossible to read his fifty-four narratives, and those additional from himself and others in the third edition which the book has now reached, without being impressed with the real curative properties of "bacillinum," and feeling that they far excel those of other remedies reputed in phthisis.

What is this "bacillinum"? Is there any distinction between it and Koch's tuberculine? and does the one claim any preference over the other? Swan's tuberculine was a trituration of phthisical sputa; but Dr. Burnett seems to think that his preparation was made from tubercle taken *e situ* after death, and showing bacilli in it. Hence the name he has given it. I have ascertained, however, from the chemist who supplied him with it that it, too, was made from sputum. The matrix "consisted of a mass of grey and yellow tuberculous matter, containing the bacillus tuberculosis. In this (the last) stage of phthisis, patients often bring up suddenly, without effort, almost solid lumps. Such was my tuberculine." Dr. Heath lays stress on this being the whole product of consumption—not a selection of one element only, as Koch's is; and the facts about streptococci which have come to light in respect of the anti-toxin treatment of diphtheria bear out the importance of these secondary factors of the disease.

So far we have been speaking of the isopathic use of tuberculine. Dr. Burnett's employment of it is frankly of this kind. Whenever he has reason to think a patient's illness to depend upon tubercle, present or threatening, or even far back in the past, he puts in his bacillinum; and whenever an outlying symptom, *e.g.*, ringworm, yields to bacillinum, he sets it down as of tubercular origin. Dr. Arnulphy, and also Dr. Mersch, of Brussels, have made

some essays towards the homœopathic use of the nosode ; but its chief advocate and expositor in this aspect is Dr. Cartier, of Paris. His valuable paper presented at our late International Congress—"The Viruses of Tuberculosis in Homœopathic Practice"—will be fresh in the memory of all of you. He agrees with Burnett and Heath in preferring bacillinum to Koch's laboratory solution of toxin, on the ground I have suggested above. He does not find it necessary to go up to Burnett's 100ths, the 30th dilution suiting him very well ; and he gives it in pulmonary affections *like* those which tubercular deposit causes, but without such deposit being present. Confirming Drs. Arnulphy and Mersch's experience in lobular pneumonia, he gives "dyspnœa resulting from bronchial and pulmonary obstruction caused by a superabundant secretion from the mucous membrane" as the condition calling for the remedy, and relates some striking cases in point. He has also had some gratifying experience with the tuberculine of birds—"aviaire," as he calls it—which seems a distinct variety of the nosode ; and esteems it highly in influenzal and other broncho-pulmonary inflammation, where cough is more marked than dyspnœa, and also in all "*bronchites suspectes*"—where the symptoms threaten impending phthisis. He further makes a valuable suggestion as to its use as an isopathic remedy. "I consider bacillinum a powerful moderator of the muco-purulent secretion of consumption. While diminishing the secretion it modifies the auscultation ; there is less fluid sputum, the cavities are drier, the peri-tuberculous congestion less intense. The clinical symptoms follow those of the auscultation ; as the patient expectorates less he is less feeble, coughs less, gains strength, and regains his spirits ; but the tubercle remains untouched. The peri-tuberculous congestion only is diminished, as one may observe with the naked eye when Koch's lymph is employed in the amelioration of lupus. The peri-tuberculous inflammation disappears ; the skin seems healthy, but the yellow tubercle remains as it was, and the patient is still uncured. Such are the limits I assign to bacillinum in its action on consumption."

This is a large subject, gentlemen, and wants a thorough working-up. I hope that Mr. Mahony's contribution and my own of to-night will be found useful as *mémoires pour servir* by any one who shall undertake the task.

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DISCUSSION ON THE PAPERS OF MR. MAHONY AND DR. HUGHES.

Dr. DUDGEON said that some of Mr. Mahony's observations were scarcely warranted by the quotations he had given of Hahnemann's opinions with regard to the matter. Among other things Mr. Mahony had stated that Hahnemann asserted *similia similibus curentur* to be a law of nature. Hahnemann nowhere said it was a law of nature. He said it was a therapeutic maxim, and the translation was "Let likes be treated by likes." Of course that depended upon a law of nature, but his formula was not stated as a law but as a maxim or rule of practice. Mr. Mahony was mistaken in supposing that what are called clinical symptoms had the authority of Hahnemann. Hahnemann said that in the midst of the symptoms of a disease, a master of the art of medicine was able to distinguish those that were due to the medicines administered, as distinct from the symptoms of the disease; but by clinical symptoms they now understood symptoms that had been removed in the course of the treatment of a disease. For instance, a patient would present a number of symptoms; on giving a medicine these symptoms disappeared, and these symptoms were incorporated in some of their *materia medicas*. They were the clinical symptoms, and were totally different from the symptoms that Hahnemann said might be observed while treating cases of chronic disease. Mr. Mahony stated that in the Allopathic School vaccine was largely regarded as a cure for variola. It was not regarded as a cure, but as a substitution. They considered vaccinia was a modified variola which was inoculated in a healthy subject, not with a view of curing but of preventing the natural smallpox. So used it did not belong to the category of curative nosodes at all. When vaccinin or variolin were

given in homœopathic practice, of course they reckoned these as a nosode for smallpox. He did not think the results of giving these medicines could be considered very trustworthy, because they all knew that many cases of smallpox which occurred in persons who had been vaccinated ran an extremely modified course. If they had given vaccinin or variolin they naturally ascribed the rapid and successful termination of an apparently severe case to that remedy, but they observed under all treatments that the same thing happened, with or without medicine. In a vaccinated person the eruption would often suddenly fade away, even though it had commenced with great intensity. Therefore it was not a fair test of the value of a remedy when used in the case of persons who had been already vaccinated. With regard to Hahnemann's view that potentization altered the nature of a medicine, he would remark incidentally that those practitioners who had been most energetic in the introduction of so-called high potencies, and had written most about their efficacy, differed from Hahnemann entirely in their modes of preparing these potencies. Their mode of preparation of these remedies was a mere dilution. It wanted the particular processes of trituration and succussion which Hahnemann asserted to be equal in importance to his rule of *similia similibus curentur* itself, and it was by these processes, which the high potentizers neglected, that Hahnemann conceived the medicine became altered and spiritualised, though in the last edition of the "Organon" he asserted that however much attenuated a medicine may be it still remains the same medicine. Of course many homœopaths did not accept the idea that the medicine was altered at all by Hahnemann's method of dilution. The general view was that it remained the same thing, but that by being diluted and spread over a larger surface it became more suitable for acting on the minute histological tissues concerned in the production of disease.

Dr. GALLEY BLACKLEY said Dr. Dudgeon had undoubtedly put his finger upon one of the weak points in Mr. Mahony's paper, for the author spoke as if all homœopaths accepted the doctrine that potentization of an animal secretion or poison or product gave similarity in place of identity. In that he thought Mr. Mahony was quite mistaken; most homœopaths did not think so, especially of late. Since they had had the tuberculinum of Koch in the market in a fairly uniform strength and absolutely free from all suspicion of bacilli, those who used it, he himself amongst the number, did so because it gave them the identical substance in a

diluted form. The process of dilution in no sense of the word altered its properties, until of course the boundary line between the physiological and therapeutic effects was overstepped. He had certainly seen medicinal aggravation occur from the exhibition of the third centesimal dilution of tuberculin, and he had then gone higher, giving the sixth and even the twelfth. In another matter also he thought Mr. Mahony was somewhat in error, certainly with regard to tuberculin. Mr. Mahony stated that it was only since the microscope had been brought to bear upon the substance that it had become identified—that, in fact, the recognition of the drug depended upon the sense of sight only. That this is not the case, however, anyone could see for himself by making a subcutaneous injection of a tangible dose of the sterilised and filtered product. Here the drug was recognised by its physiological effects alone. Chemical analysis, too, showed it to be a body of constant composition and fairly stable, and reacting to certain chemical tests. One question naturally rises to the lips of a man of this generation when he reads the accounts of the effects of some of the nosodes as related by Dr. Garth Wilkinson and others, who speak of this or that symptom being cured by a dose of psorinum, for instance. The question was, “What about the totality of symptoms in these cases?” An isolated symptom in cases of chronic bronchitis, for instance, might be relieved or cured by a dose of psorinum, but what of that? Such records were, after all, absolutely uninformative, and, as compared with those where the totality was looked to in the true Hahnemannian spirit, comparatively valueless. With regard to psorinum, he would venture to suggest that the negro who furnished the material for the first supply of psorinum, living, as he probably did, in a sugar-producing country, had what was commonly known as *grocer's itch*, which we now knew was not itch at all. With regard to the question of the acarus secreting poison somewhat resembling a toxine, he granted that such a thing was possible, but his experience of itch showed him that it frequently occurred in people who were unusually vigorous and healthy. The odour supposed to be peculiar to scabies is very easily explained. Nine cases out of ten, when they presented themselves for the first time to the physician, had already been treated with sulphur ointment, and the smell noticed was absolutely and entirely the effect of the sulphur, which had either been used as an ointment or the patient had taken flowers of sulphur internally. With regard to the use of psorinum as a prophylactic for itch, he (Dr. Blackley) would very much like to know what a prophylactic for itch was expected to do?

Dr. DYCE BROWN thought that Mr. Mahony's theory about the relation between the idem and simile and simillimum assumed too much. He hardly ever used nosodes, so that his practical experience was almost *nil*. He had used bacillinum in several cases, but had seen no result whatever. Many of Dr. Burnett's cases were really useless from a medical point of view, because they gave no reliable details to enable one to form a diagnosis in one's own mind.

Dr. GOLDSBROUGH said they were apt to think when they used a toxin which constituted one of the nosodes that its effects on the healthy would be a representation of the disease from which it had been obtained. But that did not at all follow. Take tuberculinum, for instance, how were they to regard that substance? Were they to take it as a drug which could be used on the rule of similars in the same way as they could any other drug? It seemed to him it could not legitimately be used in tuberculosis on that principle, for the reason that in tuberculosis they had really a series of phenomena which in themselves did not in any way constitute one disease process, but several. Dr. Hughes had made the remark that in the case of lupus the tubercle itself was not cured, but only the peri-tubercular inflammation. What would constitute a cure? An entirely different process from that of the peri-tubercular inflammation. It would mean an increase of connective tissue encapsulating the tubercle, and a fatty degeneration taking place, so that the bacillus was starved. This was an entirely different process from that of peri-tubercular inflammation, and no one could say that the administration of tuberculinum could be the means of bringing such a process about. There was an ulterior biological problem to be dealt with and various questions arising as to what influences could be brought to bear on the disease processes so as to promote a natural cure. They had to consider whether, treating tuberculinum as a drug, it would produce a condition as nearly as possible similar to the condition in the patient, and as nearly as possible similar in point of time as well as in point of character. This latter point has been brought out by Dr. Ord and it was one they ought always to think of. He himself had endeavoured to discuss Hahnemann's speculations in the matter of psora in the contribution he had made to the International Congress the year before last, but he would point out again that Hahnemann's position was entirely different from that of Dr. Gailliard and many other homœopathic practitioners. Hahnemann generalised with regard to chronic diseases from what he thought of as one con-



dition which was now known to consist of a very large number of forms of disease. Dr. Gailliard's contribution produced no conviction in his (Dr. Goldsbrough's) mind at all.

Dr. JAGIELSKI said he had tried the bacillinum treatment in eight cases. Some of them were still under treatment, and some of them had been very much improved. He followed Dr. Burnett's advice in endeavouring to remove first those symptoms which did not belong to the bacillinum group, and then proceed to treat the consumption. Bacillinum itself should only be given every week or ten days in order to have its full effect. He thought it rather an advantage to have several dilutions, as the 30th, the 100th, and 200th; if it happened that the lower gave headache, or disturbed sleep, or increased expectoration, it would be easy to avoid these by giving the higher dilution.

Dr. JAMES JONES said he had had no success at all with tuberculinum. He would ask Dr. Hughes what was the strength of the glanderine which Dr. Wilkinson recommended.

The PRESIDENT (Dr. Edwin Neatby) said that the subject was one of some importance, because it marked a distinct transition period in the important subject of treatment by animal extracts or disease products in general. They were advancing now from the old position of giving some product to which fancy names were attached, to that of very definite chemical substances which they could reproduce. He was afraid they must regard the old nosodes as really very bad examples of polypharmacy, because there was no doubt that the substances which had been given were to some extent toxines, but toxines which were of very uncertain and varying composition—toxines due to the action of bacilli and bacteria of a variety of kinds mixed together—and it was practically impossible to get a repetition of an agent which had been given on a former occasion, because very few sources are identical. The fact that phthisical sputum might be obtained in each instance did not make it sure that an identical agent was being used. Then again, to put it on a sounder basis, having ascertained as far as possible, by the scientific measures which were now adopted, the chemical nature of their toxines, they must prove them on the healthy subject; they must not simply take them as chemical agents having a biological power, but they must prove them on the healthy subject before they used them on the sick.

Dr. HUGHES, in reply, said that he had given a number of references to authors who had treated on the subject of the use of vaccinine in smallpox in his *Therapeutics*. Dr. Wilkinson

used hippozænine in the 6x. Dr. Goldsbrough seemed to assume that tuberculine was to be treated as still awaiting proving. He did not see why the disease set up by the tubercle bacillus should not be regarded as a proving of the tuberculous toxin. It seemed to him that they might very fairly proceed homœopathically upon the proving already instituted by nature herself. He was surprised at Dr. Goldsbrough saying that Dr. Gailliard's paper had no weight on his mind; it seemed to him (Dr. Hughes) to be the rescue of psorinum. Hitherto he had been unable to listen to any claims for it; but if Dr. Gailliard's facts were true they had a genuine pathogenetic agent which they could employ homœopathically when occasion served. He was afraid that Dr. Blackley's point as to the sulphuretted hydrogen smell was truly made, and that that must be eliminated from the list of symptoms. He had simply given them the quotations. A point he wished to emphasise was the objection which Dr. Dudgeon had made to Mr. Mahony's assumption that Hahnemann must be right in saying that potentization altered the *idem* into a *similimum*. That was an unsupported and improbable statement, and one which he could not accept on the *ipse dixit* even of such a master as Hahnemann. Hahnemann gave no argument for it but only assumed it, and Mr. Mahony merely quoted it and did not support it. As he (Dr. Hughes) had said in his paper, there was obviously a great difference between giving psorine for scabies and for prurigo; and there was a great difference between giving tuberculine for phthisis and for lobular pneumonia. What went on in the recesses of the organism he did not venture to suggest, but that the indications, the principle and method of choice, were different, he thought everybody must admit.

Mr. MAHONY, in reply, said that with regard to Dr. Dudgeon's remarks, all he could say was that that was not the way in which he read Hahnemann's opinions. It seemed to him that the way that Hahnemann thought and practised was different to the views Dr. Dudgeon had propounded. He did not understand what Dr. Blackley meant by saying he did not accept potentization, because gold as gold, and gold potentized, were certainly very different things. He believed the great point with regard to potentization was that there should be thorough mixture. The nearest analogy was latent heat in chemistry. Everyone knew that when water and sulphuric acid, both cold liquids, were mixed together, they became intensely hot—a power that was there had been developed. That is the whole thing in potentization: the latent power was brought to light. It was there before, but was not to be

appreciated. He objected as strongly as Dr. Blackley to the cure of isolated symptoms. He thought in his paper he had emphasised the point that the characteristic symptoms were what were wanted, and if there was a medicine which suited them then that should be given and not the nosode. He thought grocer's itch was a form of psora. They had to remember the wide way in which Hahnemann used the term psora—far wider than in the present day. Notwithstanding what Dr. Dyce Brown had said, he thought Hahnemann's reasoning with regard to *idem* and *simillimum* was most logical—that the nearer they could go to *idem* the more they had the *simillimum*. He did not understand Dr. Goldsbrough's observations on tuberculinum. He would not give tuberculinum because a person had a tendency to phthisis in his family or a phthisical cough, but if he had the other symptoms, such as the peculiar chill down the back, and so on, which Dr. Swan spoke of, he would do so.

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## THE GENIUS OF HAHNEMANN.<sup>1</sup>

BY THOMAS SIMPSON, M.D.

*Hon. Medical Officer to the Hahnemann Hospital, Liverpool.*

I AM fully conscious of the difficulties which attend a judicious selection of a suitable subject for study on the occasion of your monthly meeting, and I confess to feeling some anxiety lest you should regard the title of this paper as indicating a worn out and antiquated theme, yet in reliance on your clemency I venture to anticipate that you will not so regard it, but will concede readily the claims which great thinkers and men of profound scientific research have upon the attention of all studious, ingenuous men.

The most significant feature in the history of an epoch is the manner it has of welcoming a great man, for in truth a great mind as it comes from the hand of Nature is ever a source of intense interest.

<sup>1</sup> Presented to the Liverpool Branch, February, 1898.

No man is adequate to accomplish anything majestic and enduring, but he is, first of all, in right earnest about it, what we call a sincere man ; sincerity (deep, great, genuine sincerity) is the first characteristic of any man in any way magnanimous and heroic—his sincerity does not depend on himself, he cannot help being sincere ; though all men should forget the great aim of existence and walk in a vain show, he cannot. Such an one we look upon as an original man ; he comes to us, at first hand, a messenger sent from the Infinite unknown with tidings to us ; an inspiration gives him understanding ; we are constrained to listen to him. In the true literary man there is ever (acknowledged or not by the world) a sacredness ; he is a light in the world, guiding it in its dark pilgrimage through the waste of time. Brilliant examples of such luminaries may be found in every age,—philanthropists such as John Howard, Sir Thomas Fowell Buxton, the Earl of Shaftesbury ; pioneers of civilisation like Columbus, the Pilgrim Fathers and Carey ; and in the medical world, John Hunter and Jenner, Harvey and Sydenham, and last of all, the illustrious founder of homœopathy, whose life, genius and work we propose briefly to discuss on this occasion.

And first we may admire his energy, his invincible determination, a purpose once fixed and then death or victory. This trait of character was finely exhibited in the means he adopted of pursuing his studies in the medical school at Vienna, for which he carefully accumulated sufficient money to maintain himself. Another proof lies in the unwearying efforts he made to follow up the truth he had recently found,—efforts, undeterred by the pecuniary privations he had to endure, and the bitter persecutions which confronted him at every juncture and which mainly contributed to his retirement from the haunts of men and to his misanthropy, censoriousness and intolerance, and which led him to say, “He who does not walk on exactly the same line with me, who diverges (if it be but the breadth of a straw) to the right-hand or to the left, is an apostate, a traitor, and with him I have nothing to do.”

This, and other expressions of hostility towards those

who dared to differ with him, and to be self-assertive, should be a solemn and salutary warning to all his followers never to imitate his example of uncharitableness. We think it would have contributed greatly to the general adoption of homœopathy had Hahnemann been more confiding in his friends and followers, more charitable and less despotic; there would have been less friction and not so sharp a contrast between the old effete systems of medical treatment and the novel and startling methods he propounded. Yet we cannot ignore the possible advantages which may have accrued to the internal development of the new system. Perhaps it is essential to the success of any discovery that its promoters should suffer persecution, and endure hardness and ostracism in forced retirement from the glamour and tumult of life, in order that they may pursue their object under auspicious influences, so that the truth may be elaborated and their enemies silenced.

Hahnemann felt bitterly the injustice and the vindictiveness of the accusations laid to his charge, and was not slow to express the distaste and disgust which he entertained towards his calumniators; for among the papers found at his death, one bore the following inscription (intended as an epitaph on his tomb), which sounds like the despairing cry of hopelessness, *liber tandem quiesco*. Would that such heroism were now the characteristic of his followers! "the brilliant triumph of soul over self" which he manifested would lead us to accomplish great things. How conscientious, too, was this great man, willing to suffer the loss of all things, if thereby the cause of truth was furthered.

After ascertaining the toxic effects of drugs, he proceeded still further to find out more accurate pictures of morbid states corresponding to the natural diseases he had to deal with, by testing drug-effects carefully and systematically upon the healthy subject; nor did he shrink for a moment from the great risk to comfort and health and life which such a course involved. In the ten volumes of provings we possess a legacy of infinite value, and if we desire to show to the world his monument we may say *Si quæris monumentum circumspice*.

Unwearied and undaunted by the magnitude of his labours he proved nearly 100 drugs, he wrote upwards of 70 original works on chemistry and medicine, and made translations from 24 works—English, French, Italian and Latin.

In private practice he expended an enormous amount of time, and exercised a degree of patience over recording minute details, which to us appears almost incredible; he sought unwearied until he found the simillimum, if such existed.

His philanthropy and generosity were conspicuous traits. Devotion to duty, self-abnegation and unwearied patience are manifested in the fact that he was always labouring for the good of others, forgetful of ease, honour, or emolument. Writing to Hufeland he says:—"If experience should show you that my method is the best, then make use of it for the benefit of humanity, and give God the glory."

Whilst pointing out these leading features in the life and character of Hahnemann, we cannot omit reference to his buoyancy and sanguine expectation as to the ultimate triumph of his doctrines. He says "our art needs no political lever, no worldly badges of honour, in order to become something; only have patience! It strikes its root deep in the earth, gains strength imperceptibly but all the more certainly, and in due time it will grow up a lofty oak, which no longer bends to the storm, but stretches far away into all the regions of the earth; and mankind (who have been tormented) will be refreshed under its beneficent shadow."

Then we have abundant evidence of his sterling integrity. He was conscientious to a fault, and deviated not from duty's straight and narrow path (through the flatteries or the threats of men).

"Whoso would be a man" says Emerson, "must be a nonconformist. He who would gather immortal palms must not be deceived by names, but must explore for himself the foundations upon which he builds up his character and bases his opinions. Nothing is at last sacred but the integrity of your own mind. A man should conduct himself in the presence of all opposition as if everything were titular and ephemeral but he. I am ashamed to think

how easily we capitulate to badges and names, to large societies and dead institutions. We ought to go upright and vital, and speak the rude truth in all ways." We have a brilliant example of a typical physician in Hahnemann, from which it is our privilege to frame our life and conduct. Burke once said, "He who calls in the aid of an equal understanding doubles his own, and he who profits by a superior understanding raises his power to a level with the height of the superior understanding." He who aspires to the character of such a man as Hahnemann has taken upon himself the performance of no common task. His goodness of heart and generosity excite our envy. To the poor he was liberal in giving them advice, and Hahnemann deserved the gratitude and not the censure of his contemporaries for devising just methods by which the true interests of the profession were protected, in that he charged correspondents for advice according to their means; and he certainly believed in adequate remuneration and prepayment. He had an exalted idea of the dignity of the medical profession. He says:—"The physician's high and only mission is to restore the sick to health; the highest ideal of a cure is rapid, gentle and permanent restoration of the health or removal of the disease in its whole extent (its annihilation), in the shortest, most harmless, most reliable manner, on easily comprehensible principles"—could any ideal be more inspiring? His trenchant denunciations of existing systems of medicine were perhaps fully justified by the barbarism, empiricism and ruthlessness which characterised them at that period.

The original ideas and scientific proportions which are scattered through the pages of "The Organon" evince a comprehensive grasp of the relations which should be established between medicine and diseased states, and display a genius of no ordinary type. He believed that what is rational is real, and that what is real is rational. To do easily what is difficult for others is the mark of talent. To do what is impossible for talent is the mark of genius. To know how to suggest is the great art of teaching, and all his arguments are peculiarly suggestive. Great men are the true men—men in whom Nature has succeeded.

They are not extraordinary, they are in the true order. It is the other species of men who are not what they ought to be. Every man then possesses, in himself, the analogies and rudiments of all things, of all beings, of all forms of life. He who knows how to divine the small beginnings, the germs and symptoms of events, can retrace in himself the universal mechanism and anticipate (by intuition) the series of things which he himself will not finish. Such capacity we find portrayed in the subject of this paper in a pre-eminent degree. When he was convinced of any fact he enunciated it with the greatest clearness, and it was seldom he allowed any influences to turn him from his projects. He says, "I am borne out by the most extensive experience and I claim unlimited confidence."

His treatment of the insane was a most humane and unique method: he says, "I never allow a patient to be punished, because there can be no punitive influence where no responsibility exists, and because such sufferers only deserve pity, and are always made worse by rough treatment;" hence he was greatly in advance of his time in this respect. Again, in his treatment of typhoid fever we perceive the sagacity and ability of the man, denouncing as he does the lowering and stupefying plans then popular, and urging wine and cinchona, which is the treatment to-day.

His originality led him to suggest methods of preparing drugs for administration which had never been used before, *e.g.*, mercurius sol. for venereal diseases. His preparation of the sulphide of calcium from oyster shells and sulphur (kept for ten minutes at a white heat in a crucible) is instructive, and his explanation of the rationale of the cure by it of a number of cases of "crusta lactea" is interesting, because we are often baffled in our attempts to cope with it.

Let us now pass from consideration of his capacity as a physician to look at him as a medical reformer. He was Carlylean in his denunciation of what was evil in his sight. With penetrating glance, and with consciousness of rectitude, he saw more and more clearly the utter worthlessness of the therapeutics of his time, and the disastrous methods



adopted by the majority of the doctors of that day in combating disease.

In 1808 he sharply and truly criticises the actual condition of therapeutics, speaking of it as deplorable and unsuccessful, unscientific and unwarrantable. Nevertheless, he was not blind to the services of others. He shows this in regard to Brown in his excellent essay, "Observations on the Three Current Modes of Treatment." Very few physicians (perhaps none) saw as clearly as Hahnemann in those days: it was his firm hand which first succeeded in putting down the mob of bleeding and blistering doctors and their baneful practices.

In the earlier part of his career he prescribed material doses of bark for ague, and mercury for syphilis. He gave 12 to 15 grains of belladonna powder for a dose, with the precaution that "some giddiness should follow the administration of this powerful drug if it is to do any good."

It is the same with aconite. The extract prepared from the juice was to be given in doses from gr.  $\frac{1}{2}$  to gr. iv. several times a day, and he directed that hyoscyamus was to be given in the extract form—at first 1 grain three times a day, increased to 30 grains a day.

He called an ordinary dose of digitalis half a spoonful of the freshly-expressed juice of the leaves several times a day. That he was at this time greatly in favour of powerfully acting medicines is manifest in the following note. Monro had recommended fomentations to be sprinkled with spirit of camphor before being applied; hence this comment: "Such feeble prescriptions, of which contemporary practice can show many instances, we should abandon to the busy do-nothing practice of the common herd of practitioners."

He says in a certain place, "I may here remark and insist that heroic drugs should be given in very small but continually increasing doses, till some severe symptoms manifest themselves, such as are produced by the drug given in rather too large a dose." If this is not done, neither hyoscyamus, aconite, belladonna nor calcium can yield valuable results.

He considered *ambra grisea* in 30-grain doses a good analeptic, and prescribed *ignatia* in large doses of 10 grains of the powder to adults, and 2-3 grains to children.

But after four years his doses became gradually smaller, though not uniformly with all drugs, such as mercury; in gradually increasing doses he found increased benefit, and when good results were obtained, advised a discontinuance of the drug. In this we see the practical therapist who knew what he was aiming at—the zealous careful observer, the conscientious physician.

Even in chronic diseases (in which it was the common practice to give powerful drugs, not previously carefully proved upon the sensitive organism, and to continue to give them for weeks and months) he frequently gave only three or four doses, and then observed the changes effected by them in the diseased organism, and noted accurately the duration of their action. This practice was peculiar to him and distinguished him from all his colleagues.

While, on the one hand, he was in favour of vigorous treatment, we see that he very soon, on the other hand, began to employ some remedies in small doses, and gradually increased the number of these remedies, though at first he did not raise the smallness of the dose to a general therapeutic principle.

He first only accumulated experience, and carefully conducted observations. He advises caution in the use of drugs in various places; thus in "Cullen" ii., 265, he says: "Though I have above remarked that I thought the smallness of my doses was the cause of the unfortunate result, this must not induce beginners to give large doses of opium in such cases."

In 1793 he recommends a dose of  $\frac{1}{10}$  to  $\frac{1}{8}$  of a grain of arsenic, instead of the usual dose of  $\frac{1}{2}$  grain.

"In future times, when we may expect to be more conscientious, clear sighted, and circumspect, this virulent poison will be converted into an extremely useful remedy for the most desperate ailments of suffering humanity."

In the first decades of his work and research, starting from purely material conceptions, he gradually arrived at

dynamic views, and indeed these occurred to him as a consequence of his pharmaceutical doctrine. He says: "Diseases must be considered as dynamic derangements of the vital character of our organism, they must therefore be cured by agents capable of causing dynamic change." Therefore a disease (not surgical) considered as a separate entity from the living whole, from the organism and its vivifying vital force and hidden in the interior, be it of ever so simple a character, is an absurdity. Hahnemann considered that most diseases were general affections.

Hahnemann, together with his great achievements, had also his weaknesses, like other human beings, and especially all geniuses, have. Such reformers, endowed with unusual strength, have erratically formed heads and rugged characters, and whoever attacks their asperities with the intention of destroying them may expect the fate which befel the gnat (in the fable) who thought it had killed a sleeping lion, but while it was singing its song of victory he rose up and went for his tiny foe.

When the passions and antipathies conceived and fostered in atmospheres of controversy shall have perished, we believe that the judgment of an impartial posterity will reverse the condemnation of the common herd, and award a niche in the temple of Fame among the greatest and best of the world's benefactors to the Father of Rational Physic, Samuel Hahnemann.

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Dr. CHAS. HAYWARD noticed that the reader had been very fair in referring to Hahnemann's bigotry and intolerance. He believed two great reasons for the antagonism to homœopathy were: (1) Hahnemann's bigotry, and that of his immediate followers, and (2) the success of the system. The paper also brought up the dose question, and here he contrasted Hahnemann with Drysdale. The latter used lower doses as he got older. He admired Hahnemann because he was a pioneer of a truth which he knew to be unpopular.

Dr. HAWKES thought a question might well be raised sometimes as to whether we diluted a drug to bring out fresh characteristics, or to prevent it from doing harm. In the case of

mercurius cor., mercurius cyanide, &c., lower dilutions were superior, but with carbo veg., for instance, the higher dilutions were more effective. Then comes the question: At what particular point down the scale did crotalus, naja, and such drugs cease to be powerful? He referred also to the remarkable fact mentioned by Dr. Hughes, that chamomilla  $\phi$  and 6 were equally efficacious, the medium dilutions not being so useful. Many of us were satisfied with the lower dilutions, and an occasional use of the higher. He recalled a case of eczema behind the ear which resisted the ordinary medicines—graphites among others—in low dilutions, but yielded to sulphur 200.

Dr. GORDON said he was glad to find Dr. Simpson had not been afraid to point out Hahnemann's defects. With regard to the higher dilutions which he recommended in his later years, possibly if he had lived for another fifty years he would have prescribed both high and low. For his own part he was convinced that some medicines acted better high than low.

Dr. GREEN said that carbo veg., to get into the villi, required to be intimately subdivided, but he thought it was subdivision and not dynamization which rendered the attenuations more potent; and this he thought was also the case with the tinctures. He should like to ask why we gave crotalus 6 and silica 6 and not any other dilution—was it mere habit? In the case of eczema mentioned by Dr. Hawkes, he would have given sulphur 6 and not 200. He certainly thought Hahnemann's teachings were open to criticism.

Dr. CAPPER had studied the life of Hahnemann. His intolerance was in the first place promoted by the chemists. He, perhaps, would not have been the great man he was if he had not met with opposition. His foresight in treating the insane and other matters showed him to be far ahead of his time. He considered the good results obtained by the earlier homœopaths to be largely due to the care which was taken over the prescription.

Dr. ELLIS said that the change in Dr. Drysdale's views on the dose question was, he thought, due to the fact that during the last ten years of his life he confined his reading very much to allopathic literature; and this would undoubtedly influence his mind.

Dr. HAYWARD said that Hahnemann had been compared to Newton, Bain and Darwin, as well as to Carlyle, by the reader of the paper; and each time greatly to his credit. From his boyhood Hahnemann showed a voracious appetite for knowledge,

and, like all true geniuses, this characterised him through life. It was only as the result of persecution that he became dogmatic. He remarked on the fact that he had seen Hahnemann's pocket case (owned by Dr. Stuart) and this contained some mother tinctures.

Dr. SIMPSON briefly replied.

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## ON THE STUDY OF THE HAND FOR INDICATIONS OF GENERAL DISEASE.<sup>1</sup>

BY EDWARD BLAKE, M.D.

ON those rare occasions when the aid of the European physician is sought for a female member of any Mohammedan family of distinction, the only part of the patient which the doctor is permitted to see is the hand, which is thrust for that purpose through a small opening in a curtain. Is it possible, we may ask, that a fairly respectable diagnosis might be based upon a sight of the hand alone?

Part of the purpose of this paper is to give a small instalment of the very large amount of general information that may be gleaned from a patient study of the hand itself.

The extent to which we may add to our knowledge concerning occupation, health, habit and character, by merely grasping the hand, would scarcely be suspected. How characteristic is the firm and friendly grip of a vigorous man, healthy alike in body and in mind! Should the hand be both horny and strong, we say "here is a man

<sup>1</sup> Presented to the Section of Medicine and Pathology, Thursday, February 3, 1898.

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in whom muscular exertion enters largely into his method of earning his living, or at least of employing his leisure." If the palm be callous and the grasp be feeble, we think of xeroderma due to arsenical poisoning, or of some other type of hyperkeratosis.

The hand is usually dry in cancer and in paralytic dementia. If the hand be dry and claw-like, the possibility of diabetes enters the mind; if hot, dry and emaciated, the hectic of advanced tuberculosis is suggested. When one hand is persistently hot and the other is cold, the case may be one of subclavian aneurysm, but it is much more likely to be gout or else lead-poisoning. If the palm be not only hot but also clammy, the causes may be excitement, recent exertion, or hyperidrosis. A cold and dry hand may mean starvation, anæmia, feeble circulation, or one of the innumerable forms of vaso-motor ataxia. The hand is cold, harsh, and swollen in myxœdema. If cold and clammy, hysteria, dyspepsia, certain depressing emotions of the mind and the action of some nerve poisons, as tea, tobacco, &c., present themselves to us.

As regards the *appearance* of the hand, the first point that naturally attracts us is its colour, which it will be convenient to consider at the same time as its texture.

#### COLOUR AND TEXTURE.

From the tint and texture of the hands, we may get many valuable hints as to occupation, habits, tendencies, mode of life, &c.

Sometimes a profession is selected on account of the form of the fingers, while certain trades leave an imprint, more or less pronounced, upon the hands.<sup>1</sup> Thus artistic persons usually have slender and mobile fingers. Musical people have sensitive hands. We expect to see corns on the left finger tips of violinists, on all the fingers of harp players; goldbeaters have a thick right thumb, with large attached muscles; copyists often show a corn on the

<sup>1</sup> See "Forensic Medicine." By Husband. Edin.

little finger of the right hand, with a groove at the free end of the medius; the pulp of the left index is pricked and blackened in seamstresses; photographers have typical stains of pyrogallic acid; turners and coppersmiths have flattened finger tips, the latter with green discolouration; bricklayers, too, have flattening of the digital pulp, but this is on the left hand, and is chiefly seen on the thumb and index; plasterers are marked on the left thumb and index with corns due to grasping the "hawk," which carries their cement. Coachmen also have corns on the right hand from using the whip and on the sides of the left fingers from friction of the reins.

By careful study of the hand, a fair hit can often be made as to inveterate habits. Thus, if with marked tremor of the hands, we notice that the forefinger and the thumb, especially those of the left hand, be stained yellow, we may think of immoderate cigarette smoking; whilst such widely differing causes as the use of arsenic as a cosmetic and the carrying of a walking stick will both lead to thickening of the skin of the palm. A white hand suggests good birth and indolent habits; an exceptionally white hand shows that, amongst other things, the arteries are either small in calibre or flaccid as to coat. Such a state of things may mean, too, that pigment is deposited in small quantities, or else that the arterial blood-supply is poor in quality or deficient in quantity. This would bring before our minds the possibilities of anæmia, of carcinoma, of toxics by tea, tobacco or sewer gas, or else by some inorganic poison as lead, arsenic, or mercury. A smooth, thin, satin-like texture of the skin, indicating atrophy, a condition usually associated with *asteatosis*, or lack of oil in the skin, unless the patient be in advanced life, when that is normal, betokens a result of neuritis, of nerve injury, or else of vasomotor disturbance.

A swollen hand, pitting on pressure, if bilateral and wax-like, would speak of advanced renal disease; on the other hand, if the œdema be unilateral, of axillary aneurysm, adenoma, or traumatism. Swelling of the hands with bloated face might suggest alcoholism. A purplish tint,

especially during warm weather, would hint at defective blood-aëration, starvation, scurvy, or such a vaso-motor ataxia as we see accompanying various disorders which involve local asphyxia, as in Raynaud's disease. When combined with clubbing of the finger-ends, some mitral affection would be suggested, or we might think of Marie's disease (pulmonary hypertrophic osteo-arthritis).

Purple spots are found on the skin of the hands in a great variety of disorders. When the physician is summoned to a case of complete loss of consciousness, their presence may form a valuable element of diagnosis, in a condition which is always embarrassing enough. Should he hesitate between the coma of diabetes and that of uræmia, then the existence of yellow spots on the back of the hand would be in favour of diabetes, whilst purple maculæ would point to uræmia.

Petechiæ on the dorsum of the hand might be due to the bite of a flea, to senility, scurvy, rickets, gonorrhœa, syphilis, small-pox, scarlatina, septicæmia, malignant endocarditis, pyæmia, jaundice, cancer, typhus, measles, albuminuria, and Hodgkin's disease.

Many toxic agents have the power of producing petechiæ. Amongst the commonest are quinine, copaiba, mercury, belladonna, ergot, but above all the iodides. Some of the petechial eruptions attributed to syphilis are undoubtedly due to iodide of potassium.

Purpura accompanies many of the neuroses. It is seen with chorea and with rheumatism, but more especially with the myelopathies, such as locomotor ataxia and its allies. The sites of lightning pains are particularly prone to be visited by purpura.

All this means that the various forms of neuritis are prone to be followed by vaso-motor paresis, with consequent exudation of blood-products, which may be both altered in constitution as well as modified by the presence of morbid material.

If ecchymoses occur in a child, then we may think of the relapsing purpura of Henoch, formerly known as "febrile purpuric œdema." Other juvenile forms are



epidemic hæmoglobinuria, or Winkel's disease, in which the spleen is occasionally found enlarged. Some cases are complicated with acute fatty degeneration of the internal organs, the condition known as the disease of Buhl.

Many years ago, Graves, of Dublin, pointed out that purpura is very prone to be associated with the diarrhœa of children, now looked upon as nearly always bacillary.

If purpura occur in a girl, it is then probably either angio-neurotic œdema, or the morbus maculosus of Werlhof, known in this country as purpura hæmorrhagica. This disease sometimes proves fatal within twenty-four hours; it is then recognised as purpura fulminans. A very complete account of the different forms of purpura and allied eruptions may be found in Osler's "Medicine."

Ecchymoses easily form on the hands of the subjects of hæmophilia, a disease which differs from the other allied conditions by being nearly always hereditary.

When the petechiæ are associated with nettle-rash (purpura urticans)—and with these there are found to exist multiple arthritis, scanty and albuminous urine, and raised temperatures—we may have to do with Schoenlein's disease (peliosis rheumatica). Here sex and age will help us, for this disorder is practically confined to males between twenty and thirty years old. All the adult forms of this purpuric group are apt to be associated with arthritis.

If the nail be transparent, then a most convenient window into the circulation is afforded by it. It is valuable for viewing the state of the peripheral circulation. Various changes in the blood and in the tubes which convey it, such as anæmia, supervenosity, &c., may be estimated here. Again, capillary pulsation may be studied at this point.

Yellowish red papules or nodules, occasionally seen on the back of the hand, but more commonly on the elbow, may be xanthoma diabeticorum; in any case the matter should be set at rest by an examination of the urine for sugar.

Larger and darker spots, round or oval in shape, incorrectly known as "xanthoma, or xanthelasma rheumaticum," are especially found on the hands, face, and neck.

They are really a form of lentigo. When seen on the upper extremity, they correspond with the cutaneous distribution of the musculo-spiral nerve. I described the connection of these perverted pigment changes, with rheumatoid arthritis, seventeen years ago, four years before they were so carefully re-described by Dr. Kent Spender, of Bath.

Brown spots, which do not disappear on pressure, are seen on the dorsum of the hand in the later stages of many of the diathetic diseases, notably in adult scurvy, in syphilis, in osteo-arthritis, in tubercular phthisis and carcinoma, one common factor being the presence of the pyogenic process. Arsenical poisoning, Graves' disease and morbus Addisonii often have this symptom in common. Brown pigment spots on the face and on the extremities, I observed in Norway to occur in leprosy. However white the hands may have been, they usually grow red in the earlier stages of rheumatic gout. At a later period the tendency is to grow brown. As the skin atrophies, the tone generally deepens: even a brilliant blonde may steadily grow as dark as an Asiatic.

Paludal fever causes a typical change of tint in the nails. A peculiar slate-grey discolouration of the finger-nails appearing before the rigor, increasing during the cold stage, and attaining its maximum in the middle of the hot period, after which it slowly disappears, is said by Boisson, a French military surgeon, to be pathognomonic of an ague fit.

This is quite possible, because it is now known that the hot and cold stages of ague—the heat and cold, by the way, are subjective—correspond with the fission of the malarial protozoon. At this point a large proportion of the hæmatin has been destroyed by the protozoon, and converted into a melanic material, which is set free by the disintegration of the protozoon. The presence of this melanin in the blood, together with the absence of hæmatin, would explain the grey look of the nails.

White spots on the nails are without doubt often due to local injury; but this is by no means the only cause. On two occasions Langdon Down saw transverse markings of the finger nail, occurring with ulcer of the cornea, in a professional man of studious habits.

Doubtless there are other pathological relations of white nail which will presently be observed and recorded.

The lunula owes its white colour to the fact that the matrix here contains a number of opaque elements which scatter light. These are the "transition," or so-called "keratogenous" cells. They stand midway between the prickle-cells and the nail-cells proper.

It has been asserted that brittle nails accompany diabetes mellitus; as a matter of fact, the subjects of glycosuria are prone to neuritis, and any form of peripheral neuritis, from gout to beri beri, may be followed by fragility of the nails. It is for this reason that the nail of advanced gout is so often either striated or laminated. This is not because they are gouty, but because gouty persons are so prone to multiple neuritis.

*Mode of Nail Growth.*—We will now step aside for a moment to consider very briefly the normal method of nail production. The changes in the upper surface of the nail must originate in the bottom of the nail-fold, for these are continuous. It is obvious too that the narrower the nail-fold, the more rapid is the growth of the nail and the less is its thickness.

The blood supply of the papillary layer of the substratum of the nail is divided into several areas each covered with rows of papillæ. The vascular supply is very peculiar, resembling in some respects an erectile tissue, such for example as that of the corpora cavernosa. The actual substratum consists of loose connective tissue, containing convoluted glands and some fat.

A glance at the dentated processes under the nail, alternating with the ridges of the nail bed, will show why the nails when atrophied, as after neuritis, must grow more and more ribbed.

The finger nails are normally marked with longitudinal striæ in the anthropoids. In many infective disorders, as goitre and rheumatoid arthritis, the nails are found to be ribbed and sometimes laminated.

The children who can boast of a gouty ancestry appear to be especially prone to such vaso-motor disturbances as

hæmophilia, and they are also addicted to nail biting. These two tendencies are not so wholly unconnected as they might seem at first blush to be. It is admitted that these children are neurotic in their tendencies; but I have observed that their fingers are not irritable because they are bitten, but they are bitten because they are irritable.

A paint consisting of ten grains of ichthyol to one ounce of filmogen, applied to the nail-border after washing the hands, will often cure the habit by removing the irritation.

Transverse furrowing of the nail is a sign of temporary complete arrest of unguis development. It occurs in the acute fevers, especially in those accompanied by exfoliative dermatitis, such as scarlatina.

Increase of the lateral nail-curve is said to be a sign of syphilis; exaggeration of the longitudinal curve, quite a distinct condition from clubbing of the extremities of the fingers, will, however, be conveniently described with that peculiarity.

*Rate of Nail Growth.*—A considerable divergence of opinion exists as to the rate at which the finger nails grow. Beau gives as a rule that the nails of the hand grow one millimeter per week. At this rate the nails which average fifteen millimeters in length, would take 105 days to grow out. Dufour gives 121 to 138 days.

The fact is, the pace of growth varies very much, not only at different ages but in different persons. I have known a difference of seventy days between subjects of the same age and sex.

A few fresh observations will be submitted to the notice of the reader, as to the rate of growth of the finger nails in men at different ages:—

At 21 years,	the nail was replaced in 126 days.
„ 31	„ „ „ 159 „
„ 32	„ „ „ 88 „
„ 55	„ „ „ 110 „
„ 67	„ „ „ 144 „

It is curious that the swiftest grower was a tubercular

subject, who had a sharp attack of blood-spitting during the observation.

A valuable point in diagnosis is afforded by the growth of the finger nail. In distinguishing between true paralysis of centric origin, and the various pseudo-paralyses of hysteria, which sometimes so closely simulate organic disease, it is well to remember that the growth of the nail is modified by most of the centric lesions, whilst its development is not affected by hysteria.

The finger nails are *damaged* by syphilis, *destroyed* by congenital pemphigus, the latter leaving, however, the pulp; whilst in leprosy, not only the nail, but more or less of the finger itself disappears bodily, perishing through neurotrophic changes.

Should a surgeon have to remove a finger nail, he should be careful not to promise that the nail will not grow again. It is quite a mistake to suppose that if the matrix be entirely destroyed a nail cannot be reproduced.

Tulpius gives examples of accessory nails which have appeared on the first phalanx after the removal of the second and third. They have even appeared on the metacarpals.

#### ERUPTIONS, INVASIONS, &c.

We come next to a point of extreme interest: it is the geographical distribution of skin diseases on the surface of the hand, over areas more or less defined.

The rules which govern this distribution are not indeed absolute, but within certain limits they are extremely accurate.

*Psoriasis* attacks that portion of the skin which corresponds with the free edge of the nail. Some parasitic scalp disorders affect, for obvious reasons, the same area.

*Eczema*, on the other hand, elects as its favourite site the thin and delicate skin, which fringing the lunule lies immediately above the nail-fold. It is then known as "pot-boys' disease."

*Psoriasis* of the palm, unless a "trade disease," then

usually produced by arsenic or by traumatism, is nearly always syphilitic.

It may be roughly said that the dorsal aspect of the hand is the domain of gout and that the palmar side is the area of syphilis.

The primary manifestation of syphilis on the hand has no elective site. The chancre is indeed occasionally found on the finger because, with the possible exception of the tongue, that is, next to the external genitalia, the point most exposed to infection. On the finger, a crack in the nail-fold or a hang-nail will decide the site of invasion.

We may bear in mind that chancre of the finger presents an entirely different appearance from that with which we are familiar in its more ordinary situation. It begins as a bright red spot, grows quite rapidly, and in a fortnight after its first manifestation it may exceed one centimeter in diameter.

It may be dull or rosy, depending for its tint on the tendency to venous stasis of the person infected. The surface may be very angry-looking during the active stadium, and when the acute stage has subsided, there often remains a typical brown spot which, to the initiated, tells its own story.

A ruddy injected line, raised slightly above the surface and bordering the lunular fold, is very suggestive of gout. It is interesting that a similar fold of epithelium, at the labial aspect of the insertion of the teeth, known as "the gingival organ," is also an area of election for certain gouty manifestations.

*Panaris or Paronychia.*—The site of whitlow is the site of primary specific infection of the hand.

The washerwoman's disease has been attributed to poisoning by soda, but the exceedingly valuable provings on his own person, made by Garré, detailed in the *Fort-schritte der Medicin*, vol. iii., No. 6, 1885, have put it beyond cavil that panaritium is an invasion of staphylococcus, supplied by the soiled linen of the laundry. Garré established a most important point, viz., that the *S. pyogenes aureus* requires no breach of surface to enter

the system. Only a little rubbing such as is supplied by the collar at the back of the neck is needed, and a carbuncle may be produced. This accounts easily for the elective points of localised abscess.

The possibility of a syphilitic origin in the case of obstinate whitlow would of course be borne in mind, nor should we forget that panaris is a symptom which occasionally complicates syringo-myelia. The presence of analgesia, and the loss of the thermic sense, will serve to identify this not very common disease. A good description of this curious complaint is to be found in the *New Sydenham Society*, 1887.

*Palmar Hyperkeratosis*.—Occasionally we find the palm looking like the skin of a young alligator or an old laundress; this, which was formerly known as *xeroderma volare* or *palmare*, is now recognised as *hyperkeratosis* or *keratodermia*. This one regrets to hear called by some authorities on the skin by the appalling word “hypercornification!” At a later stage large corns form, whilst between them there are frequently found deep and painful fissures. This state of things is often the effect, and sometimes a very remote effect, of arsenical poisoning. It is important to remember that arsenic is not always introduced into the body as a drug. It may be absorbed either from a cosmetic, from an art-fabric or from the use of arsenical soap; from a wall-paper or from tinned vegetables.

*Epithelioma*.—Mr. Jonathan Hutchinson has adduced evidence of such importance that epithelial cancer may follow arsenical poisoning, that when we can establish, in any given case, that arsenic can be certainly excluded as a possible cause, then long and patient trials of this drug, more especially in the higher dilutions, should be persisted in, before resorting to surgical interference.

A mild herpetic rash on the palm of the hand is not unknown after influenza, also as a sequel of severe dysidrosis, and occasionally as a result of liberal drugging. More especially is this the case with the iodides and the bromides; though the real elective areas of both the bromodermata and the iododermata are the tracts of skin supplied by the

fifth cranials and the musculo-spiral nerves. It is needless to say that the interdigital fossæ are nearly sacred to scabies.

Again, arsenic will in certain persons induce a state of things so accurately imitating locomotor ataxia, that its use in the treatment of tabes of non-specific origin should be carefully thought of.

#### FORM.

*General Contour of the Hand.*—There is seldom a great deal of subcutaneous fat found in the hand. Hence its absorption is not followed by such a marked change as is seen in parts of the body freely supplied with adipose tissue. The alterations caused by age and by those forms of toxic neuritis which accompany gout, rheumatism, &c., are due in part to outgrowths, in part to a true atrophy of the skin, which is always affected in these diseases. Another cause of the change of form seen in the hands, is the slowly progressive shrinking of fibrous tissue which has been the site of lymph effusion, itself due to a great variety of causes, including traumatism. A good example of this is Dupuytren's finger.

Many of the sufferers from gout, and most of the subjects of rheumatoid arthritis, are prone to temporary attacks of chondritis with fibrous degeneration, followed by bulging of the cartilage, known as "lipping," due to muscular traction on the opposing articular surfaces.

I will not go into the question of what is the distinction between Heberden's nodes and Haygarth's nodosities, about which so many doughty pathological knights have broken a lance! It is now the fashion to say that the former are gouty, the latter rheumatoid. We may note though that Heberden, in his original treatise, definitely states that these manifestations observed by him did *not* occur in the subjects of gout. I will merely ask the reader to note the highly interesting point that Bouchard found so great a proportion of cases having enlarged proximal phalangeal joints in his examples of dilated stomach. This



has been confirmed by the writer. It may be added that it is the terminal phalangeal articulations which are usually found affected after oral and pelvic suppuration.

It is of interest to remember that whilst gout shows a marked preference for the hallux, the corresponding pollex often entirely escapes the attacks of rheumatism and its congeners.

Exostoses usually commence as degenerative changes in the cartilage. Those due to gout are often central, attacking the middle of the phalangeal trochlea. They are frequently unilateral. They may be solitary. Rheumatoid changes, on the other hand, are usually multiple, and though rarely symmetrical, are most frequently bilateral. This asymmetry accentuates the grotesque and hideous deformities seen in advanced cases of osteo-arthritis.

Muscular distortions, due to paralysis of the intrinsic manual muscles, such as the *main en griffe* of Duchenne, and those due to paresis of the muscles of the fore-arm, as the wrist-drop of house-painters, usually owe their origin to centric changes in the nervous system.

Dupuytren's contraction, always found on the palmar aspect, sparing the thumb, is often hereditary. A tight band passes from the root of one finger towards the wrist, usually in the ulnar distribution. It is tempting to view this band as being formed by one of the flexor tendons; as a matter of fact, it is never tendinous, the fascia is the real seat of this curious disorder.

It is an adult male disease, seldom seen in women, rare in the young, suggesting trauma as an exciting cause.

It is not to be confounded with congenital contraction of the little finger, common to both sexes.

The distinctive features may be tabulated thus:—

<i>Congenital</i> form is often :	<i>Acquired</i> form is usually :
(1) Hereditary ; it is	(1) Unilateral ; if bilateral,
(2) Stationary and nearly	then
always	(2) Asymmetrical, and it
(3) Symmetrical.	is essentially
	(3) Progressive.

The general shape of the hand and the special form of the finger often afford considerable aid to diagnosis.

Amongst the most typical variations are the stunted hands of congenital cretinism, the spade-shape of myxœdema, the sausage-shape of acromegaly, the carrot-like fingers of rheumatoid arthritis, and the clubbed fingers of mitral disease and of pulmonary suppuration, especially of Marie's pulmonary hypertrophic osteo-arthritis.

*Clubbed Fingers.*—Long ere the refinements of modern diagnosis, which followed the introduction of instruments of precision by Laennec, Simpson, Recamier and others, had existed, clubbing of the finger-ends had been observed. It was held to be an important sign of "consumption." But this condition is not confined to consumption. It occurs in the course of bronchiectasis. Patrick Manson has seen it as a sequel of the evacuation of hepatic abscess by way of the respiratory passages. It has been described as a result of congenital heart disease. It is seen after nerve injury, pneumonia and spinal caries: nothing common to all these has as yet been made out. The matter is probably largely mechanical. Not supported, as the toes are, by boots, the finger tip is the point of least resistance. Venous and lymphatic flow are both obstructed, whilst vaso-motor paresis is often present.

Dr. Vivian Poore has recently republished his Bradshaw Lecture of 1881, entitled "Nervous Affections of the Hand." He has ably treated this subject in a most thoughtful paper, drawing attention to the fact that clubbing is absent in patients whose legs are swollen with tortuous veins, nor is it always present in bronchiectasis with emphysema, where there is considerable venous stasis; to this we may add that clubbing forms no part of the phenomena of Raynaud's disease.

Dr. Poore describes the case of a lady of 50, who sustained a severe injury of the brachial plexus on one side. It was afterwards found that the fingers on that side were covered with scurf and affected with chilblains. The nails grew dead and white and they were harsh in texture. Glazed spots appeared at the root of the finger nails, whilst well-marked clubbing set in on the side of the traumatism.

A very complete bibliography of the subject may be

found at the end of a capital monograph by Massalongo of Padua. It is in vol. x., M., of the *Policlinico*, published at Rome in 1897 by the Societa Editrice Dante Alighieri.

It is curious that all the cases of Marie's disease that have been recorded up to the present time have occurred in men. I am now attending a woman of 35, suffering from a second attack of spinal caries. She had Pott's disease at 14, and is now much disfigured by the so-called "angular curvature." There is, however, no trace of Marie's disease in the finger tips; perhaps this is because the respiratory organs are not yet invaded by tubercle.



Adult Acromegaly. (Dr. Harry Campbell.)

Dr. Harry Campbell has pointed out a curious resemblance between the normal condition of the gorilla and the acquired bone and skin changes of the acromegalous subject. Many of the morbid signs in this disorder, first described by Marie in 1886, are examples apparently of reversion to a primitive arboreal type. This is seen by comparing the acromegalous hand (for the use of this illustration I am

indebted to Dr. Harry Campbell) with the accompanying woodcut of a gorilla's upper hand taken from Hartmann.



Gorilla's Upper Hand. (*Taken from Hartmann.*)

The writer is indebted to the courtesy of Dr. Fisher, of King's Langley in Hertfordshire, for the opportunity of seeing a very typical case of Marie's disease, in the wards of the West Herts Infirmary.

The patient was a boy, aged 14, with a well marked angular curvature of the spine. There was a discharging sinus near the free extremity of each lower floating rib. The illness was as usual attributed to a blow; the child had fallen on the back at the age of 11 months. This may of course have been the immediate or exciting cause.

This boy measured thirty-six inches only in height and was greatly emaciated. The point of the nose, the lobules of the ear, and the ends of the long bones were all much enlarged. The nails were not much hooked, but the fingers and toe tips were clubbed and deeply cyanosed. The accompanying illustration shows the smooth, broad, flat and thin glazed nail and the clubbed fingers.

Curiously enough, in the next bed lay a man of 30, convalescent from pneumonia, who showed well-marked clubbing.

This clubbing of the digital pulp is not to be confounded with hooking of the nail. Though these may exist together they are quite distinct conditions; their respective causes and relations require careful working out.

#### SECRETIONS.

There is another important change in the skin which has not received quite its fair share of attention; I refer to the modification of function in the fat glands. These no longer secrete the normal sebum—a thin colourless oil. At first they begin to sluggishly pour out a thicker fat of no use for emollient purposes. This change itself is said to be due to a thickening of the fat-follicle, impairing the blood supply. This thickening, like the accompanying hyperkeratosis of such parts of the plantar surfaces as are especially exposed to traumatism, is a common sequel of neuritis. At a later stage, the sebaceous follicles either perish, sharing a general atrophy of the derma or true skin, or else they join the sweat glands proper in pouring out perspiration, more or less modified in its physical qualities. Thus are brought about the changed conditions now recognised as hyperidrosis and dysidrosis.

This replacement of the natural silkiness of the skin by a harsh and parchment-like condition, at times alternating with a swampy and sodden state of things after exertion or emotion, is well seen on the legs of subjects of gout, rheumatism, myxœdema and goitre. Two or more of these morbid groups are often found blended together in what Mr.



Clubbing of the finger-tips, in a boy of 14, with Marie's Disease.



Jonathan Hutchinson has so happily termed "the partnership of diseases."

In these instances the skin will become thin, tense and furfuraceous; it is covered with silvery scales, looking like a case of recent scarlatina, passing through the process of peeling.

These cases derive prompt and often persistent benefit from the inunction, after a hot bath, of thyroïdin, blended with some suitable lubricating material.

Dr. Kent Spender, of Bath, was the first in this country to draw attention, in 1885, to the fact that at some stage of the history of rheumatoid arthritis, the secretions of the skin are always disturbed.

*Edema.*—Persistent swelling of one hand, *without* discolouration, if acute, would suggest either peripheral neuritis or else traumatism higher in the limb. Obstructed vessels, venous or lymphatic, with or without glandular enlargement or other tumour, should be looked for in the axilla, whilst the possibility of aneurysm should be thought of.

Swelling *with* discolouration would, on the other hand, indicate eczema, erysipelas, acute rheumatism, or the action of some toxic agent of animal or of vegetable origin.

Persistent swelling of both hands suggests albuminuria, from lead poisoning or some other cause. If renal disease be at an advanced stage, then the dorsum of the hand rises like a pincushion, the swelling being pale in colour and of most characteristic form.

Uræmic puffing is dusky. When purple maculæ appear on the distribution of the musculo-spiral nerve, they form a portent of the gravest nature, death seldom being delayed more than three days.

It may be remembered that the mere swinging of the arms during a long walk is quite enough to cause temporary œdema of the hands.

#### SENSATION.

Such an infinite variety of causes lead to paræsthesia or perverted sensation of the fingers, that the needful limits



of this paper quite preclude any attempt to give a complete account of them here. It will suffice to say that numbness in the superficial filaments of the median, in its digital distribution on the left side, is not necessarily a sign of heart disease. It may mean fifty things. Amongst the commonest are that this deadness of the left hand, more particularly in the morning, may bear a relation to the posture assumed during the night, to the nature of the evening beverage, or to the habit that some have of uncovering the left arm when asleep. I have seen it disappear under the use of digitalis, apis, aconite and the tinct. of St. Ignatius' bean.

All the infinite forms of neuritis will cause deadness of one or both hands, especially those induced by gout, rheumatism, alcoholism, catarrh, tea, tobacco, and the modern anodynes and narcotics.

To these may be added a variety of conditions causing pressure on the axillary nerve-trunks, such as "chair" and "crutch" paralyses.

Widely different is the clinical significance of persistent numbness in the ulnar distribution. Comparatively few diseases are associated with loss of sensation in the little finger. Prominent amongst them are leprosy and general paralysis of the insane.

#### THE PULSE.

When the Oriental suffers the Frankish Hakim to touch the wrist of the jealously secluded odalisque, the main idea is, of course, that the physician may feel the pulse. Yet of the pulse nothing has been said in this paper. Nor is this needful, for all doctors are supposed to understand the pulse. Yet I will venture to remind the reader that in cases in which there is a sluggish venous flow, as so often occurs in women with pelvi-portal congestion, a state of things by no means impossible in the idle atmosphere of a seraglio, the over-distended radial *venæ comites* might be easily mistaken for a high tension pulse, even when the artery is at the time nearly empty.

Dr. DUDGEON said one of his friends had the clubbed fingers most characteristic of phthisis or tuberculosis, but had not a sign in his constitution otherwise. He (Dr. Dudgeon) had had two or three attacks of influenza, and after each attack two of his nails had a deep furrow at the base, which grew up afterwards and disappeared in the course of the 156 days which Dr. Blake tells us it takes to form a new nail. Only one of his nails still retained the marks. He had had a case—contraction of the palmar fascia—of a lady, who had this peculiar deformity affecting the fore-finger. After some time, the lady quite recovered the use of her finger, and it ceased to be contracted, although it long retained traces of the contraction.

Dr. GALLEY BLACKLEY drew attention to the value of an outline sketch of the hand in the differential diagnosis of gouty arthritis, rheumatism, and gonorrhœal rheumatism. In ordinary arthritis the distortion of the joint was bilateral, and was practically localised at the joint. In gout it was usually unilateral, and likewise did not extend much beyond the joint. In gonorrhœal rheumatism, on the other hand, the whole outline of the finger was different; it became markedly spindle-shaped, the middle joint of the finger being the thickest part of the spindle. He had on many occasions made a diagnosis of recent gonorrhœa, both in males and females, by the shape of the fingers. In diabetes the skin was by no means uniformly or always dry except in the very late stages. He had a case of diabetes in the wards at the present time where there was neither dry skin nor any emaciation, although the diabetes had been in existence for seven years. With regard to hereditary gout and multiple neuritis, did Dr. Blake mean multiple neuritis or multiple neurosis? If Dr. Blake meant neurosis, he agreed with him, but if he meant multiple neuritis, all he would say was that the great majority of the British-speaking race must be in a very bad way.

Mr. KNOX-SHAW said that when he was house-surgeon at Guy's, a man was admitted under the late Mr. Cooper Foster for very severe pain in his foot, which incapacitated him from following any employment. He (Mr. Knox-Shaw) had been thoroughly puzzled by the case, and to his astonishment it was the hand of the patient which settled the diagnosis. After examining the patient carefully, Mr. Cooper Foster asked the man his occupation, and on being informed "a labourer," he looked at the patient's hand, and having learnt from it that it had done no hard work for a long time, pronounced the patient a malingerer. He (Mr. Knox-Shaw) had that day seen a young

woman suffering from iritis and secondary glaucoma, who had noticed that since her illness she had had deep transverse furrows on two or three of the fingers, which were now coming just past the luna.

Dr. STONHAM said that with reference to distinguishing the shape of the hand in amyotrophic paralysis and lead palsy, showing in the former that the fingers were contracted, and not in the latter, Dr. Blake had said that that was caused by the fact that not only the extensor muscles, but also the flexors, were paralysed in lead palsy. Surely there were cases of lead palsy in which they got a dropped wrist exactly like that depicted in the picture, without any flexor paralysis. Was not the fact of the contraction being present in the one case and not in the other due to the fact that in lead palsy the affection was a passing one, and patients usually recovered, and consequently the flexor muscles had not time to get into the state of contraction which they got into with a more chronic disease?

The PRESIDENT (Dr. E. A. Neatby) said that Dr. Blake had said that the nails did not grow in the paralysis which followed hemiplegia. He had one case in his mind in which he knew that that was not the fact—the nails did grow. It was the case of a relative of his, and he had the office occasionally of cutting the nails of that gentleman as he could not do it very well himself.

Dr. BLAKE, in reply, wished to ask the President how soon after the clot he had noticed the nails growing.

The PRESIDENT said within the first eighteen months.

Dr. BLAKE said that that was an important contribution, but nevertheless the marking of the nails formed a valuable element in diagnosis, because hysteria did not impede the growth at all, whereas the degenerative nerve diseases, markedly those of the lower neuron, always modified it. With regard to Dr. Dudgeon's remarks, he might ask him whether his lady had the *congenital* form of Dupuytren's finger or the *acquired* variety? Because that was the whole point at issue.

Dr. DUDGEON said that it was *acquired*.

Dr. BLAKE thought it was extremely likely that some of those cases were simply cases of temporary traumatic cellulitis, allied histologically to non-specific scleroderma, and there was no reason on earth why they should not disappear in a similar way. With gouty people his experience was that the acquired form always passed from bad to worse. Dr. Blackley spoke of his cases being symmetrical arthritis. Dr. Blake's experience of arthritis was that it was very seldom symmetrical; it was nearly always bi-

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lateral. With regard to the gout he did not find it asymmetrical but unilateral. With regard to the spindle-shaped finger of gonorrhœa, he had seen it very often in maiden ladies who would seem to be above suspicion, but of course in medical matters probability goes for nothing; absolute pathological evidence is the only test. As to dryness of the hand in diabetes, he wished it to be understood that he did not say that the hand is dry in glycosuria, but in established diabetes proper. With regard to multiple or peripheral neuritis, it was the fashion to call everything neuritis now, although it was not justifiable unless there were present œdema, paræsthesia, usually burning pain or numbness, and loss of function, especially of coördination, followed by changes of skin temperature, tint, or texture, and trophic changes particularly. Without these typical phenomena he did not think they should look upon a case as one of "neuritis." The varied conditions known as "rheumatism" were different species of toxic neuritis. With regard to the explanation of clubbed fingers, he thought it was a simple matter. Dr. Blake considered that it was nothing but the point of least resistance; the toes would be just as clubbed if boots were not worn.

Dr. BLACKLEY wished to mention that in the use of the terms "symmetrical" and "asymmetrical" he was referring to the individual hand only; there was osteo-arthritis, but symmetrical with regard to the finger only.

Dr. BLAKE said he would apologise. He should have said with regard to Dr. Stonham's criticism that it was very just, and there was no doubt it was the correct explanation. It was the musculo-spiral that suffered, and that did not supply the muscles of flexion.

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## SOCIETY NEWS.

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At the meeting of March 3, Dr. Willis N. Dewey, Professor of *Materia Medica* in the Homœopathic Department of the University of Michigan; Dr. Pemberton Dudley, of Philadelphia, late President of the American Institute of Homœopathy; and Dr. Eugene Porter, of New York, Secretary to the Institute, and Editor of the *North American Journal of Homœopathy*, were elected Corresponding Members of the Society.

SUMMARY OF PHARMACODYNAMICS AND  
THERAPEUTICS.

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"GATHER UP THE FRAGMENTS, THAT NOTHING BE LOST."

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DECEMBER, 1897—FEBRUARY, 1898.

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PHARMACODYNAMICS.

**Acidum nitricum.**—Dr. Mossa has written an essay on the action of nitric acid upon the kidneys, and it appears in the January No. of the *Revue Homœopathique Française*. It contains some observations from Rademacherian sources confirmatory of Dr. Kidd's experience as to the usefulness of the remedy in some forms of lithiasis.

**Actæa.**—Dr. Burford communicates a case of ovariectomy performed during pregnancy, the medical interest of which lies in the insomnia and mental disturbance which complicated the recovery, and their prompt removal by *actæa* (1x).—*Monthly Hom. Review*, December.

**Antitoxin.**—Dr. Goodno, in the *American Medical Monthly*, and Dr. Arschagouni, in the *North American Journal of Homœopathy* (both of February), discuss the antitoxin treatment of diphtheria. The former, from large personal experience, is strong in its favour; the latter, from the statistics of the New York Board of Health, pronounces against it as substantially inferior to homœopathy.

**Apis.**—Dr. Langer, of Prague, has been experimenting with bee-virus, and finds it analogous to that of vipers and rattlesnakes. Albuminuria was observed during life, and autopsy showed a general hæmorrhagic condition, with great effusion into the pericardium.—*Monthly Hom. Review*, December.

**Aranea diadema.**—Dr. H. A. Roberts has an article on this drug in the *North American Journal of Homœopathy* for February,

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which contains some interesting observations, though some of his statements about its pathogenetic action lack support. He has confirmed, in malarial affections, Grauvogl's indications for it, viz. : great sense of coldness and aggravation by damp ; but adds also another in the shape of clock-like periodicity of recurrence of symptoms, especially of neuralgic ones.

**Arecoline.**—This is an alkaloid obtained from the areca or betel nut. It acts well (in a 1 per cent. solution) as a myotic,—less energetically, indeed, than eserine, but more promptly and for a shorter time.—*Amer. Homœopathist*, February 15.

**Arsenicum.**—Dr. Beck relates two cases, one of general phlebitis, the other of malignant disease of the stomach, in which the temporary rally of the patients under this great medicine, given in the 30th dil., was very surprising.—*Revue Hom. Française*, January.

A good case of arsenical neuritis is reported by Dr. W. Smith in the *Homœopathic Recorder* for February. Tingling and pricking in finger-tips and soles were the first symptoms, followed by numbness there. "He felt as if his boots were full of water, and at times as if something crawled from the knees to the toes." These parts felt cold to the touch, and there was loss of sensation from mid-leg down. Below the knee the faradic irritability of the muscles was wanting, and it was present but slightly in the arms. The knee-jerk was entirely absent, and in walking he put his heels down first with considerable force.

**Baptisia.**—Dr. G. Forrest Martin writes in the *Medical Era* of December to rescue baptisia alike from indiscriminate use and from neglect. When he argues thus, however, he is leaving sure ground:—"If we say that a drug which produces 'Profound depression, with tendency to disorganisation of the blood ; indescribable sick feeling, and weary bruised feeling of the whole body ; offensiveness and putridity of all the secretions and excretions of the body, even the breath ; great sensitiveness of right iliac region and confused delirium' can never be indicated in typhoid, we deny at once the whole truth of the homœopathic law." [Where does Dr Martin find evidence that baptisia has produced the first, third and fourth of these conditions?—EDS.]

Dr. Nimier, writing on typhoid fever, expresses himself more favourably towards baptisia than the French homœopathists generally. His indications for it are insomnia, great prostration, tongue brown or blackish at the centre, which indeed,

with fever and ileo-cæcal tenderness, make up the picture of typhoid in its most common form. In the last epidemic he treated, he had thirteen cases, some of them grave, mainly treated with baptisia; and all recovered.—*L'Art Médical*, January.

**Carbo vegetabilis.**—Dr. M. Louise Turton relates some cases which show that the states of prostration, with cold sweat, pulselessness, sunken features, &c., recognised as calling for carbo vegetabilis, will yield to that drug in the 3x trit., and need not its administration in the higher potencies usually selected.—*North Amer. Journ. of Hom.*, December.

**Caulophyllum.**—Dr. Luton, called to attend a primipara, was surprised to find her labour entirely painless. On inquiry, he learned that she had been drinking squaw-root tea twice a day for four or five months.—*Amer. Homœopathist*, December 15.

**Cina.**—Dr. Mohr has written, in the *Hahnemannian Monthly* of January, an article on this drug, designed to advance its use beyond the sphere of helminthiasis. Asthenopia, strabismus, prosopalgia, chorea, convulsions, pertussis and similar coughs, spasmodic asthma, gastralgia and enteralgia, enuresis, amenorrhœa and some fevers come within its range; but to indicate it, symptoms *like* those caused by worms should be present.

**Coffea.**—Dr. Rugh relates a case of poisoning from excessive coffee-drinking for three weeks. “His expression was agitated as with fear of some impending danger. His muscles were in such a state of tension that upon the slightest movement of arms or legs clonic spasms occurred, though none were present when he lay perfectly relaxed—which, however, his exceedingly nervous condition would not allow him to do. If he tried to sleep, he would be seized with hallucinations just before losing consciousness, imagining that disasters were about to overtake him, and seeing all kinds and shapes of images and objects. Then he would start up in fright, and find himself in the greatest nervous excitement. His knee-jerks were slightly exaggerated, but sensation was perfect.”—*Amer. Homœopathist*, December 15.

**Eucalyptus.**—This plant seems to neutralise the ill-effects of strychnine, not only when a decoction of the leaves is mixed with a solution of the alkaloid, but when the former is administered *per os* simultaneously with or subsequently to the latter.—*Ibid.*

**Hepar Sulphuris.**—“Mr. N., aged 50, came to me for the treatment of a cellulitis of the neck, which had been declared in

the old school incurable save by the scalpel. I found deep-seated swelling and fluctuation, the parts being so tender that it hurt him to turn his neck. His health was otherwise good; but he had had syphilis some years previously, and had taken much mercury for it. On these symptoms I prescribed hepar 30, to be taken twice a day. On the fourth day I found the swelling almost half gone; he could move his neck freely, and said that those powders worked like magic. I gave him another eight powders to be taken as before. I did not see the patient again for a week, when he came to me to say that he was perfectly cured, and was able to attend to his daily work."—J. N. M., in *Indian Hom. Review*, September—October.

**Hydrastis.**—After a series of experiments with hydrastis, Felner has arrived at the conclusion that its action on the uterus is similar to, though less powerful and continuous than, that of ergot.—*Hahn. Monthly*, February, p. 137.

**Infinitesimals.**—The *Minneapolis Homœopathic Magazine* of January cites an account of Professor Ostwald's experiments with homœopathic triturations, to ascertain how minute a portion of a chemical agent will induce crystallisation in super-saturated solutions. He found this re-action to occur as high as the 9th dec., but no farther.

**Iodine.**—Dr. Marc Jousset relates a case which seems to show that iodium (1st dil.) has considerable power in reducing the anasarca of cardiac disease.—*Revue Hom. Française*, February.

**Kali chloricum.**—Dr. F. H. Pritchard sends to the *Hahnemannian Monthly* of January an article on the action of chlorate of potash on the kidneys, which he maintains to be secondary to the changes it causes in the blood, destroying its red corpuscles, and so throwing on the kidneys the burden of their elimination.

**Kali nitricum.**—Dr. E. V. Ross has verified the indication given for this drug in "Bell on Diarrhœa," that the attack follows or is aggravated by indulgence in veal.—*Hom. Recorder*, January.

**Kali phosphoricum.**—Dr. C. T. Steele sends a case to confirm the recommendation of kali phosphoricum as an aid in uterine inertia, which it appears to bear out.—*Minneapolis Hom. Magazine*, February.

**Lachesis.**—Dr. Woodward communicates the following proving of lachesis, made with a view to ascertain its "sequence":—



“ In good health, pulse 65, took 5 grs. of 6x trit. in ʒss. of water at 7.15 a.m. At 7.20 itching of the toes, they feel swollen and burn ; 7.35, oppressed and difficult respiration when sitting ; nose and eyes watery ; 7.48, much thick saliva in mouth and pharynx ; must clear the throat ; had no appetite for breakfast ; soon after, right frontal headache, extending later to occiput, with very pale face ; 8.10, feet cold and clammy ; shooting pains in region of heart ; some apprehension lest I had taken too much medicine ; 9.0, salivation of tenacious fluid, with stinging pain in right hand ; soon after, faintness, with urging to stool, followed by great debility ; 9.10, neuralgic pains down left arm, with numbness of fingers ; 10.10, pinching in umbilical region, with sinking and tenderness at stomach ; 10.15, repeated and violent yawning, with great sleepiness. Later came drawing pains in adductors of left thigh, with weakness in loins ; 11, violent itching in arms, scratching causes voluptuous sensations and erection ; soon after, flush of heat all over, with oppression of lungs and desire for fresh air ; pulse remained normal, but headache increased. At 2 p.m., no appetite for dinner ; urine scant, of bad odour ; sharp urging to stool, without result ; 3.10, chilly, pulse 84, temp. 100° ; soon after sickening pain in left axilla and chest ; urinated again scantily ; 4.0, griping in bowels, with much soreness ; must loosen clothing ; passed much offensive flatus, this was followed by burning and itching of anus and other parts ; pulse weak and irregular ; 4.30, headache has returned, with great irritability ; this was followed by increased mental activity during the evening ; there was no desire for sleep till 1 a.m. On the second day sleepy and languid all the forenoon ; no appetite for breakfast ; great sensitiveness to (cold) open air ; violent sneezing ; 2.0 p.m., much rumbling and distension of bowels, followed by lassitude ; hands and feet swollen and tender, feet icy-cold ; 3.0, on going out, violent convulsive sneezing for some time, causing pain about heart ; pulse 102, very weak ; felt exhausted and alarmed at my condition ; 3.20, free perspiration without cause ; pulse had fallen to 80 ; 6.0, sour stomach, no appetite. Later, two large and foetid stools, with relief of all symptoms soon after.” Cutaneous ; respiratory or circulatory ; digestive ; cerebro-spinal :—this, Dr. Woodward infers, is the sequence of lachesis.—*Hahn. Monthly*, January.

**Lycopodium.**—Dr. Woodward communicates the following proving of lycopodium which he made as far back as 1878 :—“ In sound health, pulse 65. I took 5 gr. of 6x trit. in solution. Soon after, sour eructations ; ten minutes later, annoying itching

in various places; again eructations, with griping and passage of flatus; twenty-five minutes, repeated sneezing, with stoppage of nostrils; thirty minutes, rumbling and distension of bowels, with pinching pains, followed by stool earlier than usual; itching returns at intervals, with perspiration on affected parts. After one hour incarcerated flatus seems to induce cough, with oppression of lungs and husky voice. These symptoms returned now and then for two hours, when there developed a persistent aching and stiffness in lumbar region and hips as if sprained; soon after there was call to urinate, which was repeated three times at short intervals. At 1 p.m., keen appetite for dinner, ate too much, afterwards griping and distension of bowels; 2.0, obscured vision, must rub the eyes to see clearly; 2.15, obstructive catarrh in head, breath smells offensively; 2.35, mental dulness and difficult command of words while lecturing; 5.0, feverish heats with headache, pulse 84, lassitude, with cough and expectoration. Flatus and cutaneous irritation continued at intervals for two days, with catarrhal cough and urination more frequent than usual." Dr. Woodward considers that the sequence developed by this proving is (1) gastric, (2) cutaneous, (3) pulmonary, (4) renal; and that it should be used therapeutically in accordance herewith.—*Ibid.*

**Mercurius corrosivus.**—The *Leipsiger Populäre Zeitschrift für Homöopathie* has been reprinting Buchner's provings of this salt made in 1847. This is well, but it is hardly necessary for the *Homœopathic Recorder* to translate the reprint into English when this has been done for the original in the "Cyclopædia of Drug Pathogenesis," vol. iii. However, for those who do not possess the last-named work, it may be well to note the appearance of these valuable provings in the *Recorder*.

**Nux moschata.**—In a case of poisoning by nutmeg, besides the usual symptoms Dr. W. L. Smith observed a peculiar one in the shape of a sensation as if the soft palate<sup>1</sup> was rolling or curling up on itself from the tip to the base.—*Amer. Homœopathist*, December 15.

**Opium.**—Dr. S. A. Jones examines the use made by Hahnemann in his pathogenesis of opium of Young's treatise on the drug, and comes to the conclusion of all the previous workers in the same field, viz., that his mode of dealing with such material is vicious and untrustworthy.—*Med. Century*, December.

<sup>1</sup> ? uvula.—Ed.

**Physostigma.**—The power of this substance to cause astigmatism has hardly yet been utilised in practice. Dr. L. Hooper relates a case of chronic ophthalmia, where this defect existed—vertical in one eye, horizontal in the other. After the inflammatory condition had cleared away under pulsatilla, the optical defect (with some myopia) remained; but three doses of physostigma 30 brought about normal vision in a week.—*Hom. Physician*, December.

**Phytolacca.**—Dr. Charles Wheeler records a case of mammary tumour disappearing under this remedy in three months (three drops of  $\phi$  being taken thrice daily). It seemed an adenoma, but the lymphatics in the neighbourhood were involved.—*Hom. World*, February.

**Pilocarpin.**—“An old-school journal comments upon the fact that pilocarpin in minute doses is an efficient anti-sudorific, producing results diametrically opposed to the general physiological action of the drug when given in large doses. In this it resembles ipecac., which, although a powerful emetic in large doses, is used in minute doses for the purpose of controlling vomiting induced by conditions of ataxy of the stomach. These facts have been used as arguments by homœopathists to support their dogma of *similia similibus curantur*. The majority of the profession is not prepared to accept this dogma; but it must be conceded that the difference in effects of medicines in maximum and minimum doses has been neglected, much to the disadvantage of scientific pharmacology.”—*Amer. Homœopathist*, December 1.

**Quinine.**—Dr. Ayers reports a case of amblyopia occurring in a child, who took 104 grains of quinine in the course of three days! She became unconscious after the last dose, and remained so for two or three days more. On emerging from this state, she was totally blind. Vision began to return slowly after twenty-four hours, but later the colour-sense was impaired. The papillæ were found pale; and, when examined, vision was 0.6 in either eye.—*Amer. Homœopathist*, December 15.

**Stannum.**—Dr. Midgley Cash relates two cases of apparent phthisis, in which stannum (3x) brought about an at least temporary recovery.—*Monthly Hom. Review*, January.

**Strophanthus.**—Dr. McIntyre contributes a useful paper on this drug to the *American Homœopathist* for December 1. He shows how essentially poisonous is the contractive influence it exerts on the heart muscle, and mentions an instructive case of

valvular insufficiency which improved remarkably under the drug, but—the patient died suddenly on getting up. [Dr. McIntyre says that, to the best of his knowledge, this plant has never yet been proven by our school. We would refer him to the “Cyclopædia of Drug Pathogenesis,” vol. iv., p. 169.—ED.]

**Thyroidin.**—In the discussion on Dr. Bailey's paper on fibroids (see p. 226), Dr. Crawford gave his general experience with thyroidin, which seems to have been extensive. Pernicious anæmia (when arsenic has done all it can do), goitre, Graves' disease, and tachycardia, as well as myxœdema, are greatly benefited by it—some in the triturations, some in five-grain tablets of the pure substance.—*The Clinique*, January.

In an editorial in the same journal, a case of diabetes cured by thyroidin is cited, and the occasional occurrence of glycosuria in Graves' disease is recalled.

In the *Homœopathic Recorder* for February, Dr. Oehme gives a useful summary of the pathogenetic effects which have been observed from the use of thyroidin, and of the therapeutic applications it has received.

**Topical applications.**—In the *Journal Belge d'Homœopathie* for November—December and January—February, a chemist, M. Goret, gives an account of the uses of many of our homœopathic remedies as local applications. It appears to be based upon experience, and contains many novelties.

**Veratrum album.**—“I believe veratrum to be one of the best heart stimulants, in homœopathic doses, that we have. This from Dr. J. S. Mitchell. I well remember his saying, in one of his valuable clinical lectures:—‘Gentlemen, I can get as prompt results from a few doses of veratrum 3x in a feeble heart as I can from a hypodermic of strychnia.’ Three times in the last few months have I profited by this advice.”—Teal, *Med. Era*, February.

**Viscum album.**—Dr. E. M. Holland contributes to the *Homœopathic Recorder* of February some observations showing that the mistletoe is an ecboic, and a pretty effectual one. Dr. S. A. Jones has in the same journal an article upon the virtues ascribed to the plant by tradition, especially that of the Druids.

### THERAPEUTICS.

**Acne.**—Dr. Washington Epps sends to the *Monthly Homœopathic Review* of February a post-graduate lecture on acne. In speaking of treatment, he says that he has relieved and cured many an obstinate case with natrum muriaticum. The indications for this and some other remedies are very fully given.

**Adenitis.**—A writer, who styles himself "Hakim Ahtar," commends, *inter alia*, Schüssler's natrum phosphoricum and calcarea fluorica in scrofulous glands—the former when they are comparatively soft, the latter when induration has set in. He uses the lower and medium triturations. Calcarea fluorica he finds effective also in indurations generally.—*Hom. Recorder*, December.

**Anasarca.**—Dr. Amrita Lal Sircar relates a good case of general anasarca in a Hindu of 63, without definite pathology, in which apis 6 effected a cure after various treatments—British and native—had failed.—*Calcutta Journal of Medicine*, January.

**Atrophy.**—Dr. Beck, of Monthey, narrates, in the *Revue\* Homœopathique Française* of December, a striking case of hysterical anorexia with profound atrophy cured by homœopathic medication of the purest Hahnemannian kind. [It recalls that communicated to the Society nearly forty years ago by Dr. Scriven of Dublin (see *Annals*, vol. ii., p. 208).—ED.]

**Bright's Disease.**—Dr. Clifford Mitchell, who, as a urinary specialist, sees much of chronic morbus Brightii, gives in the *Hahnemannian Monthly* of February the result of his experience in its therapeutics. Ferrum and strontium seem to have done more in his hands than the usual medicines. Aurum (mur. natr.) he finds very effective against the diuresis of contracted kidney; and caffeine does best for the uræmic headache. In desperate cases, with much dropsy, he does a good deal of alternation, even of three remedies at a time.

**Broncho-pneumonia.**—In the *Medical Century* for February, Dr. Deschere gives an interesting study of the leading remedies for this malady when occurring in young children. He makes a good point in warning against changing to belladonna when cerebral symptoms manifest themselves. Phosphorus (which he gives in the 30th) will, he says, do all that they require.

**Cough.**—In a paper entitled “Our Cough Remedies,” contributed to the January number of the *North American Journal of Homœopathy*, Dr. Cowperthwaite gives a very full and clean-cut delineation of some eleven medicines in this relationship. There is nothing new in it, but it is a study well worth referring to in troublesome cases.

**Dengue.**—Dr. Bliem, of San Antonio, Texas, gives an interesting account of an epidemic of dengue which visited that city in August last, after an absence of twelve years. The pains were specially severe. As regards therapeutics, he writes :—“The remedies called for in our system of treatment narrowed themselves down to gelsemium, bryonia, and eupatorium, with now and then a call for belladonna. Nothing seemed to beat down the temperature until it had run its course.” The sufferings were sometimes so great as to require opium as a palliative.—*Medical Century*, January.

**Diabetes.**—Dr. Halbert relates a striking case of diabetes, in which, under a strict diet, the patient was going from bad to worse; while, on letting the patient eat what he liked, but keeping him on uranium nitricum 3x., something nearly approaching a cure took place.—*The Clinique*, February.

**Enuresis nocturna.**—An old-school practitioner has found that in the treatment of nocturnal incontinence of urine in children, lycopodium occupies the highest place after belladonna (which lasts he thinks best given in a single full dose at bedtime). He gives 20 drops of a tincture three times daily, increasing these up to a drachm; and has no bad effects. [He would probably get good results from much smaller doses, did he use the more effective homœopathic preparations.—ED.]—*Calcutta Journal of Medicine*, December.

**Epilepsy.**—A girl from Dalmatia, aged 18, with a genuine Italian constitution, very vivacious and excitable, since her catamenia began had suffered from cramps and pains as often as they occurred. Four years ago, in consequence of a fright, she had a fit like tetanus, lasting several hours; and ever since this has happened almost periodically, at first every two months, and then after each period; at last they appeared on every casual occasion, when the patient became much excited. The attacks became more and more of the epileptic form. She had had much treatment in vain. I gave her ignatia 6 every evening; and after using this remedy alone for two months she was

perfectly cured, and remained so until three years later, when she died of acute pulmonary tuberculosis.—Hillberger, *Amer. Homœopathist*, January 15.

**Fibroids.**—A deeply interesting paper, embodying a large experience in the extra-surgical treatment of uterine fibroids, was presented by Dr. E. S. Bailey to the Clinical Society of Hahnemann Hospital, Chicago. Nine cases were related in full, and others referred to. Dr. Bailey is still a firm adherent of Apostoli's methods, and believes they cause shrinking of the tumours as well as relief of hæmorrhage and other symptoms. The novel point he makes is the value of thyridin, of which he gives some striking instances. It acts well, if not even best, in the triturations up to the 3x, so that it is not its physiological action which is exerted.—*The Clinique*, January.

**Gangrene.**—Dr. Beck, of Monthey, was called in consultation by an old-school colleague over a case of symmetrical gangrene of the feet in a man of 32. The effects of lachesis 6 and of carbo-vegetabilis 30 (in collapse) were striking; and complete recovery ensued.—*Revue Hom. Française*, December.

**Gummata.**—Writing upon nasal syphilis (which takes the form of tertiary gummata), Dr. G. B. Rice says:—"I have known of a number of cases, under the best homœopathic medication, to have gone on from infiltration to destruction of healthy tissue without apparent interruption in the slightest degree." He thinks iodide of potassium "homœopathic to the disease," but not sufficiently so to enable us to arrest it with small doses of the drug. "Ten, twenty, thirty, and even sixty grains daily are frequently necessary to arrest its progress."—*N. Engl. Med. Gazette*, December.

**Lichen.**—As there is little experience of this form of cutaneous disease on record, it seems worth stating that Dr. Mackechnie reports a case of some months' standing cured by arsenicum iodatum.—*Monthly Hom. Review*, January.

**Locomotor ataxy.**—In an able article on this disease, Dr. Clarence Bartlett states that he finds the best palliative for the lightning pains to be acetanilid in 5 to 10 gr. doses, and methyl blue, of which 3 gr. every night are sufficient. Merck's preparation of the latter is that which he prefers.—*Hahn. Monthly*, December.

**Neurasthenia.**—Dr. Marc Jousset relates a case of neurasthenia having as a prominent symptom that described as agoraphobia, where arnica, 1x trit., taken for a long time proved completely curative. He has seen amendment in other cases also by the same treatment.—*Revue Hom. Française*, January.

Dr. V. Léon Simon, in a discussion on the same subject, spoke highly of acidum carbolicum and helleborus niger for the head symptoms of brain-fag.—*Ibid.*

**Phagedænic chancroid.**—In an instance of this troublesome affection, Dr. Dejage found lotions of chloride of zinc at a strength of 1 per cent. altogether useless, while much weaker solutions caused speedy cicatrisation.—*L'Art Médical*, January.

**Phtthisis.**—Dr. J. D. Buck has had large experience in pulmonary phtthisis, and especially in the use of inhalations. He endorses the praise given by the Italian physicians to simple essence of peppermint so employed, but has a still higher opinion of Dr. Franz Hartmann's "liquo-sulfit," which is, he says, a "modified product of the refuse acid in the manufacture of wood-pulp," and so allied to kreosote. He has "never obtained so rapid a reduction of temperature, gain in flesh, and disappearance of cough from any other remedy."—*Med. Century*, December.

**Progressive muscular atrophy.**—Dr. A. K. Crawford states that Dr. Gowers informed him, while in London, that the injection of fractional doses of strychnine would really benefit progressive muscular atrophy. He relates three cases of his own which (in two of them at any rate) strikingly confirm the recommendation.—*The Clinique*, February.

**Purulent Ophthalmia.**—An Indian practitioner relates a case of purulent ophthalmia in an adult which yielded rapidly to mercurius sol. 6 and 30.—*Indian Hom. Review*, January.

**Rhinoscleroma.**—Mrs. K. was never ill until she married, when 22 years old. Her husband always enjoyed good health, and had never had any syphilitic affection. In 1886, when 23 years old, she became pregnant. In the third month of pregnancy the nasal affection appeared, for which she consulted many physicians during the following year. In the autumn of 1887, there appeared a slowly increasing darkness and discolouration of the right upper side of the nose, about the size of a three-penny bit, and a few weeks later a similar swelling on both *alæ nasi*. The medicines prescribed did no good. The shape of



the nose became much altered, its point became flattened, the alæ broad and immovable, on the left surface of the septum there was a copper-coloured hard lump which interfered with breathing. This was scraped off with a spoon, and then burnt with lactic acid. This operation only gave temporary relief. On the upper lateral aspect of the nose, on the alæ nasi and septum, there are copper-coloured, elastic, shining indurations. The skin around is normal in appearance. The lumps can be moved along with the skin; they are quite painless even when pressed strongly. There is no appearance of inflammatory action. The nose is flattened. The patient has a nasal tone of voice, the left nostril is much narrowed. When cut or pressed with knife or scissors, there is no reaction; the wounds heal readily. The patient is otherwise well, nurses her baby. The treatment was strong doses of pot. iod. for a long time, an ointment of galls, and curetting, all without any benefit. The disease began, as before said, in the third month of the first pregnancy, and increased during the pregnancy. After delivery the lumps became somewhat smaller. In the second pregnancy the disease increased. The nose became larger, reddish-brown or purple, and a number of smaller lumps the size of sago came in addition to the larger lumps. After delivery the disease ceased to increase, but did not diminish. In 1891, she again became pregnant. Then the disease involved the left cheek. *Post partum* the disease came to a standstill; but the patient's face was so disfigured that she would not venture out of the house by day. In 1893, she came under the treatment of Dr. Kranz, senior, after which the disease did not increase, although she became pregnant for the fourth time. The disease now began to diminish, and two subsequent pregnancies in 1892 and 1895 caused no relapse. Dr. Kranz's treatment consisted of repeated doses of auronatrum chloratum 5x. This treatment was continued by his son, Dr. Kranz-Busch, until at length a perfect cure was effected, and the nose and features resumed their normal appearance. The lumps gradually disappeared together with the discolouration, the nose became of its original shape, and the nasal passages free from all obstruction.—Kranz-Busch, *A. H. Z.*, cxxxvi., 17.

**Sea-Sickness.**—Dr. H. M. Robertson, in a letter relating his experiences in Europe, mentions that he found ipecacuanha, 3x dil., superior to all the reputed remedies for sea-sickness; and that on his voyage out it produced results which quite surprised the surgeon of the vessel.—*Amer. Med. Monthly*, January.

**Sensitiveness on Lying.**—Dr. Morrow has been led to examine the medicines which have caused or cured the symptom generally described as “the bed feels hard.” Arnica and baptisia he himself places in the first rank, “with, perhaps, pyrogen a close second.” Bönninghausen thinks most of silicea, and Allen of ruta. Several other drugs have their symptomatology in this connexion exhibited.<sup>1</sup>—*Hom. Physician*, December.

**Spasmus Glottidis.**—B. G., 7½ months old, was suddenly attacked by spasmus glottidis at the commencement of the sixth month, which recurred frequently. The attacks lasted about half an hour, during which the child remained motionless and only recovered after a warm bath. For the first ten days of its life it took the breast, afterwards was fed upon milk to which was added in its thirteenth week some farinaceous food. Under this diet it increased in weight, but remained so sensitive to open air that every time it was taken out it got tracheal catarrh with cough. For the spasmodic ailment the father gave belladonna for a week without benefit. Then for a fortnight kali brom. was prescribed by a physician but without benefit. At the beginning of the seventh month the attacks were so frequent that the child had no rest day or night. The attacks lasted only a few moments but recurred ten or twelve times in an hour. The tracheal catarrh continued uninterruptedly. Another physician prescribed a narcotic which did no good. At the beginning of the eighth month two teeth were cut, after which the attacks diminished but the cough continued. The little patient was taken to a salt-ley bath, but the spasmodic affection became worse. The child was seen by Dr. Stiff on July 8, 1895. Its state was as follows:—Apparently well nourished, no swellings of lymphatic glands and no rachitic symptoms. The lungs were healthy in the fine bronchial tubes, but there was considerable tracheo-bronchitis. Profuse perspirations, especially on the head; loose stools since the commencement of dentition. Iod. 6, three drops twice a day every other day, a grain of calc. phos. every evening. July 19.—The father reported that three days after beginning the treatment there was a severe attack with copious mucous expectoration. After this no severe attack. Slight attacks seldomer, sometimes four or five hours were passed without any attack. The perspirations became less after a few days, appetite and digestion satisfactory. September 17.—The father wrote:

<sup>1</sup> Dr. Morrow has omitted carb. veg., but see *Cycl. of Drug Pathogenesis*, vol. ii., p. 23.

“ We have given the child the iodine prescribed by you for eight weeks. The spasms of the glottis have become constantly slighter and rarer, and for two weeks there have been none. After taking the medicine for four weeks the perspirations ceased, but we continued the medicine for two weeks longer, and then we stopped it. At the commencement of September, after exposure to the weather, the child got a severe cough with copious expectoration of mucus but no spasms.” October 10.—The father reported that the child was quite well. Several months thereafter I ascertained that, with the exception of occasional catarrh, the child continued well.—Stift, *A. H. Z.*, cxxxv., 178.

**Tuberculosis of the Iris.**—Dr. L. Schepens reports a well-observed case of tubercle developing upon the iris. Arsenicum, sulphur and kali bichromicum were without effect, while tuberculinum Kochii 6 given twice a day caused an immediate arrest of growth and a speedy clearing away of the deposit.—*Journ. Hom. Belge*, January—February.

**Typhoid.**—Dr. Joseph E. Wright firmly believes in the possibility of aborting typhoid, but maintains that it must be done by choosing remedies from some “characteristic” symptom, irrespective of the pathological state. He relates a case in which aloes proved such an abortifacient, prescribed because “whenever the patient took a swallow of water, a gurgling would start from the pit of the stomach, and course down the intestines, ending in a sputter of flatulence and soiled linen.” Four doses of aloes 3x brought the temperature to normal in two days, and initiated a rapid recovery.—*Amer. Homœopathist*, December 15.

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THE HOMŒOPATHIC TREATMENT OF PNEUMONIA IN CHILDREN UNDER THE AGE OF FIVE YEARS.<sup>1</sup>

BY FRANK A. WATKINS, M.R.C.S., L.R.C.P., L.S.A.

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PNEUMONIA occurring in children under the age of 5 years is generally of the lobular type, and appears to be determined by the embryonic condition of the lungs, which do not reach their mature or adult state until about the end of the fifth year.

The morbid condition is caused by an inflammation of the bronchial mucous membrane, which by direct extension involves the connective tissue, bronchioles and air cells.

The following is a short extract from the notes of a case of broncho-pneumonia, in which most of the usual signs and symptoms of the complaint were developed.

<sup>1</sup> Presented to the Section of General Medicine and Pathology, February 3, 1898.

232 HOMŒOPATHIC TREATMENT OF PNEUMONIA IN CHILDREN

Mary Collins, aged 1 year and 8 months, was admitted into the hospital on December 2, 1897. The child had previously been suffering for seven days from feverishness and cough. On admission the temperature was 103°·6, pulse 180 and respirations 56 per minute. The bowels were relaxed—motions a green colour and very offensive. Patient was troubled with a frequent short cough. There was impaired resonance over the left scapula, and sharp crepitant râles all over the chest. The temperature assumed an irregularly intermittent type—the morning temperature at times falling from three to six degrees; and the pulse-respiration ratio varied from 1 to 2 to 1 to 3, instead of 1 to 4, which is the normal.

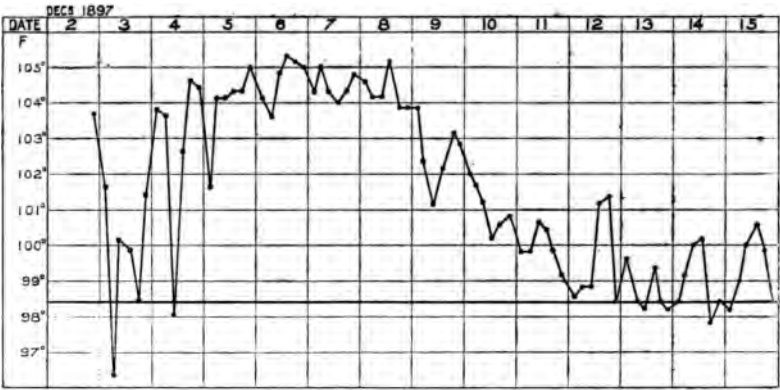


CHART No. 1.

At the end of the first week there was evidence of well-marked consolidation of the apex of the left lung; from this time there was a continuous irregular fall in the temperature until it reached the normal on the seventeenth day; the diarrhoea then ceased. From the time the temperature began to subside the consolidation commenced to clear, and this process was completed four days after the temperature reached normal.

See temperature chart, No 1.

*Diagnosis.*

With regard to the diagnosis of broncho-pneumonia the greatest difficulty is experienced in distinguishing between

the lobar and lobular forms of pneumonia, and especially that form of lobular pneumonia in which the greater portion of a lobe is consolidated and known by the name of pseudo-lobar pneumonia or the aggregate lobular pneumonia.

Croupous or lobar pneumonia generally occurs in children above 4 years of age, who have been in a previously good state of health. The attack begins suddenly with one or more of the following symptoms—vomiting, convulsions, headache, delirium—rigors being usually absent. The temperature rises rapidly, often to 104° or 105° within twenty-four hours. The temperature remains tolerably regular with morning remissions of from one to two

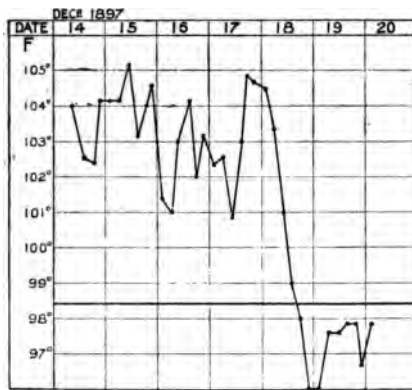


CHART No. 2.

degrees, and in the course of from five to seven days terminates in crisis. The pulse-respiration ratio is about 1 to 2½. Frequently there is a herpetic eruption on the lips. Often one lung only is involved, and the upper lobe is most frequently affected. There is an early appearance of dulness to percussion; usually bronchial breathing and bronchophony, and increased vocal vibrations, are well marked. Fine crepitation is heard during the period of engorgement and returns during the process of resolution. See temperature chart No. 2.

Broncho-pneumonia generally occurs in children under the age of 5 years. The illness begins insidiously, and is usually preceded by measles, bronchitis, whooping cough or diphtheria. The temperature rises slowly and is irregularly intermittent, with morning remissions varying from three to five degrees. It is indefinite in its duration, frequently lasting three weeks, and often much longer, and is not rarely followed by relapse or permanent impairment of the lungs; termination takes place by lysis. See temperature chart No. 3.

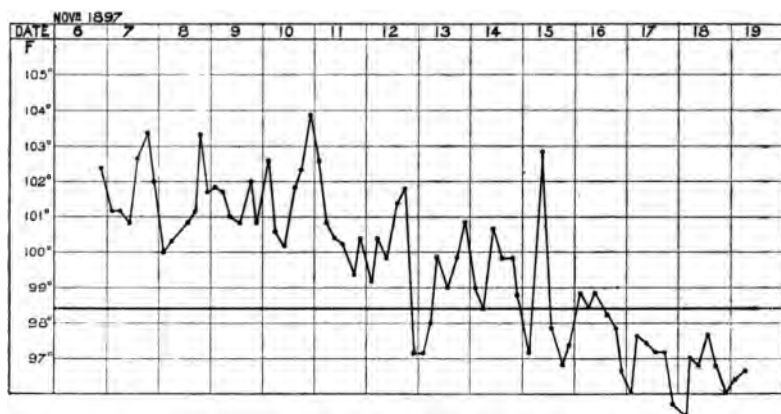


CHART No. 3.

The pulse varies from 120 to 200. Respiration is thoracic in type and often as frequent as 60 to 70 per minute. The pulse-respiration ratio is 1 to 2, or even 1 to  $1\frac{1}{2}$ . There is frequently diarrhœa and vomiting. The bronchial secretion is never expectorated in children under the age of 5 years. Is it not probable that the diarrhœa, from which so many of these children suffer, is caused by swallowing the mucus? Both lungs are generally involved. Râles of all descriptions are present; dulness to percussion is late in its appearance. Breath sounds are weak or absent, or of a blowing character; seldom bronchial breathing is heard.

## BRONCHITIS.

There is usually not much difficulty in diagnosing bronchitis affecting the smaller tubes, for here there is no evidence of consolidation of the lungs. The temperature seldom rises above 102°, and the pulse and respirations only rise in the same ratio. Every variety of pulmonary râle may be heard excepting the fine crepitation which is pathognomonic of croupous pneumonia.

Bronchitis, affecting the smallest bronchial tubes—that is, the bronchioles—only, and which used to be known by the name of capillary bronchitis, cannot be diagnosed with certainty and has never been found *post-mortem*. It is always followed by extension of the inflammation to the alveolar cells, and therefore should be considered as the first stage of broncho-pneumonia.

## PROGNOSIS.

The following are the more important signs and symptoms affecting an unfavourable prognosis :—

(1) The age of the patient. The mortality is very much higher amongst children during the first two years of life.

(2) Cases which are secondary to diphtheria, tuberculosis, meningitis and whooping cough.

(3) Where extensive areas of the lungs are affected.

(4) Accompaniment of diarrhœa and vomiting.

(5) When the respirations are more than fifty to the minute.

(6) Much alteration in the pulse-respiration ratio. When it reaches 1 to 1½ the case almost always proves fatal.

(7) When the child is unable to take a good drink at the bottle, being compelled to loose hold to get breath.

(8) When the child ceases to cry and cough.

(9) The presence of an expiratory “grunting” sound during expiration.

(10) A sudden drop of the temperature accompanied by dyspnœa is frequently followed by death.

(11) A sudden considerable rise in temperature often



takes place just before death, sometimes going as high as 108°.

#### MORTALITY.

Under allopathic treatment the mortality of broncho-pneumonia is generally conceded to be from 40 to 50 per cent.

Goodhart quotes 45 cases, of which 25 proved fatal.

Jurgensen says that from a half to two-thirds of cases under his observation terminated fatally.

Meinsen lost 50 per cent of his cases under 1 year, 40 per cent under 3 years, 25 per cent over 3 years.

Bouchut lost 33 out of 55 cases under 2 years.

Gordon Morrill collected 325 cases from various sources, all of which were under the age of 10 years; he found that the mortality reached 48 per cent.

#### TREATMENT.

Aconite is only useful during the early stage of the disease, and should be stopped as soon as there is evidence of consolidation.

Antimonium tart. is our sheet anchor, especially when there is much rattling of mucus; it should always be given in trituration as the solution readily decomposes.

Phosphorus is indicated when the lungs are in a drier state, and there is much consolidation.

Iodide of arsenic is of special value when the broncho-pneumonia is of influenzal origin, and is always invaluable when the temperature drops to normal, in order to promote resolution, and is especially useful when there is diarrhoea and other digestive disturbance.

I have tabulated all the cases of pneumonia occurring in children under the age of 5 years, which have been admitted into the hospital during the time I have held the appointment of house-physician.

I would like to take this opportunity of thanking the members of the medical staff for their courtesy in allowing me to make use of the notes of the patients treated in the wards. The table is drawn up in such form that the prominent features of each case can at once be seen.



The cases under consideration are 17 in number. The first 14 of them were cases of broncho-pneumonia, all of which recovered. The last 3 were of the croupous form. No. 15 made a good recovery. No. 16 died on the eighth day—death being preceded by convulsions, and a temperature of  $108^{\circ}4$ . On *post-mortem* examination it was found that double croupous pneumonia was present, and that both lungs contained tuberculous deposits. No. 17 was admitted in a moribund condition, and only lived five hours after admission.

The table is of interest, first of all, as showing that none of the patients were above the age of 4 years, and more than half were not more than 2 years old—that is, the age which is attended by far the greatest mortality.

The duration of the fever lasted from three up to eighteen days, and in the case of No. 3 lasted for twenty-two days, but this was no doubt in part owing to the complication of catarrhal laryngitis and whooping cough.

In 5 cases the temperature reached  $105^{\circ}$ .

Gordon Morrill quotes 2 cases in which the temperature reached the phenomenal degree of  $108^{\circ}$  before the fatal termination; it will be seen that No. 16 reached nearly half a degree above that record.

The rate of the pulse varied from 140 to 184, and in 4 of the cases reached 180. The respiration numbered from 40 up to 88, and in 1 case, which recovered, was as rapid as 100 per minute. The pulse-respiration ratio varied from 1 to  $1\frac{1}{2}$  to 1 to 3, and in No. 8 was as low as 1 to  $1\frac{1}{5}$ .

In most of the cases there was considerable morning remission of temperature, and in the case of No. 4 it fell as many as  $7^{\circ}$ . When the crisis took place in No. 15 the temperature dropped  $8\frac{1}{2}^{\circ}$  within twenty hours.

Both lungs were affected in nearly all the cases.

Termination of the fever took place by lysis in all the cases of broncho-pneumonia. The time taken for resolution after the fall of the temperature varied from three up to sixteen days. Cure took place in all with the exception of 2 of the croupous form, 1 of which was admitted in a moribund condition, and the other was of a tuberculous nature. In no case was there a relapse.

No. 3 was complicated with catarrhal laryngitis and whooping cough, and this, no doubt, in a measure accounted for the prolonged duration of the fever.

In No. 5, although the temperature did not go above 100°·6, and the duration was only three days, yet there was very great dyspnœa accompanied by retraction of the chest.

Nos. 3 and 14 were complicated with whooping cough.

In Nos. 10 and 16 convulsions were present.

The benefit derived from homœopathic treatment of broncho-pneumonia is most strikingly shown first by the great reduction of the mortality. As mentioned above, most authors place the death rate somewhere between 40 and 50 per cent., and here are 14 consecutive cases without a single fatal termination.

Secondly, I think it is a very fair inference that the course of the disease is very materially shortened. Under the old school treatment the average duration of the disease is estimated to be from two to three weeks and frequently much longer.

Reference to the tabulated report will show that only in 1 case did the duration reach the three weeks and that the average of the 14 cases would work out to be ten days.

Thirdly, under allopathic treatment relapses and recurrent relapses are of common occurrence, and not infrequently the lungs are permanently damaged; whereas the 14 cases which received homœopathic treatment recovered without a single relapse, and there was no reason to suppose that in any case the lungs had received any permanent damage.

Fourthly, another advantage of the homœopathic treatment is that after the subsidence of the fever, resolution of the inflammatory products is speedily effected, and in no case was the delay more than sixteen days, and in the majority of the instances it was completed within the week.

On examination of the hospital records for the last five years, I find that 49 children, up to the age of 5 years, were admitted for broncho-pneumonia, and that out of these there were only 6 deaths.

Four of the fatal cases were admitted in a moribund condition, and 2 were complicated with croup.

The mortality for the five years is 12 per cent.

Dr. HUGHES said he was recently summoned to attend a child for measles, and discovered that its temperature was nearly 105°. Next day broncho-pneumonia declared itself. He gave phosphorus as high as the sixth dilution, a drop every two hours, and the effect was most happy. The inflammation rapidly subsided and in three or four days all danger and anxiety from that source was over. He had always maintained that phosphorus should be given in preference to almost any medicine in acute inflammation of the chest in young children. He did not intend to depreciate antimony, but only to speak of medicines of that type as better suited to cases of bronchitis in children than such as ipecacuanha and bryonia, which only touched the tubes and did not follow the morbid process into the air-cells.

Dr. GALLEY BLACKLEY suggested that the provings of ipecacuanha upon animals led one to suppose that ipecacuanha was not only a *simile* but a *simillimum* for broncho-pneumonia, for it went quite as far in the direction of partial consolidation as anything one could possibly desire, and it was moreover accompanied by slight hæmoptysis in many cases. He thought antimonium tartaricum was more helpful than phosphorus. He would suggest that phosphorus was more akin to the croupous form of pneumonia. The pathological condition excited by phosphorus was distinctly of the croupous kind, and that excited by ipecacuanha and antimonium tartaricum was rather of the lobular variety. Recently he had had a good deal of experience in the matter of broncho-pneumonia following influenza, and thought there was a medicine which was superior to the whole lot put together, and was practically a specific, to wit, iodide of arsenic. Where influenza was at the bottom of lobular pneumonia he thought it a waste of time to give other medicines. He used it in the third decimal trituration.

Dr. NANKIVELL thought that in the case of adults broncho-pneumonia was recognised as catarrhal pneumonia. There were hundreds of cases of catarrhal pneumonia amongst the working classes which were never treated at all during the acute stages, and they finally developed into phthisis. He suspected in the long run it was quite as fatal in adults as in children. He agreed as to the value of antimony if one got the cases early. Ipecacuanha would come in where the gastric disturbance

was less well marked, and iodide of arsenic was most useful in sub-acute and chronic stages. The experience of himself and of his colleagues maintained this as a solid therapeutic fact.

Dr. STONHAM thought that the use of bryonia on the third day of an attack of measles prevented an attack of broncho-pneumonia in children. Of course, it was difficult to prove a negative, but at any rate the patients so treated never had the disease. He thought broncho-pneumonia following influenza was rather different in type. It was hardly pneumonia, but was more of an inflammatory oedema.

Mr. DUDLEY WRIGHT said when he was house-surgeon they had a fatal case of broncho-pneumonia in which the temperature rose to 109°. A well authenticated case of temperature of 108·5 occurred in a child aged 10 months. A bath of 100° F. brought the temperature down to 101°. The temperature rose again to 104°, and later on to 105°, but a bath of 100° again brought the temperature down to normal, and it remained there until recovery. Antimonium tartaricum was his favourite remedy. In the case of old people who had catarrhal pneumonia he had used carbonate of ammonia in the dose of a third of a grain, and found it one of the best stimulants. He had not to use much in the way of alcoholic stimulants when that was kept up. Ipecacuanha never used to succeed so well as antimonium tartaricum. Vomiting was nearly always present in cases in which ipecacuanha was used as a proving, yet one rarely came across cases of broncho-pneumonia in which vomiting was a symptom. He thought that rather put it out of court as being really a *simillimum*.

Dr. JONES said he had recently had two cases of broncho-pneumonia in children, both of which followed measles. In the first the temperature would not go down for many days, and when it did, under arsenic and iodide of potassium, it suddenly went up again to 104°. At that time Dr. Blackley saw the patient and suggested iodide of arsenic, and from that moment everything went well. In another case he had given bryonia and iodide of arsenic in alternation, with good results.

Dr. MACNISH had derived brilliant results in the early stage of the disease from veratrum viride, 1x.

Mr. JOHNSTONE said he had recently three cases in children of whooping cough complicated with measles and broncho-pneumonia. He had adopted with good effect the medicines used by Mr. Watkins. He wished to ask whether Mr. Watkins gave the antimonium tartaricum, or the arsenicum, first.

Mr. WATKINS said he used the antimonium tartaricum first.

Mr. JOHNSTONE said that probably arsenicum had very much the same action in broncho-pneumonia as it had in tuberculous conditions, viz., that of tending to resolve the hyperplasia of the tissues and consolidation of lung.

Mr. WATKINS, in reply, said no local applications had been used with the exception of the Gamgee wool jacket.

## CLINICAL NOTES ON ENDOMETRITIS, CHIEFLY THE SENILE FORM.<sup>1</sup>

BY WM. CASH REED, M.D.

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THOUGH I have not, perhaps, chosen for my paper a *great* theme, it is an *every-day* one for each of us, and thus its very commonness lends it dignity. Moreover it is the source of great suffering to countless numbers of the other sex, and thus again it demands at our hands a careful and critical study.

“Inflammation of the uterus,” so-called, is so protean in its signs and symptoms and is so governed, as regards these, by the “personal equation” of the patient, that it were hopeless to attempt, in the space at my disposal, to consider anything more than a brief *clinical* picture of a few cases which have recently come before me.

I shall not pretend, nor do I desire, to offer any initial *schema* of symptoms, however useful such may be in its way, and in its proper place, for the patients here considered are not lay figures ticketed and labelled for our edification. They are, or at least they pretend to be, “portraits from life,” and as such must furnish their own inferences, and point their own moral.

And now, having completed my *apologia*, I put before you the following cases.

<sup>1</sup> Presented to the Section of Surgery and Gynæcology, March 3, 1898.

CASE I.—Miss X., aged 68, consulted me last summer for a constant sensation of “bearing down” and “dragging” in the groins, and left ovarian region, which she significantly observed “affected the throat.” There is also much pain in the sacrum, and worst of all she suffers from a profuse and very offensive leucorrhœa, now bloody, now yellow, but always glutinous and glairy. This elderly lady has all her life been more or less an invalid; and but for an indomitable will and perseverance must have succumbed years ago to the dominating power of a many-sided malady, which would have swamped the individuality of any score of mediocre women, and would have left her, but for these saving qualities, a mildly protesting, fatuous, “sofa invalid,” the despair of friends, and for the doctor a doubtfully desirable, if lucrative, patient. But this lady was destined for better things, to be a stimulant to the faint-hearted and a cold douche to the hysterical.

She has inherited, along with other family heirlooms, the gouty diathesis and a lymphatic tendency. She has suffered from asthma for ten years, and from chronic bronchitis for much longer, and has now extensive emphysema of the lungs, with a barrel-shaped chest; and there is always more or less basic stasis present. Her sleep is very indifferent, and her extremities cold.

This patient has for many years been under the care of one of the most distinguished medical men of the day, and before that under one of the most able and best known provincial surgeons in the heyday of his fame.

The condition then on arrival was not one which promised a very substantial framework for successful decoration, either on the lines of surgical interference, or the gentler ones of drug selection. There was, however, one ray of light on this pathological picture, and that was that the urine was free from albumen.

But to make a diagnosis as a gynæcologist was the first thing to be done, and on examination I found a bulky, soft, easily bleeding uterus, pendent low in a capacious vagina, the mucous membrane of which was of a dark, venous hue. The sound passed in a normal direction for  $3\frac{1}{2}$  inches, with an arrest at the internal os, and considerable pain there, and brought away on its withdrawal not a little blood. The case thus looked grave, and I told the friends so, and but for one point in connection with the leucorrhœa above referred to, should have said *exceedingly* grave. This was, that the bad odour connected with this dis-



charge was not a new development in the case, but had been existent for many years. The only *treatment* which appeared to me to hold out the least likelihood of permanent benefit was a thorough curettage of the uterine cavity; and I had the satisfaction of a confirmation of this view by Dr. Burford, who travelled from London to see the case. Under an anæsthetic administered by Dr. Midgley Cash of Torquay, and with Dr. Burford's valuable assistance, I dilated the uterus to its fullest possible extent on July 24, and curetted the endometrium in the most thorough manner. Care was very necessary, for, as in the typical senile uterus, its walls were soft. Pure carbolic acid was applied to the interior of the denuded organ and the fragments removed by the curette preserved for examination. The patient was a good deal collapsed, but by-and-by rallied, and on the third day I removed the intra-uterine gauze. Convalescence so far as the operation was concerned was rapid and uneventful, but in view of the pre-existing troubles, vomiting, bronchitis and diarrhœa, kept her ill for a long time. This, however, was anticipated, though trying enough in the reality.

The further history of the case I shall dispose of in a few words, but its *pathology* demands special attention.

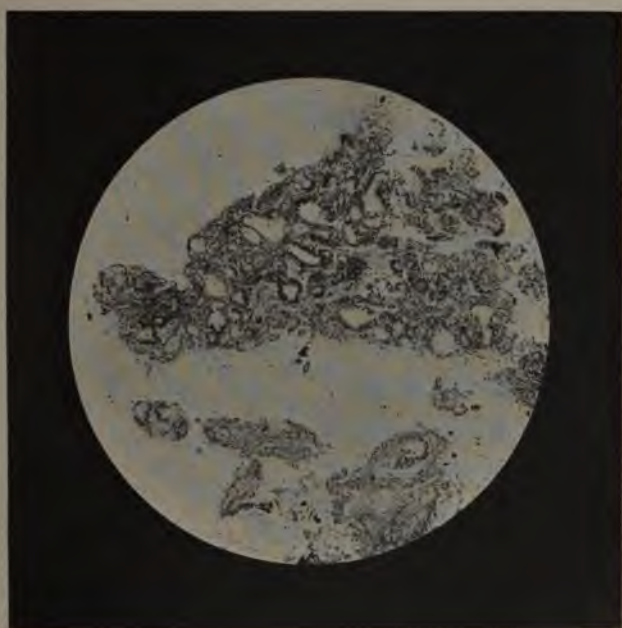
The patient ultimately returned to her home in Devonshire with a uterus normal in size, with a minimum of "bearing down" and no leucorrhœa. The involution was assisted by the liq. extr. of ergot. The chief comfort, perhaps, to the patient consisted in there being now no necessity for a pessary, which for a great number of years she had not been able to do without. From a letter received three days since, I learn that the patient remains well locally, in spite of a severe attack of "influenza" just passed through.

As to the *pathology*, I have here photographs of the slides furnished by Mr. Johnstone, and cannot do better than quote his able report in this connection.

"The arrangement of the epithelium is certainly not normal. I believe there is a papillomatous condition of the mucous membrane with a heaping up of epithelium in places. Also, occasionally we can see spots suggestive of infiltration of the epithelium. On the whole, I am inclined to think that if the condition is not actually malignant, there is at least a malignant tendency."

CLINICAL NOTES ON ENDOMETRITIS.

By DR. CASH REED.



Micro-photograph illustrating Case No. 1.



In the *British Medical Journal* of May 19, Dr. Halliday Croom is reported to have said, "Senile uterine catarrh was not among the prodromata of malignant disease; the two conditions were quite distinct. Dr. Croom had never seen a case of the simple condition later become one of cancer."

I venture to think that the case I have just described amounts to proof positive of the opposite conclusion.

CASE II.—About a year ago I was consulted by a lady, aged 36, about to be married, on account of metrorrhagia. She is anæmic and has an anxious expression. The general health is very good, and there is nothing special to remark as regards the family history, except that there is a tendency to *gout*. One point, however, is noteworthy and curious: she is the third in a family of five, and all, with the exception of the patient, are deaf, one very "much" so, from chronic middle ear disease.

I ascertained that the "periods" had always been very profuse, usually necessitating twenty changes. Further, the type of metrorrhagia described was that in which there is, broadly speaking, only about one week in four during which it can be said that the patient is absolutely free. The interval, with this exception, between the "periods" is filled up by a more or less constant sanguineous drain, and especially that week in the cycle which may be looked upon in point of time as the one prior to the normal recurrence of the flow. The drain referred to is not of the "prune juice" type, but is best described as "florid." There is no *leucorrhœa*. In view of the foregoing, I employed the following remedies: crocus, china, chin. sulph. and pulsatilla, but with not the slightest benefit, and I began to suspect there must be a local and tangible cause to account for the persistent condition.

The patient was therefore anæsthetised, and the diagnosis proved to be but the work of a moment. The examining finger came immediately upon a patulous os, situated in the centre of an area of roughness about the size of a sixpence; all the characteristics, in fact, of a *simple erosion*. *Voilà tout!* There was no true ectropion, but a desquamation of the superficial layers of pavement epithelium about the os, due probably to the acidity of a discharge, relatively slight in amount, from an endocervicitis of long standing.

The *treatment* consisted of ichthyol-glycerine locally, together with the hot douche, and the administration of platina, and later on phosphate of strychnia.

The patient made a steady recovery and is, I think, in such a state of health that utero-gestation, should it occur in the natural order of things, need not be feared, either with regard to premature evacuation of the uterus, nor undue trouble during the puerperium. In searching for an explanation of this case of endometritis in the virginal uterus, one is confronted with a difficult question at the outset. Why should an organ in the economy which, except for the periods of menstrual activity, occupies the place so well described by Dr. Burford of a "resting-spore," take on thus an aberrant functionising, and setting up anæmia as a direct result, perpetuate through it the vicious cycle of morbid changes shown in this case? What is essentially the first cause in the chain of events?

The patient was otherwise in the very best of health, and there was no evidence of *congestion* by faulty clothing, quite otherwise, nor yet as the result of a so-called "chill" at the "period." Nor was there evidence either of the introduction of microbes from without. I am inclined to hark back far in this case, and to find the first cause in the gouty diathesis previously referred to, and to regard it as that morbid entity which found its sphere of action on the mucous membrane of the middle ear, in all her brothers and her sister, but in the case of our patient the uterine mucosa was selected to bear the brunt of the impact.

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Dr. CASH REED then threw upon the lantern screen a slide showing *Leucocytosis*, probably amounting to pus, from a case of non-gonorrhœal inflammation of the introitus vaginæ, in a virgin aged 24. Cause unknown: severe, and somewhat intractable to treat. A sister of patient has just died of phthisis, but there are no tubercle bacilli to be found in this case. It may be regarded as illustrating the initial stage of a non-specific peripheral inflammation of the genital tract, which, unchecked, would ultimately reach the peritoneal end of the same tract, resulting in well-known lesions.

He next exhibited a slide taken from a case of *Hæmorrhagic endocervicitis* in a patient aged 52. "The specimens showed diplococci. The cultivation proved them to be *staphylococcus albus*."

The symptoms were essentially, pain in "bottom of back" accompanied by a coloured discharge. The "period" only ceased five months ago, and ever since she has had this discharge.

The next slide showed *Hypertrophic endometritis* (glandular form). There was a clinical history in this case sufficiently suggestive of a "missed abortion" to warrant careful investigation. After curetting the enlarged uterus and submitting specimen to the Clinical Research Association, he received the following report:—"The uterine curettings consist of hypertrophic endometritis, and there is no placental tissue present in portions examined."

The next case was one of columnar-celled *Carcinoma*. The specimen was obtained from a widow, aged 50, who complained of a "drain," and strongly resented the suggestion that it might be a matter of importance. Examination revealed a nodular and friable cervix, practically conclusive of carcinoma.

A portion removed with the finger nail was submitted to the Clinical Research Association, which sent the following report:—"The tissue from the cervix uteri is infiltrated with a columnar-celled carcinoma—much of the growth is necrotic."

"I am greatly indebted to Mr. L. Sexton, L.D.S., Hon. Dental Surgeon to our hospital, a keen and able microscopist, for the lantern slides (with two exceptions) exhibited during the evening."

Dr. MADDEN said if a simple hypertrophic condition of the uterus with catarrh in old women was liable to turn into malignancy, was it not desirable, when it had begun to change, to remove the whole of the affected organ? It was surely beyond dispute that to remove simply the diseased portion of any organ affected with malignant disease was merely a temporary remedy, and that the disease was bound to return so long as the organ in which the disease had started remained in the body. It would certainly lead one to be more ready to propose operative interference in the milder cases which had not begun to show a malignant tendency, to know that there was a tendency to take on the malignant change. He thought that both Mr. Johnstone's slides and his report would lead rather to a pious suspicion than to any certainty as to the presence of malignity. He should like to hear from Dr. Cash Reed whether his case was not one rather of continued activity of the uterus than of renewed activity; and whether he could really say that there was malignancy present rather than a mere suspicion of it.

Dr. HUGHES asked how long they must wait for the development of malignancy in cases in which the uterus has taken on morbid activity after the climacteric. How long were they to wait before they regarded as an evil omen any recurrence of the monthly loss? He observed that most cases developed malignant disease not long after. He now had a patient, aged 85, who had a recurrence about twenty years ago, and he was very anxious at the time lest it should have a fatal meaning for her. He gave her some *vinca minor*, which his friend Dr. Henry Madden used to swear by in such cases; and the flow soon ceased. He had had to attend the lady lately for *tic douloureux*, but she had had no uterine trouble since.

The PRESIDENT (Dr. Edwin A. Neatby), said that the first point in the paper which he would mention was that some of the patients had many other lesions beside the local one, and that Dr. Cash Reed's general treatment combined with the local treatment had been exceptionally successful. He thought that they ought all to take courage in their homœopathic treatment, because cases like those in question had often baffled their best efforts. When they heard of definite results from homœopathic treatment combined with careful local measures, they should take fresh heart of grace. He would like, in passing, to confirm what had been said about the danger of the recrudescence of activity in a senile uterus. He thought that they all recognised this danger sufficiently nowadays. There was no doubt that it was a totally different thing when they got suspicious cases, even evidenced by the microscope, when this occurred before the menopause. He thought that they were all learning to look with some suspicion on the microscope. It was extremely useful, and they could not possibly do without it, but they did not know enough about it and enough about pathological conditions to draw absolutely certain inferences from it. There were two or three cases in his mind in which competent observers had reported that there was commencing malignant disease of the endometrium, and he had, on the strength of that, recommended prompt removal of the uterus. Naturally, patients liked to have a say in the question themselves, and in more instances than one they had declined the suggestion that he had made, and had "lived happy ever after." He had therefore come to the conclusion that they must be very careful in arriving at a certain conclusion of that kind, and he thought that they could say that a little thorough curettage of the uterus was a very definite help in cases like this. No doubt if the process was to go on

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unchecked, and the cells were to spread and infiltrate the tissues, recrudescence would occur, and malignant disease would develop; but he believed very strongly in the good results of a very thorough curettage combined with anti-carcinomatous remedies, if he might use the expression.

Dr. CASH REED, in replying, said that Dr. Madden had asked why, after a strong suspicion of malignancy, the whole organ was not removed. He could not say what would be the best practice in other cases, but, in the case which he had mentioned, he was perfectly certain that the patient would not have stood the operation, from the fact that she was exceedingly ill otherwise. She had chronic basic stasis together with chronic bronchitis and other ailments to which he had referred. With reference to the question whether, under similar circumstances, given a healthy individual, it would be wise to amputate the uterus of a woman aged 70, he could only say that he endeavoured to ascertain whether there was anything definite and tangible by giving the patient an anæsthetic, and by a very careful exploration of the pelvis he could find no lump of any kind whatever, but simply the heavy large soft uterus which he had referred to; so that, even if the patient had been strong, he should not have felt justified in recommending the more radical measure. Whether this case could be looked upon as one in which natural changes had taken place he could not say; *i.e.*, whether there had been a proper arrest and then a recrudescence of the symptoms after the "period" had once ceased, he did not know. He could only say what he judged to be the case when he saw her. He saw the patient about three months ago, which was three months after the operation, and he thought that there might be a very strong malignant tendency in the case. He explored the pelvis again without an anæsthetic and he was quite certain that he felt with the examining finger a hardish irregular nodule which he had never felt before. He had not had the opportunity of seeing the lady since, but the disease appeared to have been in abeyance. He could not say whether it would start into activity, but it would appear to be probable. His point was to try to prove that the two conditions of senile endometritis and malignant disease had a very close affinity, and the one had at least a tendency to run into the other eventually.

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SHORT NOTES ON THREE RECENT CASES  
WHICH CLOSELY RESEMBLED CANCER;  
WITH SPECIAL REFERENCE TO THE QUES-  
TION OF A PRE-CANCEROUS CONDITION.<sup>1</sup>

BY JOHN D. HAYWARD, M.D.LOND.

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THE energy requisite to stimulate the busy practitioner to report a case is less when such case is of recent occurrence than when it has occupied his attention at some distance of time. The recent case, with all its interests of diagnosis, prognosis, and treatment, is fresh in his memory and his note-book; it appears to him as worthy of relation, and looms large in his view; whereas, should he postpone his record thereof for that anticipated convenient season which never arrives, the case, regarded through the distance of time, appears of less comparative importance, as do hills to the traveller as he leaves them behind. Often have I heard a colleague promise, and even seem anxious, to report a case of special interest, where afterwards I have noticed how procrastination has prevented him doing so, until eventually the case or the experience has faded from his memory, or has come to appear unworthy of special note; whereby his brethren were defrauded of their birthright to our common professional clinical experience, and another good intention went to add a tile to the pavement of the road to the home prepared for such defaulters.

The conviction that these reflections apply pertinently to myself has led me to prepare the following short account of three recent cases, although I am aware of the drawback that an early report may prove a premature one, in so far as it lacks the test as to result which often only a long period of time can apply. However, to borrow a simile from my gynæcological colleague, better a premature birth of a living, if weakly, foetus, than a prolonged incubation

<sup>1</sup> Presented to the Liverpool Branch, March 10, 1898.

of what may degenerate into a mummy or prove to be only wind.

These three cases have little in common except that each closely resembled carcinoma, was operated upon as such, and then appeared not to be so. I believe each was urgently in need of operation, and was probably in the pre-cancerous condition, if such there be. We used to be taught that growths were benign or malignant from their origin, that a tumour once innocent remained so. I believe that now the view is—that benign growths may, and frequently do, take on malignant change. In such a degradation there must be a period when the process is, so to speak, prepared for or in its earliest transition. This *pre-cancerous* condition is, where possible, to be elected or anticipated for operative measures, and so its recognition becomes of importance. This change of type, as a result of local or constitutional irritation, of functional disuse or over-use, or of retrograde tissue-metamorphosis, can be but rarely observed until it has actually taken place, but its probability is deserving of careful recognition, both from a surgical and therapeutic point of view.

I will give as brief an account of my three cases as will suffice to illustrate the remarks I wish to make upon their diagnosis, and upon the question of cancer in general.

CASE I.—On June 11, 1895, I performed left inguinal colotomy upon Mrs. B., aged 36. The patient had been examined by various medical men, who had diagnosed extensive carcinoma of the rectum and had told her that her disease was incurable, but that a palliative operation might become necessary. Her condition dated from a marital kick inflicted nearly eight years previously, since when she had never felt right locally. She lost flesh and suffered much local pain, with severe constipation; the suffering and discomfort increased until her life was a misery. At her urgent request she was admitted into hospital, for observation and local treatment. Her condition then was that of a very thin cachectic woman, with a careworn and suffering appearance. The rectum and vagina formed one cavity, as far as the finger could reach, and through this cloaca fluid fæces drained. The anal and vaginal orifices were intact; but the fæces and discharge came almost entirely through the vagina. Discharge was copious

and offensive, while hæmorrhages were frequent. The walls of the cloacal cavity consisted of indurated, cauliflower, ulcerating tissue. To avoid detailed description, it may be said that the new growth, which formed the middle portion of the rectum and the posterior wall of the vagina, was apparently indubitably cancerous. There was no history of syphilis; but anti-syphilitic treatment, with local antiseptic applications, was given a prolonged trial with little benefit. The emaciation and debility were so extreme that, even for the relief of the local pain and misery, an operation seemed unadvisable and she was discharged. In a few days she was brought back, begging for something to be done. She had heard the question of colotomy discussed during her previous stay in hospital, and was willing to run any risk even for temporary relief. The operation was performed, though it bore the suspicion of euthanasia. However, she made a quick and uneventful recovery, and is now a fairly well-nourished and healthy woman. Ever since leaving hospital she has earned her own livelihood by fairly arduous duties. The chief interest lies in the history of the local condition. All the fæces pass by the inguinal opening, with but little inconvenience or unpleasantness. There is a little pouching of the scar and some tendency to prolapse of the bowel mucous membrane; the former is controlled by a belt, and the latter by a lignum-vitæ plug shaped like the distal half of a Hegar's dilator, with a collar turned on it; this fits into the opening and is kept in place by the belt. They are removed at certain times, and an india-rubber bag substituted to receive the motions. The process is therefore under control. In the locality of the original disease there is now no pain and but little discomfort; after the operation the local irritation rapidly diminished, though for a few months there was discharge and occasionally a little fæces. The gristly, knobby new growth persisted for some time; indeed, eighteen months after operation, at a consultation on the case, the diagnosis of cancer was confirmed, despite the general and local improvement. However, when recently examined, two years and eight months after operation, the local condition was found much improved. There is still, of course, the cloacal cavity and its walls are thick, hard and irregular; but there is much less of the cauliflower excrescences, while there is no pain, bleeding or discharge. The woman menstruates regularly, and what little "whites" she has exhibits no fæcal odour. Ever since the operation the patient has taken arsenic for months at a time; occasionally interrupting the drug for the purpose of rest, or for the treatment of bronchial catarrh, to which she is liable.

Time has, no doubt, disproved the malignant diagnosis, and the induration and ulceration may have been simple or lupoid, due to trauma and continued irritation. It is further possible that the pathological condition was syphilitic, or that the apparent improvement may still eventuate in cancerous extension. These alternatives are perhaps more probable than that an early cancerous condition was cured by the removal of irritation and by the specific effect of arsenic. Whatever the pathology, the result has justified the operation, and, despite her inguinal anus, the patient is exuberantly grateful, as evidenced by frequent offerings of flowers, handkerchiefs, braces, and such "small deer."

CASE II.—Early in October, 1895, Mrs. B. was sent to me with a tumour, the size of a goose's egg, in the breast. The growth was very hard and somewhat tender; it was not very adherent to the skin or to the pectoral fascia; the axillary glands were not distinctly enlarged, although the nipple was markedly retracted. The patient was a stout lady with large breasts; she was just over the menopause, and not quite 50 years of age. Early in the year she had fallen down and injured the breast, which was painful for a while, but apparently quite recovered from the injury. Some three months later the patient noticed a small lump in the breast, which gradually increased until the time when she showed it to Dr. Gordon who diagnosed scirrhus, with which opinion I quite agreed. She desired operation, and this we performed on October 30. The whole breast and the skin over the growth were removed. The tumour was very hard and on section had the naked eye appearance of a scirrhus to a marked degree. It spread up to and involved the base of the nipple, and we should have considered it an undoubted carcinoma, but for the fact that a second and casual incision opened a small abscess not far from the centre of the growth, and containing about a drachm of thick greenish pus. The growth, therefore, was as likely to be one of fibrous change around a traumatic abscess as one of a scirrhus in which a purulent deposit had occurred. We gave her the benefit of the doubt and did not interfere with the axilla. She made a good recovery and over two years later was in good health. The scar was soft, and there was no trace of return either locally or in the axilla. The retraction of the nipple was probably due to the same cause as produces that symptom in cancer, the implication and contraction of new tissue acting on the galactiferous tubules. On microscopic examination, I believed myself to find

evidences of carcinomatous change, and regret now that I omitted to have my observations checked by a more experienced microscopist.

CASE III.—On August 10, 1897, C. P., spinster, aged 33, came to ask me to remove a mammary tumour. The patient was a slight woman of good general health; she had a hard growth, the size of a duck's egg, in the right mamma. This was painless, it was not adherent to the skin and there was no retraction of the nipple. The growth appeared to be somewhat attached to the muscle beneath, and there were markedly enlarged glands in the axilla. In the left breast there was a distinct hardness, almost enough to call a tumour, and in this axilla also the glands were distinctly enlarged; that there was anything suspicious on this side was unknown to the patient or her medical man. The woman was of wiry frame, accustomed to athletics and an outdoor life; there was no history of any injury or of any case of cancerous or other tumour in the family.

No hint of cancer had been given to the patient or her relations, and as she had set her mind on operation this was performed. Against a diagnosis of cancer were her age, the lump in the other breast, the absence of pain, the freedom from skin implication or retraction of the nipple, and the history; on the other hand, the enlarged glands were unfortunate. It was felt that if cancer was present the operation would not be effectual, on account of the implication of the other breast and the extensive infiltration of the glands. Therefore only the tumour itself was removed and chiefly for diagnostic purposes. It was found to be intimately adherent to the pectoral fascia and a tedious dissection of this membrane was necessary. On cutting into the removed growth the classical section of a scirrhous appeared, mottled, hard, gritty and distinctly cupped. The members of the staff present agreed in a diagnosis of cancer and that, considering the extensive nature and rapid growth of the tumours and the widespread glandular infection, further interference was uncalled for.

Rapid recovery from the operation resulted; the wound healed by first intention, and the patient left hospital in ten days.

I forbore to hint my suspicions as to malignancy to the patient, but wrote to her doctor in the Isle of Man. In the course of his reply he said:—"About a month before my patient, C. P., consulted you, she came to my house and told me that

when she was taking her morning bath she observed that her right breast was larger than the left one. She had never suffered any pain and did not know there was anything the matter with it. I was astonished to find the entire breast very hard, regular in outline, nipple not retracted, skin not infiltrated. I could not detect any gland in the axilla. Not wishing to alarm her I asked her to let me see it again in a month. When she came again the breast was markedly increased in size, and there was an enlarged gland in the axilla. I then told her I thought it would be better to have the breast excised. I am sorry to hear your report of the condition of the left breast and axillary glands and fear that the new growths will eventually prove to be of a cancerous nature."

I had the tumour as removed examined at the Pathological Laboratory of University College, Liverpool, and received the following report:—"The growth consists of fibrous tissue, some very young, but most of it has undergone a curious hyaline change. No epithelial elements present."

The patient was prescribed arsenic, to be taken daily, and left for the Isle of Man.

In less than two months she returned to Liverpool, on her doctor's advice, for further operation. She had been made aware of the growth in the left breast and was anxious for its removal. Except for the pale soft scar the right breast was normal and the enlarged glands in the right axilla had disappeared. The growth in the left breast had somewhat increased, as had the indurated glands in that axilla. On November 1 an operation was performed. The growth in the left mamma was found so adherent, and it permeated the breast tissue to such an extent, that the whole organ required removal, the nipple only being left for cosmetic reasons. The axilla was not interfered with. The patient made a good recovery, though not speedy, as on the previous occasion, owing to the occurrence of some stitch abscesses. She left hospital in two days over the fortnight.

This growth was also submitted to the pathologist of our local bacteriological laboratory and his report was:—"No signs of carcinoma, cell irritation round the glands."

Despite the microscopical reports, I did not feel secure in the prognosis, and therefore was more sorry than surprised to find at the end of December that there was a distinct recurrence in the right mamma. At her own desire and her medical man's advice, a third operation was performed in January last. On this occasion a free removal of the growth was made, some of

the pectoral muscle and fascia being dissected away. No enlarged glands could be noticed in either axilla. The patient recovered well. The tumour was forwarded to the University and the prompt diagnosis "scirrhus" was returned. The pathologist, on being written to on the subject, referred to the notes of the previous examinations and remarked that the curious hyaline change noticed in the early fibrous tissue and the evidence of cellular irritation round the glands were suggestive of malignant tendency, and he added to his note the sentence: "this shows the importance of backing up pathological by clinical evidence."

In this case the pathological verdict led me to give an opinion to the patient and her relatives which was the opposite of that which the clinical history and physical characters would have suggested. I regret to add that even in the short period which has since elapsed there is evidence of return.

These three cases illustrate in themselves little beyond difficulties in diagnosis; but may serve as an introduction to a few desultory reflections.

Without discussing the questions of the constitutional or the germ theories of malignant disease, or denying that the local disease readily infects and modifies the system, thereby appearing in distant parts and recurring after removal, I may express the opinion that cancer is primarily a local disease in most instances.

Cancer cells are lowly organised tissue of embryonic epithelial type, in an environment suitable to their abnormal multiplication. These cells do not, as does the normal embryonic tissue, organise or proceed to higher forms of growth; but devote their energy to propagation.

Epithelial cells stimulated by friction, over-use, injury, or other irritation—the basement membrane which separates them from the deeper tissues of the skin, mucous membrane or gland on which they are planted being also injured or destroyed—increase and multiply at the expense of the neighbouring tissues. In addition such tissues, and the system generally, may have their normal resisting powers to such invasion impaired by heredity, by increasing age, by unhealthy living, or by constitutional disease or debility. Such cells, which normally would only reproduce sufficiently

for the protection of the skin or mucous membrane, or for the function of the gland or other organ, now take on a virulent and destructive action; like a parasite which has entered a succulent and accommodating host, or a weed which would grow slowly and humbly in the arduous surroundings of the wayside, but will flourish and reproduce apace when the limiting membrane [for example the garden wall] is circumvented and it invades the rich soil of the plantation.

It is to the early days of this proceeding that the term pre-cancerous may apply.

It follows from such views that I am an advocate for the early and free operative removal of malignant growths, and that I am sanguine of the frequent success of such proceedings. I can recall a good percentage of cases in my own experience in which such treatment has led to complete cure, in so far as from five to twenty years' immunity can prove such. I have no faith in any medical or local treatment yet known, other than the prompt, thorough, and even liberal removal of the focus, its lymphatic glands and related tissue, as being able to stop a definite cancerous growth. The profession is looking and hoping for such alternative means; it has had delusive hopes in Chian turpentine, and many another agent, but the time is not yet. It is to be anticipated that our system of therapeutics may provide us with agents which, during the pre-cancerous stage to which I have referred, may retard or prevent the downward process; or, after removal of the established malignant focus, may delay or forbid return. Arsenic internally and locally has, up to the present, the best evidences of success; and, as was to be expected, the drug which is likely to cure is able also to cause; as is demonstrated not only in our own literature, but by the researches of Mr. Jonathan Hutchinson. Occasional cases of recovery from cancer without operation are doubtless genuine, and may be accomplished by unaided Nature or follow the interference of the doctor or the quack. Many of these are no doubt merely apparent and due to simulation, as in two of my recorded cases. But I am prepared to believe that



in some, which have been attacked in the early or transition period, the local caustic or irritant, or even the internal drug, may have inclined the wavering balance and enabled the surrounding healthy tissues to conquer the invader. Genuine cures, however, are too rare and too uncertain as yet for any confident adoption or selection. Possibly, in further bacteriological research or in the discovery of some potent nosode, may the desired agent be found.

It is a little unfortunate that this pre-cancerous stage of epithelial cell irritation, this period of histological retrograde change in the epithelial cells which leads them to propagate and degenerate, to form tumours or depart as ulcers, instead of growing up, organising, functioning and indulging in rational reproduction, should not only be the desirable period for surgical operation, but also the most hopeful for experiments in other local and in medical treatment. It is in this stage that local injections of arsenic, methyl blue, alcohol, &c., are worthy of trial; and arsenic, hydrastis, conium, chelidonium, thuja, and other drugs hopefully administered. Internal medication also gives promise of preventing or delaying return after removal. We need agents which will catch the cells in their young days of early pathological vice, before they have become confirmed tissue criminals; and which will then, by force or persuasion, guide them back into the paths of physiological rectitude.

The theory of a pre-cancerous stage emphasizes the importance of avoiding or removing sources of continuous or repeated irritation, especially in places liable to cancer and after middle age. The breast should be protected from injury or abuse of function, irritated or cracked nipples attended to, cervicitis cured, an irritating tooth, pile or fissure removed, pipe irritation stopped, and so on. By so doing we may anticipate actual carcinomatous development, and assisted Nature may be able to restore the pre-cancerous condition to one of safety.

With regard to the three cases it seems probable that only the third was actually cancerous. In that particular case it would seem as if the physical appearances had been

of more importance than the microscopical; the former suggesting and the latter negating a cancerous diagnosis.

Though unfortunately the third case proved to be malignant it really appeared the least likely to be so of the three. No doubt many cases which, like my first two, closely resemble carcinoma in physical characters, are on the borderland which separates indurated, irritated, epithelial structure from the actual, proliferating, malignant, epithelial tissue which we call cancer.

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Dr. CHAS. HAYWARD said that, in the first case, if the result of injury he should expect there would be more damage externally than internally. The last case quoted was distinctly cancerous from the first. If cancer appeared in both breasts it was useless to operate, as it showed that the patient was thoroughly cancerous. With regard to treatment, if the disease was purely local medicines were useless, and removal all that was necessary. But he thought medical treatment had some effect in staying the course of the disease. It was quite possible that there was a pre-cancerous stage. He had seen accounts of arsenic used locally and internally with good results. He asked the author of the paper whether there were any statistics to show the prevalence of cancer in the arsenic-eaters of Styria.

The SECRETARY (Dr. B. Thomas) pointed out the necessity of complete removal of the growth, even going beyond the affected area. In cancer of the breast it was necessary to clear out the axilla, for cancer cells had been found microscopically in the fat where no enlarged glands could be felt.

Dr. MOORE remarked that he was interested more with the medical than surgical treatment. He mentioned the case of a woman with what was pronounced by two doctors to be undoubted cancer in the breast. It was supposed to have originated from the kick of a cow. The nipple was ulcerated and the axillary glands enlarged. He gave arsenic and hydrastis alternately, and in eighteen months the breast had become soft and the glands disappeared, and she continued well for three-and-a-half years. No one could deny that there was difficulty in diagnosis and also in prognosis, as an apparently innocent growth might become malignant. He believed in the possible curability of cancer by medicines.

Dr. NIVEN thought medicines were useless. He mentioned the case of a child, 3 months old, with oily motions—a condition

pathognomic of cancer of the pancreas—he gave arsenic, but the child died. He also mentioned the case of a woman with a growth in the tongue, which he thought might be specific, and he gave large doses of iodide of potassium without any result, and now he looked upon the disease as cancerous. He had seen an old lady with diabetes, which was found eventually to be due to cancer of the pancreas.

Dr. GORDON said, with the exception of those cases due to trauma, he had always thought cancer to be a hereditary disease. This was often difficult to establish from ignorance of patients' descent. He mentioned a case that had been operated upon three times, where the "cinnamon cure" had subsequently been most deleterious, while arsenic had resulted in improvement for a time.

Dr. ELLIS questioned whether the tumours themselves underwent cancerous degeneration, or whether some hereditary tendency led to degeneration of cells in the neighbourhood. He recommended prompt and early removal of any suspicious growth, and they could all recall many cases where this had resulted in non-recurrence.

Dr. HAYWARD hoped to have some further elaboration of the pre-cancerous condition. He would like the President, Dr. Clifton, to be there to give his opinions. He understood the condition to involve a constitutional state, just as the pre-tubercular indicated a certain well-known diathesis. In his (Dr. Hayward's) opinion, both constitution and trauma were necessary. He mentioned a case of scirrhus of the breast, which he removed in his early practice. He then put the patient on kali iod. and conium and there was no return for four years, until the fashion of tight-lacing came in, when pressure caused a return. In any tumour it was impossible to tell whether some of the cells were not already in a degenerate condition, and hence early removal was necessary.

Dr. WATSON advocated a thorough clearing out of the axilla. He mentioned a method of staining the tumour with a solution containing nitrate of silver. The healthy tissue was stained, the cancerous unaltered.

Dr. MOIR mentioned several cases that had occurred in his own practice. Among others two cases of uterine carcinoma; one operated upon, death following a month after; the other inoperable, where the patient had lived somewhat longer. He mentioned a case of cancer of the stomach which had not been diagnosed during life. The symptoms were those of dyspepsia,

but the true condition was discovered *post mortem*. A case of cancer of the gall-bladder where an operation had been performed for gall stones : On opening the abdomen the gall bladder was found to be cancerous and was extirpated. He should at once advise early removal, and would not trust to medicines alone.

Dr. MEEK was in favour of medical treatment as against operation. He thought that homœopathy was specially successful in this disease. He mentioned several cases where he thought the treatment had prolonged life. He said it had been stated that cancer generally occurred in long-lived families ; some irritation occurs and sets cells growing in a wrong direction.

Dr. JOHN HAYWARD, in reply, criticised the last cases mentioned. In reply to Dr. Chas. Hayward, in the first case a hurt inflicted on the perinæum could cause damage to the vaginal wall and rectum ; as the soft parts would be pressed against the bony pelvis, the more external parts would probably escape. A good many cases of so-called recovery from cancer were due to faulty diagnosis. With regard to statistics of the arsenic-eaters of Styria he could not speak, but Jonathan Hutchinson's cases were from people who had arsenic medicinally and were virtually arsenic-eaters.

The proceedings then terminated.

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## THE MOLECULAR PHYSICS OF THE "X" RADIATION.<sup>1</sup>

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PROBABLY to some present it may seem that an apology should be forthcoming, or at the least some explanation, to account for my choice of subject. What possible light can so theoretical and conjectural a matter as this of molecular physics throw upon practical homœopathic therapeutics, the business of this Society ?

<sup>1</sup> Presented to the Section of Surgery and Gynæcology, March 5, 1898.

Nevertheless, I make no apology, and will allow the matter to make its own explanation as we proceed.

I do think, however, that a few words on the general question of the study of the theoretical (and perhaps apparently abstruse and unpractical) fields of natural philosophy in connection with therapeutics, may not be out of place.

Time and lives occupied in such matters are not lost, and the work of the practical therapist is helped more than he supposes, by the labours of such theoretical students.

I go further, and say that the first essential characteristic for the making of an efficient and reliable medical practitioner, is that he should be a "natural philosopher," a "naturalist" in the widest sense.

Do you not think, that if we homœopaths had numbered in our ranks a considerable number of such men, more men with a power of thinking out the deeper and abstruse physical reasons which would account for the facts we see, more Drysdales, in short; we should not have long ago appealed with success to the judgment of the world's men of real science? (You will not, of course, suppose that under this heading I include the main bulk of the medical profession.)

I assert that the subject of molecular physics has very practical bearings upon homœopathy, and I select the "X" rays as the text in illustration of this assertion, both because their molecular physics have been to a great extent made clear by Crookes, Lenard, Roentgen, and a host of others, and the demonstrations to support the theories advanced are exceptionally practicable; and for the lesser reason, that my own favourite recreative study has for years been in this field of thought.

Can we ever truly say that any scientific theory, or any discovery in the realms of natural law, can have no useful application in medical practice for the benefit of mankind? To-day we are applying for that purpose, successfully, a natural law which may be stated thus: That medicinal substances develop their true penetrative and active thera-

peutic powers only when their mass has been changed by some method of diffusion, dilution, or subdivision, into a state of extremely impalpable minuteness, and, short of that stage, the processes whereby medicines obtain access to the animal blood distribution cannot act; osmosis, the passing of dissolved matter through animal membranes, such as drugs must pass through to enter the blood stream, takes place with facility when the molecular subdivision has reached a certain point of minuteness, and not before that point.

And to-day we are actually able to render visible to our sight, and to record by photography, the internal structures of the animal body during life, without any suffering or mutilation being inflicted in the process.

Yes, this is a practical power we possess to-day. Let us go back nearly a century, and hear some of those "unpractical dreamers" of science, whose work the "practical man" of even to-day sometimes passes unregarded, as merely useless to his own work. Ninety years ago, a young man stood in the room at a meeting of the Royal Society, and in the course of a discussion said, "It will be when we can so far subdivide matter that its state is one of molecular separation as much greater than that of a gas, as the gas presents in comparison with the fluid, or the fluid to the solid, that we shall have matter in the 'radiant' form.

"Then," the speaker continued, "we shall see the fuller powers of matter in movement."

That young man, whose name you come to sooner or later in any retrospective investigation in physics, was Michael Faraday, and this was one of his great scientific inspirations, one of his wonderful intuitions, leaping at one bound over years of slow, laborious studies, right into the presence of a great Law of Nature; one of his natural prophecies, destined to be fulfilled and demonstrated only to-day. Michael Faraday spoke, and his words fell on careless ears; it was not until the speaker had passed away that his recorded words arrested another student's attention. William Crookes, who is with us now, full of intellectual vigour, is the "modern dreamer of useless theories," who

has devoted his life to the working out of that great prophecy of Faraday. It was a thought which held the germs of Homœopathy and the Roentgen rays. But where was the man to seize it at the time?

We dare not assert that any such abstruse thought is useless to us; nor can we afford to pass judgment, from the standpoint of "practical workers," against the men whose minds move in the atmosphere of theories.

I have always felt that the fact which most strongly condemns the prevailing methods of therapeutics is, that those who practise them despise so openly every claim advanced to uphold the deeper, intangible, and invisible phenomena of medical science. It is a superficial mind that can believe only those facts which are patent to the least intelligent, facts which *must* be observed, however unobservant the observer (not that, in the case of the medical practitioner, at least, the facts then observed obtain their right *interpretation*, however).

[Mr. Gerard Smith then gave a demonstration of the "Crookes' Phenomena," using his fine 12-inch spark App's induction coil and a series of very beautiful vacuum tubes and bulbs supplied and made by Mr. Cossor, the well-known scientific glass blower; these demonstrations followed the line of Sir William Crookes' splendid experimental proofs of the truth of his theories, and the actual fulfilling of Faraday's prophecy of ninety years ago.]

The line of thought we follow in these demonstrations takes us (to state it quite crudely) "from plenum to vacuum"; of course, with the reservation that we are unable really to produce, or even to imagine, either the absolutely full or the absolutely empty; the terms are merely comparative, for convenience.

The reality of what we term "solids" needing no proof, it is only necessary for a few minutes to impress on the mind the fact that the most "solid" substances we know, such as the heavy metals, consist of really separate and totally separable "molecules," nothing that exists being actually "solid" in the sense of being an absolutely continuous, impenetrable structure; the only *continuity* in,

for example, the kitchen poker, is space: the iron molecules contiguous, not touching each other in space; if the question be asked—Is then nothing continuous? the reply is, the question states the answer. Nothing is continuous, for there is nothing continuous except nothing, *i.e.*, space.

The solid may have its molecules separated by heat or other means, so that they are further apart and occupy more space; the metal gets larger when hot: this may go on until the molecules begin to move so far apart that the metal is fluid, and occupies still more space; the freedom of movement for each molecule in every direction growing still larger (the "mean free path" it is termed scientifically); the fluid may become vapour, and the vapour, gas, as the acting cause increases in extent, and the molecules thus are so far apart from each other that they no longer form an image perceptible to the eye; though often they can in this state penetrate our tissues more actively by far than can the solids, and we can taste and smell them, which we could not do with the solid (unless it gave off its molecules from its surface). And then—what beyond the vast, invisible, newly active, and powerful state of a gas? The substance is still in existence, it acts on the animal economy with greater force. What next?

Faraday revealed what next, a still larger free path between the molecules, still greater and new powers of "radiation," *i.e.*, of movement from a centre outwards, and the development of that "fourth state of matter"—the "radiant," in which the most powerful influences are possessed by any substance upon its surroundings.

And who can presume to say where this process of developing greater activity and newer actions has its end? Already we have found totally unsuspected powers in the free moving air molecules, placed 10,000,000 times further apart than they were in the ordinary crowded state in what is called "an empty bottle"; we hurl these thinly scattered air molecules with inconceivable rapidity and force, by the enormous electro-motive force of 800,000 volts, produced by this induction coil, in successive impulses at a rate of perhaps millions each second (we could not so



move them in the ordinary contiguity of air), and find that it is when the molecules are so few, when matter is so infinitesimally sub-divided, that their free path is enlarged to the greatest extent which we can produce with our vacuum pumps,—it is then that the totally new and more energetic powers are brought into action; then it is that we find “radiant matter” as prophesied by Faraday, and that we see the molecular movement so intensely strong that the substances we term “solids” oppose no difficulty to the passage through them of the molecular stream; and it is then that we find other substances responding by new forms of molecular vibration to the passage of the flying stream of radiant matter—responding each in its specific way as I have shown you by the beautiful pure colours of these various minerals in vacuo, evoked by the intense bombardment of the electrically impelled free moving molecules.

Need I now apologise for my choice of subject, or have I said and shown you enough to suggest at least some lines of thought which are worth the effort of pursuing, as to the importance of molecular physics in explanation of the curative action of greatly subdivided medicinal substances?

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## THE STUDY OF TEMPERAMENT, DIATHESIS AND DYSCRASIA AS AN AID TO TREAT- MENT.<sup>1</sup>

BY BERNARD THOMAS, M.B., C.M.

THE study of constitution has a special interest for those who favour the treatment of disease by the law of similars, for it deals with the individual and his morbid or special tendencies; and takes into account the existence of certain proclivities or peculiarities, made known to us by the appearance, manner and history of the patient. The subject

<sup>1</sup> Presented to the Liverpool Branch, April 14th, 1898.

of this paper is, however, a practically inexhaustible field of enquiry, and it is, therefore, unnecessary to state that I have only attempted to write an introduction, which will, I hope, suggest material for consideration at some future time.

We find little reference in the more recent text-books of medicine to diathesis and temperament, nor do we hear much concerning these conditions in our student days. On the other hand, we are early impressed with the importance of bacilli and their toxins. This must not give rise to a wrong conception of etiology, for not only must the seed be there, but the soil must be capable of receiving it; moreover, the nature of that soil will modify, prevent or hasten its growth. In other words, there must be a proclivity to a special disease on the part of the individual, besides the accident of germ infection. And similarly in those diseases which have another exciting cause than the ubiquitous microbe, there is the same tendency among one or other to resist, to modify, or to succumb. Before proceeding further it is necessary to define some terms which will be employed in this paper. Jonathan Hutchinson, in his lectures on "The Pedigree of Disease," says:—"The term *Temperament* is applicable to the sum of the physical peculiarities of an individual, exclusive of all definite tendencies to disease. Different temperaments are to be assumed to be likely to give some degree of peculiarity to morbid processes when such have been induced by other causes; but they do not themselves involve any special proclivity. When most strongly marked temperament is still consistent with the prolonged enjoyment of perfect health."

The same authority says of *Diathesis*—"It is any bodily condition, however induced, in virtue of which the individual is, through a long period or usually through the whole life, prone to suffer from some peculiar type of disease. Some diatheses are inherited, others are acquired. Of some the effects are permanent or constant, of others they are transitory, or recurrent after long intervals of health."

"To distinguish between temperament and diathesis, we may say that the former is a matter of physiology, and the latter of disease, and that the former term is applicable only



to peculiarities which are a part of the original organisation of the individual, whilst the latter may be acquired as well as inherited."<sup>1</sup>

It is important not to confuse diathesis with dyscrasia, for the latter term implies the "peculiar and immediate effects of disease."<sup>2</sup>

Lastly, cachexia expresses an extreme degree of bodily debility, consequent upon advanced and severe disease.

The condition of the constitution of an individual may be denoted by these four degrees of health and disease. A temperament alone indicates perfect health. A diathesis stands in a somewhat intermediate position; it indicates the tendency, though in many cases what we now call diathesis may at some future time be recognised as "latent disease." A dyscrasia, and in a greater degree a cachexia, are obviously morbid conditions. Arranged in the order of severity we thus have (1) a temperament, (2) a diathesis, (3) a dyscrasia, and (4) lastly, a cachexia.

Various attempts have been made to classify the different constitutions and diatheses. It is usual, it is interesting to note, for theorists to be satisfied with grouping these into three divisions. Professor J. Engel<sup>3</sup> gives three crases or dyscrasiæ, according to the relative amount of fibrin, albumen and serum in the blood: (1) the fibrinous crasis, including all acute inflammatory diseases; (2) the albuminous crasis, including all chronic inflammations, hyperplasias and new growths; (3) the serous crasis, including all dropsies and degenerations. These divisions seem to indicate stages in, and not differences of, morbid processes.

Grauvogl<sup>4</sup> mentions three constitutions (diatheses): (1) the hydrogenoid; (2) the oxygenoid; (3) the carbo-nitrogenous.

Hahnemann regarded psora, sycosis and syphilis as sufficient to explain the existence of all chronic diseases.

<sup>1</sup> "The Pedigree of Disease," by Jonathan Hutchinson, F.R.S., 1884.

<sup>2</sup> *Loc. cit.*

<sup>3</sup> "The Doctrine of Dyscrasia," by Dr. J. Engel, *Brit. Journ. of Hom.*, vols. iv. and v. (1846-1847); an extract from vols. i. of the *Zeitschrift der k. k. Gesellschaft der Aerzte zu Wien*.

<sup>4</sup> "Text-book of Homœopathy," by Dr. v. Grauvogl.

These three dyscrasiæ correspond more especially to sulphur, thuja and mercurius respectively.

This drug correspondence to constitution leads me to remark that those versed in homœopathy would understand the significance of terms such as the following: the *nux temperament*; the *calcareæ carb. diathesis*; the *mercurius dyscrasia* and the *arsenic cachexia*. But this aspect of the subject I will defer for the present.

#### TEMPERAMENT.

The time-honoured division of mankind into four temperaments cannot be passed by unnoticed.

*The sanguine temperament* is characterised by vascular activity. It is shown by a florid complexion; sandy hair, straight and coarse; blue eyes; firm flesh; full, quick circulation and a mind impetuous and excitable. Ailments of the circulatory and respiratory systems and inflammations are said to predominate. Diseases run an acute course and terminate quickly in death or recovery.

*The nervous temperament* is characterised by nervous activity and excitability. The head is large, the hair flaxen and inclined to curl, blue eyes, fair skin, firm flesh, the body inclined to be slender, quick and fine circulation, quick and excitable mind. Nervous diseases predominate, head complications and nervous symptoms are common in other affections.

*The bilious temperament.*—The outline of the body and countenance is angular; the hair, eyes and skin are dark; circulation strong and vigorous, and the mind steady and unexcitable. We may add that the complexion is often sallow or slightly icteric. The individuals with this temperament are disposed to take life seriously, they are even inclined to be pessimistic, while the sanguine are more given to optimism. The bilious temperament denotes a liability to bilious and gastric derangements and complications.

*The lymphatic temperament* is shown by a tendency to fatness and softness of flesh; roundness of outline; pale complexion; light, straight hair; grey eyes; slow, weak circulation; deficient energy and a mind slow and sluggish.

There is a liability to diseases of mucous and serous membranes, to dropsies and cedemas. Diseases run a slow and retarded course and there is little tendency to reaction.

Dr. Hayward, in a paper on cachexia of young children,<sup>1</sup> to which I am in great part indebted for these descriptions, remarks that in infancy the nervo-sanguine temperament is the most prevalent, and that more children of this type die than any other. This may be due to the greater activity of the nervous and vascular system during early growth and development. It is my impression that the majority of adult males conform most nearly to the bilious, and females to the lymphatic or lymphatico-nervous temperaments. It is the exception to meet with an individual who has the qualifications of a single temperament; more usually we have a combination, as nervo-sanguine, lymphatico-bilious, &c.

Jonathan Hutchinson looks upon these temperaments as arbitrary, and of little clinical value. He says, "I cannot but think that what has been called temperament divides itself naturally into these two parts, *race* and *diathesis*."<sup>2</sup> Here we may agree that the complexion, whether light or dark, is a racial distinction, and has little to do with a person's proneness to modify disease. Complexion is determined by the quality or quantity of pigment, and also by the fineness or coarseness of the skin; it does not depend essentially on the degree of vascular or nervous activity. It cannot be denied, however, that some persons have more vascular activity, some more nervous excitability, and that others are sluggish or bilious. The chief fault of the above descriptions of temperaments is that they are a little too detailed and too precise to be easily adapted to any given individual. But it is of practical importance and interest to notice, in selecting the appropriate remedy, the conditions or special drug temperaments which aid us, more especially, perhaps, in chronic cases.

As two types of the nervous temperament, we have

<sup>1</sup> "The Cachexia of Young Children," by Dr. J. W. Hayward, *Brit. Journ. of Hom.*, vol. xvi., 1858 (read before the Liverpool Homœopathic Medico-Chirurgical Society).

<sup>2</sup> "The Pedigree of Disease," by Jonathan Hutchinson, F.R.S., 1884.

*nux vomica* and *ignatia*, the former for men, the latter for women and children. Farrington says of *nux vomica*, "It does not necessarily follow that you must not use *nux* if the constitution is not what I am going to describe; but it does follow that it acts better in the constitution about to be mentioned. *Nux* is best adapted to rather thin, spare people; it does not act so well in the fleshy. Especially is it indicated if the patient is rather irascible and quick to action on his motives. He has a nervous temperament; the face is rather sallow or yellowish. There is a sort of false plethora that gives the patient at times red cheeks on the yellow background. Generally, too, you will find that the patient suffers from any strain on the mind, particularly if this overstrain of the mental powers is intensified or rendered more injurious by sedentary habits." This masterly description conveys, I think, an admixture of the bilious with the nervous temperament.

The following account of *sepia*, from the same author, seems to indicate that it should be useful in lymphatic women of a bilious tendency, and we may add to it that it is recommended, more especially, for the dark complexioned. "Sepia has been found to act well in men, and more often in women, who are puffed or flabby, less frequently emaciated, who have a yellow or dirty yellow-brown, blotched skin; who are inclined to sweat, especially about the armpits, genitals, and back; suffer from hot flushes, headache in the morning and awaken stiff and tired."

As types of the more purely lymphatic we may mention *pulsatilla* and sulphur.

Hahnemann says of *pulsatilla*, "the medical employment of the drug will be more salutary when in the maladies to which this plant corresponds as regards bodily evils, there is at the same time a timorous, fearful state of mind and tendency to inward depression and quiet grief, or, at least, to pensiveness and resignation, especially if in health the patient was kindly and pleasant (or even of a light and changeable disposition). It therefore especially suits the lymphatic constitution, and is consequently but little appropriate to men quick at their course of action and energetic

in their movements, even though they appear kindly disposed."

*Sulphur* "is especially adapted to persons of rather light complexion (although the dark-complexioned may also yield to its influence), who are easily angered. It is one of our mainstays in the treatment of the negro. Whether this is owing to the rapid growth of scrofula in that race or not I cannot say. It is also suited to persons who are subject to skin affections, particularly to those who have a harsh rough skin, which very readily breaks out with eruptions of various descriptions, varying from a simple erythema to a positive eczema. There is apt also to be an offensive odour from the body (perhaps originally due to uncleanness, for the sulphur patient is not fond of water), but this is not removed by washing; hence you must consider it also an abnormality of the skin. The patient is rather of coarse fibre, his hair is harsh and coarse."<sup>1</sup>

Both *ferrum* and *aurum* are recommended for the sanguine temperament and for persons with a florid complexion, but a further delineation is wanted.

Among other drugs, a few of which it is only necessary to briefly describe, we may contrast the temperament of aconite with that of agaricus.

*Aconite* is especially applicable to the plethoric, or those leading sedentary lives, dark hair and eyes and persons of rigid fibre.

*Agaricus* to those with light hair and lax skin and muscles, and in old people with indolent circulation.

*Alumina* for dry, thin withered subjects or old people, and this drug is somewhat similar in this respect to *conium*.

*Causticum* suits those with dark hair and rigid fibre, thus somewhat resembling aconite.

*Graphites* for persons inclined to obesity, particularly females with a disposition to delayed menses and constipation.

*Secale* is a contrast to *sepia*, in that it is more suitable to tall, scrawny women of lax muscular fibre, and to the feeble and cachectic, also to very old and decrepit persons.

<sup>1</sup> Farrington's "Clinical Materia Medica."

*Silica* may be compared for points of resemblance and contrasted for its differences with *calcareo carbonica*.

*Thuja*, which we have seen is recommended in sycotic conditions, is suitable to dark complexioned people with black hair, dry fibre, and not very fat, but of lymphatic tendency and lethargic nature.

These by no means exhaust our list of drug temperaments, but they will serve sufficiently as examples. It is necessary to understand, however, that it is no part of this paper to dispute their validity. They have been found, we may suppose, by provings on persons of these temperaments who have reacted more quickly, or they are the result of clinical observation; but whether the one or the other does not concern us now. That they are a useful addition to our means of finding the simillimum is undeniable. The question is how are we to make use of them? I would answer that we should use them in much the same manner as the antipsorics, either alone for chronic diseases, where indicated, or as intercurrent remedies to supplement the action of more superficially acting drugs. And perhaps we may be right, though this is always debatable ground, to give them in the higher dilutions, 6, 12, 30, 200th, &c., and at long intervals. Thus, supposing we are treating a patient of the *nux-temperament* for subacute rheumatism, we may make use of bryonia, of rhus tox., of any other remedy, but an occasional dose of nux will help on the cure, although one would not think of this drug as a specific for rheumatism. Such a case occurs to my mind at present.

#### DIATHESES.

We have now to consider those special tendencies to disease which are known as diatheses. There is the difficulty already mentioned of distinguishing diathesis from dyscrasia. Thus there is no ground for believing the existence of a syphilitic diathesis. Congenital syphilis is a dyscrasia; for the new-born infant inherits the actual disease and not the tendency to it. A child inherits syphilis in precisely the same way as it inherits small-pox.<sup>1</sup> Again, the *malarial*

<sup>1</sup> "The Pedigree of Disease," by Jonathan Hutchinson, F.R.S., 1884.



*diathesis* is an acquired tendency from a previous attack, and is not to be confounded with malarial cachexia, the constitutional change resulting from ague saturation.

There is a condition known as the *oxalic acid diathesis*, which is probably only a form of dyspepsia. It is more commonly found in men of good positions, who are accustomed to good living and sedentary habits. It is accompanied with the symptoms of atonic dyspepsia, with the presence of oxalates in the urine, and with a peevish, irritable and often melancholic state of mind. For this condition Dr. Begbie recommends non-saccharine diet and nitro-muriatic acid.<sup>1</sup> We can hardly, in view of the definition of diathesis, call this more nor less than a form of dyspepsia, seeing that there is no special tendency to a particular type of disease, except perhaps the possible accident of the formation of an oxalic acid calculus.

Diatheses are not, as a rule, easily recognised, they are more often learned from a study of the family history (hereditary diathesis), from the personal history (acquired diathesis), or from both. At least two well-marked constitutions are exceptions to this, in that they present obvious physical characters. Of the two varieties of struma about to be mentioned, I feel it probable that there is some disease already present which interferes with nutrition and produces a condition of delicacy and debility, which prepares the way for more violent scrofulous or tuberculous manifestations. After a description of these a reference will be made to the tonsillar dyscrasia, which, as you all know, represents the physical changes brought about by mechanical obstruction to respiration in the naso-pharynx and fauces, but which, however, bears some relation to struma, and sometimes precedes it.

*The scrofulous diathesis* has long been recognised by two types:—

(1) The sanguineous or serous is thus described: "There is a general want of muscular development, for although the figure may be sometimes plump and full, the limbs are soft

<sup>1</sup>"Contributions to Practical Medicine," by Dr. James Begbie, M.B., F.R.S.E., &c., Edin., 1862. See *Brit. Journ. Hom.*, vol. xxi., 1863, and others.

and flabby; the skin is fair and thin, showing the blue veins beneath it; the features are very delicate, often a brilliantly rosy colour of the cheeks contrasts strongly and strikingly with the surrounding pallor; the eyes, grey or blue, are large and humid, with sluggish pupils sheltered by long silken lashes; hair fine, blonde, auburn or red; teeth white and often brittle; there is frequently a fulness of the upper lip and *alæ nasi*; the ends of the fingers are commonly broad, with convex nails bent over their extremities. Such persons usually possess much energy and sensibility, with elasticity and buoyancy of spirits; they often possess, too, considerable beauty. In this variety, with the same delicacy, the skin and eyes are sometimes dark."

(2) The phlegmatic or melancholic: "The skin, pale or dark, is thick, muddy, and often harsh; the general aspect, dull and heavy; hair dark and coarse; the mind is often, but not always, slow and sluggish. Children, especially those in whom the diathesis is strongly marked, are often distinguished by the narrow and prominent chest, the tumid and prominent abdomen, and the paste-like complexion. The limbs are wasted, the circulation languid, chilblains are common on the extremities; the mucous membranes particularly, and above all the digestive, are liable to morbid action; the breath is often sour and foetid; the tongue is furred, and the *papillæ* towards the apex red and prominent; the bowels act irregularly, and the evacuations are unusually offensive; the digestion weak, the appetite variable and capricious." (Sir Wm. Savory.)

Of these two the sanguineous or, as it is often distinguished, tuberculous diathesis is more liable to visceral tuberculosis, especially to phthisis. I think it corresponds most nearly to the genius of iodine, but we also find points of resemblance to *aurum*, *pulsatilla*, *calcareæ carb.*, and I think, in some measure, *agaricus*. The phlegmatic or more purely scrofulous diathesis has a greater liability to bone diseases, joint diseases and skin affections. It suggests sulphur, also *mercurius*, *hepar* and *silicea*. I need not mention in both diatheses the utility of hygienic treatment and cod-liver oil.

*The tonsillar dyscrasia* is a condition of childhood, or early puberty, produced by the obstruction to respiration caused by the hypertrophy of the tonsils or by adenoid vegetations; often both conditions exist together. Children, before the age of puberty, are nose-breathers, and hence any nasal obstruction has greater effect on the respiration than in the case of adults. Moreover, these lymphoid structures are normally larger and more active before, and tend to atrophy after, puberty. This constitution is characterised by snoring and buccal respiration; the speech is thick; there is sometimes stammering, and often a greater or less degree of deafness. The mouth is open, the upper lip is short, thick and protruding; the *alæ nasi* drawn in; the face pointed, but flattened laterally. The chest is small and narrow, while the respiratory movements are limited and imperfectly performed. The mind is usually slow, there is a vacant expression, and often a lack of intelligence. Undoubtedly baryta most nearly of any of our drugs corresponds to this condition. There is the hypertrophy of lymphoid tissue, especially the tonsils, the liability to attacks of tonsillitis and also the slowness of mind which is so often associated. With regard to the local removal of the vegetations and tonsils; when the period of puberty is near and immediate interference unnecessary, it is best to wait, to counsel gymnastic exercises which will improve the capacity of the thorax, and to see if the condition itself will not improve and the glands atrophy.

We will now briefly consider a few diathetic conditions which are not so plainly manifest by observation alone. *Gout* is one of the most important. Here hereditary tendency is marked, and in those predisposed the least indiscretion will promote a paroxysm. Although a disease of middle or advanced age, it has been known to occur in early manhood or even before puberty where the hereditary tendency was a strong one. Treatment is principally dietetic, and the avoidance of sedentary habits. As a medicine in the goutily disposed, I should place most reliance on *nux vom.*, and next to that on *lycopodium*.

The *hæmorrhagic diathesis* is rare. Hereditary influence

is important but, oddly enough, although most frequent in males it is transmitted through the female members of a family. Jonathan Hutchinson<sup>1</sup> says it has a distinct affinity to gout, which usually figures in the pedigree. I have fortunately had no experience of the complaint—for I can conceive of no more distressing condition to treat—but would accept phosphorus as the best established remedy.

The *rheumatic diathesis* is ascertained from the history, and where such exist the evidences of former attacks. Here I am speaking of the acute or subacute disease. We know that it is to a certain extent hereditary; we know also that some individuals have one attack after another from seemingly trifling causes; and we also know that there is a relation between acute arthritic rheumatism, myalgia, chorea, endocarditis, pleurisy, &c. I call to mind one little patient who had an attack of acute rheumatism, followed by chorea, and this finally by another attack of acute rheumatism, all within a few months' time. Prophylactic treatment is the obvious avoidance of the direct existing cause. As a drug I would suggest *actea racemosa*.

A *catarrhal diathesis* is often mentioned. It has some similarity in ætiology with the aforementioned. But I think catarrhs are more frequently produced by change of temperature than by damp or a wetting. It is denoted by a tendency to inflammations of the skin, or mucous membrane, of a catarrhal nature, from apparently slight causes. Certainly there are people who are more susceptible in this way. They are often subject to cold hands and feet; the circulation is slow and they have a somewhat lymphatic tendency. The result of exposure may be dermatitis, coryza, diarrhoea, &c. For the diathesis *pulsatilla* seems most indicated; for the actual attack we have our usual remedies such as aconite, bryonia, arsenicum, dulcamara, &c. I think senega should also find a place. Hering says of it that it is useful "for the phlegmatic, also for fat children predisposed to catarrh, or to the sluggish who react from colds indifferently."

<sup>1</sup> "The Pedigree of Disease," by Jonathan Hutchinson, F.R.S., 1884.

## DYSCRASIA.

The diatheses are in many cases so intimately linked with the dyscrasiæ that this paper would be incomplete without some mention of them. It will only be possible to select some examples.

The condition of rickets in its later stages is manifested by obvious bone changes well known to all. The rickety cranium must be distinguished, on the one hand from chronic hydrocephalus, where the head is more spherical and the eyeballs are displaced downwards; and on the other hand from congenital syphilis, where we have the hot-cross-bun-like or natiform skull. I have also found it remarked that the hair on the scalp in rickets is generally thin, and that the skin becomes thick, opaque, and covered with downy hairs. We know further that rickety children are prone to suffer from convulsions, laryngismus stridulus, &c., and also that there is special danger from whooping cough, measles, bronchitis, or broncho-pneumonia. The subsequent effects of rickets are the bone deformities resulting in pigeon breast, kyphosis, genu valgum, varus, &c.

General treatment consisting of a proper dietary and hygiene is essential. Our most efficient constitutional remedies are those containing phosphorus (*i.e.* phosphorus, phosphoric acid, calcarea phos., &c.).

Scorbutus or scurvy is manifested in children by an earthy pallor, emaciation, spongy gums, tenderness and swelling of the legs, referable to hæmorrhage beneath the periosteum, œdema of the feet and separation of the ends of the long bones, indicated by crepitus. In adults we have the petechiæ or purpuric spots, usually situated at the base of a hair; the ecchymosis or actual hæmorrhage, the spongy gums, and the tense brawny swellings which are most frequently found in the popliteal space, at the bends of the elbows, under the angle of the jaw and front of the tibia. The face is sallow and bloated; there is œdema of the feet and the patients are breathless and liable to attacks of syncope. Treatment consists in corrected diet and lime-juice. Of medicines the muriates seem to act best. Farrington recommends chlorine, natrum mur., and ammon.

mur. (the latter has caused an analogous condition). We might also add acid mur. on pathogenetic grounds.

In the dyscrasia of osteo-arthritis we have first the evidences of disease in the joint changes. We notice that the phalanges and metacarpals deviate to the ulnar side, the joint at the base of the index finger is often much swollen; the ulna sometimes projects at the back of the wrist. The hip, which is often alone affected, shows its implication in a characteristic manner, first by pain and stiffness, next by shortening and eversion. The knee and jaw are sometimes involved. When it begins in those more advanced in life one joint only is often affected and undergoes extensive change. In the young adult many joints are involved, but at first less severely. Besides these changes there is also more or less atrophy of the muscles, the interossei, the muscles at the lower end of the femur, and the deltoid being more particularly involved. The constitutional effect is marked by anæmia and debility. There is also noticed in advanced cases a peculiar velvety softness of the skin of the hands.

The disease is incurable. To modify the pains—and we can do little more—I place most reliance on colchicum, arsenicum and rhus.

The cachexia produced by advanced phthisis is unmistakable. In the first place, the emaciation is noticed, and this is often more marked about the body and limbs than in the face. We notice an anæmic condition, with the hectic flush of the cheeks, or, sometimes, cyanosis, which may mask this condition, either in those acute cases where a large area of lung is involved, or in the more chronic, where the right side of the heart is dilated. Further, on inspection of the chest, we notice the alar contour, the flattened infra-clavicular regions, the ribs, which can easily be counted, the protruding scapulæ, and the atrophied deltoids. Besides these, we notice the clubbed finger ends, the red margin of the gums, and the frequent presence of xanthelasma.

The *cancerous cachexia* is marked by emaciation; by a peculiar sallow complexion with a yellowish earthy tint; a careworn, gloomy expression; debility and languor;

anæmia and its accompaniments; and irregular fever. The cachexia is most marked in gastric carcinoma. Arsenic is undoubtedly the drug which most corresponds to this condition.

Among other dyscrasiæ and cachexiæ we may mention the constitutional changes produced by myxœdema (cachexia strumipriva), cretinism, Graves' disease, acromegaly, pernicious anæmia, lymphadenoma, leucocythemia, Addison's disease, and many others, including those caused by the various poisons, as alcohol, lead, and mercury. Most are characterised by a form of anæmia, which varies somewhat according to the particular disease present, so that the countenance is itself, in some measure, an indication of the special morbid disturbance. But too much time would be occupied in a satisfactory consideration of so many conditions.

To sum up, we find first certain temperaments which, apart from the disease with which our patient is suffering, we must take into account in treatment. Next, the diathesis is important both for prophylactic and therapeutic reasons. Lastly, the dyscrasias and cachexias are treated by the specifics, where such exist, for the diseases which have given rise to these conditions. These remedies must be used, whether indicated by the special symptoms or not, on the grounds of the general condition.

Lime-juice for scorbutus; mercury and the iodides for syphilis; cod liver oil for struma, is the treatment advocated impartially, or almost so, by both schools. For ourselves we might add iodine for the tuberculous, sulphur for the scrofulous, phosphorus for the rachitic, the use of baryta for the tonsillar, the muriates for scurvy, and so on.

In conclusion, we have two great classes of remedies, the first corresponds to the direct result of the determining or exciting cause, unmodified by any special diathetic or constitutional tendency. Drugs of this class, although equally useful even in combating grave morbid conditions, are nevertheless superficial or local in their action. The second class corresponds to the constitutional condition, and acts more profoundly and generally on the system. The first is

necessary to the treatment of acute diseases (for example, aconite in inflammatory processes), and may be all that is required. The second is of use in chronic diseases, and also occasionally in the acute, in order to effect a more speedy and permanent cure.

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Dr. GREEN explained the importance of the study of temperaments, and added a caution as to the significance to be attached to clinical symptoms on which most of these drug-temperaments depended, not only on the patient, but also on the part of the observer.

Dr. MOORE mentioned as part of his experience the alternation in heredity of a cancerous and tuberculous diathesis, also the existence of a rheumatico-scorfulous constitution. He also quoted an extract from Kopp, of Hahnemann's time, in support of various diatheses (venoso-hæmorrhoidal, catarrhal, &c.). He corroborated the reader's list of drug temperaments, and also that of kali bichrom, which drug might well be called a polychrest.

Dr. HAWKES emphasised the occurrence of the oxalic acid diathesis, and particularly called attention to the sudden and altogether uncalled-for outbursts of irascibility.

Dr. ELLIS believed that temperament was of much more value as an aid to prognosis than to treatment, chiefly so on account of the nature of the methods, viz., clinical and personal symptoms. He pointed out that in rheumatic families it was common to find children in their teens suffering from throat affections, at 20-35 affections of the fibro-muscular structure, and over 50, liver complaints.

Dr. HAYWARD defended the temperament symptoms as founded on pathogenesis.

Dr. CAPPER expressed his belief in the value and efficacy of drug temperament. He also endorsed the use of nitro-muriatic acid in oxaluria. He agreed with Dr. Ellis's remark about the connection between throat and liver affections.

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ON THE ACTION OF SOME OF THE PRINCIPAL  
HÆMATICS.<sup>1</sup>

BY J. GALLEY BLACKLEY, M.B.LOND.

*Senior Physician to the London Homœopathic Hospital.*

DURING the last decade a great deal has been done to add to our knowledge of the changes wrought in the blood by disease; and hæmatology has during that period taken its place as an integral part of clinical medicine. It is but natural, too, that the enquiring pathologist should wish to know the condition of the blood in drug-provings in the course of pharmacological experiments. As there is already a fair mass of material bearing upon these three points which I venture to think should be of special interest to us in this Society, I propose to bring a few of them before you as my method of opening a discussion upon the subject named at the head of my paper.

## I.—IRON.

As early as 1847 an attempt was made to apply all then known methods of precision in recording the results of provings, and Bernhardt and Löffler, in the *Journal of Experimental Medicine*,<sup>2</sup> give records of provings of iron by six different individuals, in all of which minute analyses of the blood were made both before and after the proving. The results showed:—

- (1) Increase of the watery parts of the blood and corresponding decrease of its solid constituents.
- (2) Diminution of the solid constituents of the serum with very slight variations in its earthy constituents.
- (3) Increase in the earthy parts of the clot.
- (4) Increase of salts soluble in water in the blood ash.
- (5) Darker colour of the blood.
- (6) Deeper colour of the blood corpuscles.

<sup>1</sup> Presented to the Section of Medicine and Pathology, May 5th, 1898.

<sup>2</sup> Quoted at length in "Cyclopædia of Drug Pathogenesis," ii, 564-571.

(7) Slight diminution of fibrine in four cases, still slighter increase in one.

(8) Increase of colourless corpuscles in four cases, diminution in one.

(9) In one case iron in ash unchanged, in another slightly increased and in three actually diminished.

(10) A constant and invariable symptom was general debility, the sensation of weakness, of heaviness and prostration, of disinclination for corporeal or mental activity, fatigue, insufferable drowsiness, all signs of a diminution of strength.

Coagulation time was increased in one case from 5' 54" to 8' 54", in another with a somewhat larger dose it was not visibly affected. In a third, with double dose, slight increase of coagulation time. In a fourth slight decrease. All showed increase of leucocytes (a phenomenon which has been abundantly confirmed during recent years).

As to the general effects of iron when taken by the healthy, Nothnagel and Rossbach, from observations made upon those living in the neighbourhood of iron springs, and who use the chalybeate water as a daily drink, found a wonderful frequency of anæmic conditions, and it is to be hoped that some trouble will be taken by others to test the value of this statement. Cutler and Bradford, painstaking workers, observed no effect when iron was administered to healthy individuals, but Fenoglio records<sup>1</sup> an increase of red cells. Its effect upon the number of white cells is immediate and undoubted. Limbeck gave 0.25 grm. of dialysed oxide of iron to a healthy dog by subcutaneous injection. The number of leucocytes rose in an hour from 14,500 to 23,000. This quite corroborates the results obtained by Bernhardt and Löffler fifty years ago. So much then for the pathogenetic effects of iron upon the healthy subject. With regard to its helpfulness in the treatment of anæmic conditions, the accumulated experience of many generations of medical men is so overwhelming as to be no longer capable of being called in question. With regard to the preparations

<sup>1</sup> Probably from small doses.

of iron suitable for the purpose their name is legion and fresh ones are constantly being introduced. In this country at the present moment Blaud's pill and the saccharated carbonate of iron may be said to hold first place. Romberg, in Germany, has recently published a long series of cases of chlorosis treated, some with ferr. carb. sacch., and others with an organic preparation of iron called "carniferrin" and the remainder with "ferratin." The proportion of cures with the two first mentioned is about the same, viz:—64 per cent.; and the average increase of hæmoglobin in each ten days is within a fraction of 10 per cent.

For myself, whilst deprecating fashion in therapeutics, or too slavish an adhesion to a single remedy in the treatment of chlorosis, or indeed, of any disease, I have, after trying most of the remedies brought out during the last quarter of a century, certainly had most success with the protoxalate, a remedy first introduced by Prof. Hayem, and much in favour in the Paris hospitals at the present day. Some of my results you will find given *in extenso* in the pages of the *Monthly Homœopathic Review* for July last, and in those of the "Hospital Reports" for last year. In one case under doses of gr. ii. *ter in die* the hæmoglobin rose in seven weeks from 32 per cent. to 95 per cent., in another case from 40 per cent. to 90 per cent. within five weeks, and in a third from 40 per cent. to 100 per cent. within the space of twenty days.

Limbeck gives a case treated with ferr. protoxal. for a space of twenty days, with results as follows:—From 35 per cent., at which the proportion of hæmoglobin stood before the treatment was begun, it rose in five days to 45 per cent., in eleven days to 50 per cent., and in seventeen days to 65 per cent. His results with Blaud's pill are, apparently, equally good, for in a case of pure chlorosis, where the hæmoglobin percentage was down at 22 before treatment was commenced, it rose in twelve days to 38 per cent., and continued to rise steadily, until, at the end of the ninth week, it stood at 82 per cent.

The action of iron in retarding coagulation, in increasing the proportion of leucocytes, and in favouring an obviously

anæmic condition, with its attendant symptoms of weakness, heaviness, drowsiness, and hebetude, would lead one to select iron as the remedy in hæmophilia, and clinical tests show the correctness of this decision. Here I have had the best results with the acetate and the muriate of iron.

## II.—ARSENIC.

The influence of arsenic, in the shape of "Fowler's solution," upon the blood of the healthy human subject, has been investigated by Cutler and Bradford, and also by Stierlin and Delpuch, and all four are agreed as to the effect being chiefly seen in a lowering of the number of red corpuscles. In commenting upon these observations, Limbeck makes the following pathetic remark:—"These remarkable effects upon physiological conditions stand quite opposed to the mass of information we possess as to the influence of arsenic in certain anæmias, especially the pernicious form, and also in leucæmia." Unfortunately, none of the above-mentioned observers give us any information concerning the effects of arsenic upon the *shapes* of the corpuscles, or as to the presence or absence of nucleated red cells, but it is to be hoped that these gaps will soon be filled in.

As a therapeutic agent in the treatment of anæmia, arsenic has undoubtedly great power, especially in the pernicious form; indeed, judging by the cases recorded in the medical press, both homœopathic and allopathic, one might say it is the only remedy upon which reliance may be placed, though, unhappily, success is the exception and not the rule; relapses are all too frequent, and a captious critic might well ask how much of the improvement was due to the drug, and how much to the well-known remittent character of the disease itself. A good case of pernicious anæmia, treated mainly with arsenic, and which was under observation for eighteen months by Dr. Moir and myself, you will find in the *Monthly Homœopathic Review* for September last. In this case the corpuscles gradually rose from 1,200,000 to 4,000,000, and the hæmoglobin from 40 per cent. to 75 per cent.

## III.—LEAD.

The anæmia of saturnine poisoning is a striking feature of its symptomatology, and I have elsewhere suggested that there should be something of a future for lead in the treatment of pernicious anæmia. Malassez and Limbeck in examining the blood of saturnine patients have found the number of red corpuscles very much below the normal, the figures ranging from 3·7 down to 2·2 millions. Malassez also noticed in his cases the appearance of megalocytes. Hayem regards the change as being rather chlorotic in character, but in noticing the diminution in number of red cells records their irregularity, both of size and shape, and observed that some were partially decolorised. I have been able to verify this quite recently in a case of lead poisoning (colic and drop-wrist, with well-marked blue line on the gums): although the number of red corpuscles and hæmoglobin percentage were little out of the ordinary, the poikilocytosis and variations in size were pronounced and a few megalocytes were present.

Quite as striking from the hæmatologist's point of view "are the profound changes in the gastric glands of an atrophic character, described by Kussmaul and Meyer in the cases of chronic saturnism examined by them, a condition probably directly responsible for the anæmia, as Henry, Osler, and Kinnikut have all directed attention to the common co-existence of grave anæmia; with profound changes in the gastric mucous membrane. In the somewhat rare disease known as *psilosis linguæ*, or 'Indian sprue,' the essential lesion of which is an atrophic condition of the mucous membrane of the alimentary tract, the blood condition is such that but for the history of the case one might easily mistake it for one of pernicious anæmia."

## IV.—PHOSPHORUS.

The effects of phosphorus upon the red blood corpuscle are so well known that I will not detain you by describing them in detail. I will, however, venture to suggest that the

irregular forms and evidences of fragmentation of corpuscles betoken the effects of a hæmolytic rather than of a dynamic stimulant or depressor of the hæmatopoietic organs. Over and above changes in shape there is evidence that in cases of acute phosphorus-poisoning the number of red cells is much in excess of the normal, rising as high as 8·65 millions in one recorded case. Taussig was the first to describe this condition, and it has since been abundantly confirmed by Von Jaksch and Limbeck. The number of leucocytes is also usually high. The percentage of hæmoglobin, or rather the corpuscular value, in acute poisonings is apparently low, but in minute doses the opposite is the case, the percentage being raised from 9 per cent. to 17 per cent.

#### V.—MERCURY.

In chronic mercurial poisoning anæmia has long been known as a constant and prominent symptom, and this appears to be equally the case whether the subject has been previously healthy or has been attacked with syphilis. Given in minute doses, for a limited period, to a healthy subject, Keyes found there was a slight increase in the number of red corpuscles; and Buganski found, under similar conditions, that the hæmoglobin was raised both relatively and absolutely. Cervello and Barabini found small doses of mercury raise the percentage of hæmoglobin as much as 17 per cent., as measured by Fleischl's hæmometer.

In syphilitic patients under energetic mercurial treatment there is constantly found a decrease in the number of red corpuscles, with signs of degeneration and breaking up. In spite of all this M. Labadie-Lagrave speaks of mercury (presumably in small doses) as the "true remedy for syphilitic anæmia."

#### HÆMOLYTICS.

Out of a large mass of hæmatological material I have selected one more class upon which I propose to say a few words, that, viz., of the "hæmolytics" *par excellence*:—

It is a large class and contains many apparently dissimilar bodies. With very few exceptions, the chief of which are the alkaline chlorates, they are organic in origin and most contain nitrogen, either feebly united in the shape of nitrites, such as nitro-glycerine and nitrite of amyl, or in the more stable bodies of the ammonia-type, such as aniline and its derivatives, nitro-benzol, tri-methylamin, antifebrin, phenacetin, &c., &c. A few are hydrocarbons, like naphthol, pyrogallol, &c. They resemble each other so far that when absorbed into the circulation they cause the appearance of methæmoglobin in the blood, with more or less cyanosis as a result thereof. Their primary effect upon the blood is evidently destructive, for they cause a breaking up of the red corpuscles, but they also appear to act by diminishing the power of combining with oxygen in the hæmoglobin. As these effects are chemical rather than dynamic in character they are perhaps of doubtful value from a therapist's point of view, but the observations of several modern hæmatologists on cases of poisoning by various drugs of this class go to show that there are dynamic as well as destructive effects produced by most of them. In slow poisoning by chlorate of potash, for instance, there is found to be a gradual diminution of red corpuscles and increase of leucocytes. In a case lasting seven days Brandenburg found the red corpuscles diminish gradually from 4.3 to 1.6 millions per cubic mm.

In another case reported by Jacob, the white cells rose on the first day to 80,000, but fell to 14,000 before death on the sixth day. On the fifth day the red cells were 2,200,000, and the hæmoglobin 20 per cent.

Cases of nitro-benzol poisoning are tolerably frequent of late years owing to its use in the preparation of aniline and its derivatives. Most of these poisonings, being acute, show merely the destructive action upon the blood, but a case of slow intoxication by the same drug recorded by Ehrlich and Lindenthal is much more instructive. Cyanosis from the presence of methæmoglobin in the blood was present throughout. Microscopic examination of the blood during the first two days showed nothing abnormal; on the third

day striking variation in the size and shape of the red cells was found, with occasional nucleated normoblasts and some leucocytosis. During the next few days poikilo-cytosis increased, numerous megaloblasts were found and the number of normoblasts rose,—the total number of nucleated to normal red cells rising as high as 1 to 56; the leucocytes increased until the proportion on the thirteenth day was as 1 to 18. The character of the leucæmia was suggestive of a myelogenous origin. At death the red cells were much below the normal, and the anæmia was pronounced. After death fatty degeneration of heart, liver and kidneys was found.

In a fatal case of phenacetin-poisoning where 5 grammes were taken at a single dose, there was found marked leucocytosis (polymorphonuclear) with great variety in size and shape of red corpuscles. In some the hæmoglobin was broken up into fragments, in others it formed merely a marginal ring, whilst others were emptied completely.

Acetyl phenyl-hydrazine is interesting from the fact that in addition to causing profound alteration in the figured elements of the blood, it diminishes both the density and alkalinity, but augments the coagulability of the blood.

What the exact future of this class of bodies may be as therapeutic agents remains yet to be determined. My only serious experience is limited to the use of toluylen-diamin in a case of paroxysmal hæmoglobinuria. (This case is recorded at length in the "Hospital Reports" for 1892.) After many weeks of steady treatment with above-named drug the patient left the hospital practically *in statu quo*.

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Dr. HUGHES asked how iron acted in anæmia? Were they really giving a remedy which acted as arsenic did, where they were quite sure, from its physiological effects and from the small doses required, that it did act as a homœopathic remedy? Could they have the same confidence in the matter of iron? There were some things in favour of the view that it was; but, on the other hand, there were several which made one lean to the view that it acted, in some way, in the shape of a food. Some few results of minute doses of iron in cases of anæmia had been recorded,



but they had been mere flashes in the pan ; there had been no systematic observation. On the whole, the evidence seemed to be that it must be given in tolerably substantial doses, and again, that it was best given after meals, whereas all truly homœopathic remedies were best given when the stomach was empty. He asked whether phosphorus acted directly upon the blood, or whether it acted through the medium of the liver ? He had not been able to find any recorded case of phosphorus poisoning in which its effects as a blood dissolver, causing hæmorrhage and dissolution of the blood corpuscles, had existed apart from the various phenomena which went to make up its action upon the liver, which induced acute atrophy of that organ with the so-called hæmatic jaundice, and, sometimes, a condition resembling uræmia. Whatever the action was, which was always accompanied with more or less dissolution of the blood, he wished to know whether it was the phosphorus which had that effect, or those tyrosins and leucins which come from the liver owing to the action of phosphorus upon that organ. The remarkable results which were obtained from phosphorus in cases of purpura, and other conditions in which there was a tendency to hæmorrhage, favoured the view that it acted directly upon the corpuscles, and that it was a true hæmatic in that respect.

Dr. NANKIVELL said that at Bournemouth there were many cases of anæmia in maid-servants, and it was very difficult to get rid of it until the patients had been away for a change. He supposed that was due to some peculiar effect of the sea air upon the digestive system. He mentioned two cases of pernicious anæmia, both of which were extremely benefited or cured by arsenic. In one case he had tried phosphorus and iron without the slightest effect, but in using arsenic for a week, the improvement was very marked. In another case, the use of arsenic had, apparently, the effect of increasing the diarrhœa and exhaustion, and irritating the stomach, so that the patient could not take food, and, therefore, he decided to use arsenic subcutaneously. He injected ten drops of a 2x solution subcutaneously every other day, and, after the second dose, the patient showed improvement ; in three weeks' time he was walking about, and then went off to Cannes. When he returned he engaged in a great deal of arduous work in town, and had great strain and worry, and about five months afterwards he broke down and ultimately died, not from the anæmia, but from its results ; a large clot formed in the saphenous vein, and some part of it became detached and passed into the circulation, causing embolism, first in the lung, and,

afterwards, in the brain. In some cases he had found a German preparation, called hæmatogen, of great assistance; it consisted of iron and hæmoglobin.

Dr. MADDEN asked if he correctly understood that Dr. Nankivell had injected ten minims of arsenicum 2x.

Dr. NANKIVELL said he had done so quite safely, and never had any arsenical symptoms whatever produced thereby. There was a little pain, perhaps, but if the spot were rubbed with the fingers, so that the solution was taken up rapidly by the blood, it soon passed away.

Dr. MADDEN wished to ask the author in relation to the action of the coal tar products of an analgesic or antipyretic action which were so largely used, whether the experience of himself and others would tend to show that the continued use, which was so extremely common among many patients nowadays who took on their own responsibility tablets of antipyrin, and so forth, for neuralgia and headaches in doses of from 5 to 15 grains, would produce any deterioration in the blood, or whether that was only when large doses were taken, as they were occasionally by misadventure or experimentally.

Dr. GOLDSBROUGH thought that Dr. Blackley had done great service in calling attention to the use of the protoxalate of iron. Since the cases in the "Hospital Reports" were published he (Dr. Goldsbrough) had used it in the out-patient department on several occasions, with the greatest possible benefit. The protoxalate seemed to act quickly, in the course of a week one saw an alteration in the patient's condition, whereas the effect of Blaud's pill was not seen sometimes for two or three weeks. A few patients could not really take iron in any crude form of the metal or a salt. It produced effects which were in themselves symptoms, and conditions which had to be relieved, such as constipation, and sometimes a too early and too profuse menstruation. In cases of that kind, where there was a distinct indication for iron, he had persevered with the homœopathic preparations of iron over some months with success, generally the 3x or 3c trituration of the ferrum met. In cases of suspected ulcer of the stomach, where the symptoms of anæmia were well marked, and there were severe pains in the epigastrium accompanied with vomiting of all food, he looked upon the acetate of iron as a remedy next in importance to arsenic for the condition. He gave it in 1 or 2 drop doses of the 3x dilution.

Dr. NEILD said there was a very interesting point referred to in the paper as to whether anæmia was common near chalybeate

springs. He came from Tunbridge Wells, where they were constantly drinking slightly chalybeate water. When he went to Tunbridge Wells twelve years ago he was very much struck with the absence of anæmia. At that time it was a comparatively rare thing, but he could not say that that had been the case of late. Anæmia was now common, though not anything like so common as it used to be in Plymouth, where he previously practised. It was found prevalent among servant girls, as he supposed was the case everywhere. Cases of anæmia in Tunbridge Wells were often difficult to treat. They needed iron, and they did well upon iron in spite of the fact that they were always drinking iron water, and this seemed to him a very curious and suggestive thing. He simply mentioned that fact without deducing any theory from it. From his experience he thought that protoxalate of iron was one of the best preparations. He had given it in substantial doses, but he found that 1x did very well.

Mr. LESTOCK REID thought that in the neighbourhood of Hertfordshire there was a disproportionate amount of chlorosis, certainly far more than he had ever seen in London. It was the general opinion of medical men in the neighbourhood that that was so, and the Watford Medical Society decided about a year ago to take up the subject and try to obtain some definite statistics in the matter of its treatment. As he was the only homœopathic doctor there, he wanted to get some comparative homœopathic results by treatment with what ought to be admitted by them as homœopathic doses and drugs. He found that in mild cases of anæmia one could do very well with pulsatilla and sulphur on the ordinary symptomatic indications, but they were quite unsatisfactory with typical cases of bad chlorosis, and he had obtained by far the best results from material doses. He had found Blaud's pills, freshly prepared, in something like 20-grain doses, the most satisfactory of any. At the end of the first week there was a very marked improvement. Mr. Reid mentioned a case which had come before his notice, where a patient had profound anæmia from long-continued use of one of the coal tar products; but he administered plumbum with excellent effects.

Dr. VINCENT GREEN said he attached much importance to the relieving of the constipation usually found in chlorosis. He would suggest that chlorosis was due in most cases to the absorption of toxins generated within the bowel, which were specially inimical to hæmoglobin,—the production of these toxins being favoured by, though not necessarily the result of, constipation; and he thought the action of the iron was to prevent this absorp-

tion by its action on the toxins. Such a theory as this would explain why iron often cured when given continuously in massive doses, when it had failed in small doses, notwithstanding the fact that the total amount in the body was less than five grains. Recently Professor Stockman had shown that if a certain quantity was given by the mouth, the same amount will be found in the excretions. It would need to be thoroughly mixed with the ingesta to accomplish its work, perhaps this is why it acts best when given immediately after meals. Dr. Blackley has had excellent results with protoxalate, and it is interesting to note that this preparation of iron has a decided action on the bowels. In seeking for the cause of chlorosis in any given case, one should remember that there is such a thing as "diarrhœa of constipation."

Dr. PURDOM had found ferrum redactum of use in cases of anæmia, and a combination of phosphorus and iron for more delicate patients. Very often by giving doses of mercurius to counteract the constipation, one got a much more rapid action from the iron.

Dr. DYCE BROWN had found Levico water of very great assistance in the treatment of anæmia. It was an Italian water containing arsenic and iron, but the amount of iron was very small. There were two strengths, the strong and the mild; the mild preparation was almost the colour of pure water, but it had a distinct taste of iron and contained arsenic. Water from the springs at Llandrindod Wells, which was perfectly pure and liquid, and no one could tell it from pure water, was useful; but it required to be drunk at the spring, because if it stood for half an hour in the glass it became of quite a yellow brown colour.

The President (Dr. EDWIN NEATBY) said that they needed to get a more clear relationship on modern lines between the drug and the disease. It had always been his feeling that in the rough and ready use of iron in anæmia, they had administered it as a food, at least it had acted as a food, because there was no doubt that it required material doses to produce results in the large majority of cases. There was a residuum of cases of anæmia in which iron in bulk did no good at all. It might do good, if it happened to fit symptomatologically, if it were given in infinitesimal doses — that was, it acted dynamically, and not as a chemical agent, and not as a food. Other drugs, which were not so well known as hæmatics, acted similarly, such as sulphur, calcarea, and natrum muriaticum. There were two ways in which iron acted, and they ought to distinguish the two. It might act

as a food, or in some analogous way, or it might act as a distinct dynamic drug, in other words, as a homœopathic remedy.

Dr. GALLEY BLACKLEY, in reply, thought they were all pretty well agreed that infinitesimal doses of iron in chlorosis of the ordinary type did no good whatever. With other anæmias it was totally different. He had spoken particularly of iron in chlorosis; with other symptomatic anæmias iron was not the remedy at all, and they must choose one of a score of other drugs. But iron seemed to him to be the remedy which was called for in the majority of cases of chlorosis. He had given manganese occasionally of late, and with very good effect, especially where the chlorosis was complicated with amenorrhœa. The manganese appeared to have a specific action upon the menses with the result that if the menses were re-established the chlorosis was cured. In spite of the massive dose of iron, he was inclined to think it was not a food but was a dynamic drug, but he had not thoroughly made up his mind about it. He could not think that the action of phosphorus, as suggested by Dr. Hughes, was due to the purely destructive action of the substances liberated by the liver. Of course it must not be forgotten that the liver was a very important hæmatopoietic organ, that it was intimately connected with the spleen and the red bone marrow; phosphorus acted either as an inhibitory or as an over-stimulus to the hæmatopoietic action of the liver, and that accounted for the destruction of the red corpuscles. He did not think the action of phosphorus a destructive one in the same manner as after the exhibition of the nitrites, nor was it a purely chemical destruction either. He thought the phosphorus had a dynamic effect upon the liver, the liver was over stimulated and the blood which passed through it was allowed to escape into the circulation, whereas in health it was retained in the liver and not allowed to escape. He was surprised to hear Dr. Nankivell say that  $\frac{1}{10}$  of a grain of arsenic in a watery solution could be given hypodermically without producing any unpleasant results in the way of pain. It was certain that it could not be done on the skin locally. If one applied arsenic to lupus it was extremely painful. Dr. Goldsbrough's reference to the small dose of acetate of iron interested him, because he gave the acetate in certain cases of anæmia, and generally in the 1x or 2x dilution. He did not find it necessary to give large doses. In hæmophilia also he had generally given the third decimal tincture. Protoxalate of iron presented one enormous advantage over nearly all the other iron preparations as a remedy for chlorosis, namely, that it did not produce con-

stipation at all, but relieved it very speedily. Within three or four days of the taking of the protoxalate the constipation was gone. *A propos* of constipation, he could not think there was any reasonable probability of Dr. Green's theory being correct, for the simple reason that there were a good many cases of chlorosis where they had alternations of constipation and diarrhoea, and yet the chlorosis lasted while the diarrhoea was present. They had had quite recently one or two girls in the hospital with typical chlorosis where that was the condition. With regard to Mr. Reid's advocacy of the use of plumbum, he had himself used it in cases of anæmia. He had said nothing in his paper about the organic compounds of iron; but in his hands hæmoglobin and a number of those thoroughly organic compounds had failed entirely; they did not seem to give the effect of iron at all. That was not his experience alone. He had used Levico water very freely and found it very satisfactory. He could not say that he knew the Llandrindod water, but he had known Strathpeffer water used—that was a carbonated iron water slightly effervescent.

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BRITISH HOMŒOPATHIC SOCIETY: LIVERPOOL  
BRANCH.

REPORT OF SESSION 1897-8.

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DURING the Session the usual eight meetings were held, and the following papers presented to the Society:—

*October 14*: Presidential Address—"Clinical Observations and Indications as aids for Drug Selection in Homœopathic Therapeutics"—Dr. Clifton. *November 11*: "A Digest of Ten Years' Work at the Children's Sanatorium," by Dr. Storrar. *December 9*: "Sudden Death and Premature Burial," by Dr. Green. *January 13*: "Vicarious Menstruation," by Dr. Meek. *February 10*: "The Genius of Hahnemann," by Dr. Simpson. *March 10*: "The Pre-Cancerous Condition, with Notes on Recent Cases," by Dr. J. D. Hayward. *April 14*: "The Study of Temperament, Diathesis, and Dyscrasia, as an Aid to Treatment," by Dr. B. Thomas. *May 12*: "Notes on Some Recent Cases," by Dr. Gordon.

The membership now numbers thirty-two, five new members having been elected during the session, viz., Drs. Nankivell, Cox, Moir, Compston, and Watson.

The following is a complete list:—*Fellow*, Dr. Hayward ; *Members*, Dr. Hawkes, Dr. J. D. Hayward, Dr. Jones, Dr. Gordon Smith, Dr. Stuart, Dr. J. E. Williams, Dr. Gordon, Dr. C. W. Hayward, Dr. Capper, Dr. Hale, Dr. E. H. Thomas, Dr. Meek, Dr. Nicholson, Dr. Niven, Dr. Murray Moore, Dr. Hayle, Dr. Douglas Smith, Dr. Blumberg, Dr. Simpson, Dr. Green, Dr. Ellis, Dr. B. Thomas, Dr. Finlay, Dr. Mitchell, Dr. Storrar, Dr. Clifton, Dr. Nankivell, Dr. Cox, Dr. Moir, Dr. Compston, Dr. Watson.

The officers elected for 1898-9 are:—*President*, Dr. John D. Hayward ; *Vice-President*, Dr. Douglas Moir ; *Representative on Council*, Dr. Hawkes ; *Secretary and Treasurer*, Dr. Watson.

The Balance in hand is £1 10s. 9d.

The Society has every reason to congratulate itself on the attendance at the meetings, and the interest sustained in the proceedings.

It is also a source of gratification that the membership has been augmented, and principally so by the admission of *confrères* from the neighbouring city of Manchester.

BERNARD THOMAS, M.B., *Hon. Secretary*.

BALANCE SHEET, 1897-8.							
<i>Dr.</i>				<i>Cr.</i>			
£ s. d.				£ s. d.			
To balance in hand, October, 1897	..	..	2 10 9	Printing .. ..	..	..	0 6 6
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**SOCIETY NEWS.**

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DURING the past quarter the Society has sent its donation of ten pounds towards the restoration of Hahnemann's tomb. At the June meeting of the Society Dr. Hughes reported that he had visited Paris, accompanied by Dr. Süß Hahnemann, on May 25th, and witnessed the exhumation of the remains of Hahnemann and their re-interment in a beautiful and frequented spot of Père La Chaise cemetery. An International Commission propose to erect a suitable monument on this spot, to be unveiled at the International Homœopathic Congress meeting in Paris in 1900.

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At the final meeting of the Session of the Liverpool Branch, held on May 14th, a vote of thanks was accorded to the Secretary, Dr. Bernard Thomas, on his retirement from office. The Society expressed great regret that his departure for Australia deprived it of his services, and wished him success in his future career.

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At the June meeting the President reported the loss to the Society, by death, of Dr. Ker, of Cheltenham, and Mr. Ockenden, of Brighton.

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SUMMARY OF PHARMACODYNAMICS AND  
THERAPEUTICS.

“GATHER UP THE FRAGMENTS, THAT NOTHING BE LOST.”

MARCH—MAY, 1898.

PHARMACODYNAMICS.

**Absinthium.**—Dr. Middleton has seen much benefit from this drug in the insomnia of typhoid, and in nervous excitement with sleeplessness of children. He does not mention his potency.—*Hahn. Monthly*, May, p. 333.

**Acidum nitricum.**—Dr. Mohr gave nitric acid, 3x dil., to a patient suffering much from cancer of the liver. “It stopped his pain in the liver and stomach; it stopped his vomiting; it stopped his constipation, so that he had movements from the bowels every few days quite well formed; and that man died of a cancer cachexia without suffering one hour’s pain after he got that nitric acid.”—*Hom. Recorder*, May, p. 210.

**Ammonium carbonicum.**—Dr. Mifflin, of Baltimore, in an article on uræmia, advocates a curious piece of isopathy. Adopting Frerichs’ theory that retained urea poisons by conversion into carbonate of ammonia, he gives that drug as a remedy when uræmia is present, and thinks he gets good results from its 2x trituration.—*Southern Journ. of Hom.*, May.

**Anacardium.**—Dr. Halbert relates a good case of neurasthenia in a male adult, in which, after strychnia phos., picric acid and other remedies—with electricity—had failed to benefit, anacardium 3 acted curatively. The loss of memory and the “plugged” sensation of the drug were both very marked.—*The Clinique*, April.

**Arnica.**—A woman, suffering from influenza with pneumonia, had been treated for several days homœopathically. When Mau was called in she lay completely apathetic. When asked how she felt she replied, "Nothing ails me." The sputa were strongly tinged with blood, and she tossed restlessly about. Arnica 30 brought speedy relief. She took this for eight days, and sulphur completed the cure.—Mau, *Arch. f. Hom.*, vi., 337.

**Chamomilla.**—In the *Edinburgh Medical Journal* of February Dr. A. C. Dutt, of Hull, writes to commend chamomilla in the summer diarrhœa of children, and in many of the nervous affections incident to dentition, where he says it acts as a specific. He gives drop-doses of the tincture every hour.—*Hom. World*, March, p. 105.

**Cinnabar.**—Dr. Pinart gives a case of balanoposthitis simulating chancre, in which the curative action of cinnabar 3 was very decisive.—*Revista Homeopatica*, March.

**Colchicum.**—Dr. I. R. Simpson had a case of typhoid which showed the peculiar symptom of one pupil being widely dilated, and the other as firmly contracted. Panelli's monograph on typhoid gave this as an indication for colchicum. Further symptoms corresponding with this remedy, it was administered. Delirium and insomnia yielded at once, and recovery set in. [Dr. Simpson writes:—"I fail to find that symptom in any *Materia Medica* or repertory." He will find it at line 75 of the first case of poisoning by colchicum in the "*Cyclopædia of Drug Pathogenesis*."—Ed.]—*Hom. Recorder*, March.

**Cratægus.**—Testimonies are multiplying to the value of this drug in cardiac disease and debility. Dr. Armsbury reports in the *Medical Counselor* of May a case where, from acute rheumatism, there was "a terrific murmur due to both mitral and aortic insufficiency and stenosis" (!) No improvement occurred under ordinary remedies, but five-drop doses of cratægus tincture gave great relief to the subjective symptoms (which were severe), and restored the patient to active life.

Dr. Clements relates his personal experience in the *Homœopathic Recorder* for May. He was attacked with angina pectoris, which was gaining ground on him. Glonoin and cactus did nothing, but cratægus in six-drop or ten-drop doses of the tincture seemed to liberate the heart from permanent distress, and have so far kept off severe attacks.

**Crotalus.**—"Crotalus is undoubtedly a remedy to be remembered in connection with purpura hæmorrhagica. I remember the case of a young lady seen in consultation with Dr. Searle. Crotalus was recommended when the case was despaired of, and the patient recovered promptly. I have knowledge of a case of umbilical hæmorrhage occurring in a family in which two other babies had died from a similar cause. This third case responded to the use of crotalus and recovered."—*Hasbrouck, N. Am. Journ. of Hom.*, April, p. 30 of appendix.

**Curare.**—Dr. Barckhard, of Berlin, reports excellent results from curare, 4th dil., in a number of cases of diabetes mellitus. The discovery of the power of this poison to induce glycosuria, made by Claude Bernard, is well known.—*Journ. Belge d'Homœopathie*, March—April.

**Epiphegus.**—Dr. Von der Luhe considers the headache of this drug to be such as is liable to be brought on by mental strain; and gives cases which seem to show that it can modify the tendency to be so affected.—*N. Am. Journ. of Hom.*, April.

**Eucalyptus.**—We have made as yet little internal use of this drug; but a case communicated by Dr. Deschere seems to show it to be efficacious in some chronic nasal catarrhs. He gave it in fractional doses of the tincture.—*Ibid.*, p. 265.

**Euphrasia.**—Dr. Eadie, of Ithaca, N.Y., has found a new use for euphrasia. He relates two cases in which the necessity for hawking away offensive mucus from the throat was apt to cause vomiting of the breakfast, and in both of which euphrasia, in highly attenuated form, proved curative.—*Hom. Physician*, Feb.

**Fucus Vesiculosus.**—Dr. R. N. Foster writes to communicate a long and unvarying experience with this seaweed as a remedy for goitre. He gives it in teaspoonful doses of a fluid extract, from once to three times a day. [Dr. Foster does not refer to the iodine contained in this substance, and by which its use in other hands has been superseded.—*Ed.*]—*Amer. Homœopathist*, May 2.

**Grindelia.**—"Patient, man nearly 70 years old, subject to asthmatic attacks, in which he would awake suddenly in the night, the room seeming too small for him, and gasp and struggle for breath. In a few minutes he would get a little quieter, and

just as he would commence to lose himself again in sleep would suddenly awaken, frightened and gasping, because he seemed to have forgotten to breathe, and would usually spend the remainder of the night sitting up, in order not to repeat the experience indefinitely. *Grindelia robusta* 30 relieved him at once. He now always keeps a few of the powders on hand, one of which always gives him immediate relief and ensures a good night's rest."—*Ibid.*, March 1.

**Hydrastis.**—The use of this drug in old-school practice is increasing. The *New England Medical Gazette* for March cites the experience of Sanger and Verstraten with it as reducing expectoration to a marvellous degree in phthisis and bronchorrhoea.

**Iodine.**—Drs. Stiker and Vellessen find that when iodide of potassium is given in cases of suspected pulmonary tuberculosis, it will, if the suspicion be well founded, set up a local catarrh in the diseased part, while in non-tubercular cases there will be no reaction.—*Hahn. Monthly*, April.

Huchard has extended the use of iodide of potassium or sodium from aneurism and angina pectoris to arterio-sclerosis in general. Vierordt and Lemoine confirm his recommendation, and describe their results as "striking and even brilliant." Of course, substantial doses are given.—*Ibid.*, May.

Pagenstecher praises the potassium salt in incipient cataract. He uses an ointment of it about the eye, and has no doubt that it can bring the cataractous process to a standstill, and in some cases increase the vision.—*Ibid.*, May.

**Mercurius Cyanatus.**—"Luddecken-Liegnitz, of Germany, reports wonderful cures from the use of teaspoonful doses of a 1 to 10,000 solution of cyanide of mercury in water, in both scarlet fever and diphtheria—thirty-one cases of the former and eighty of the latter, with but a single death from each. Only one case of nephritis, and that in the single patient for whom antitoxin was used."—*Minneapolis Hom. Mag.*, April.

**Mezereum.**—Dr. Hanchett has a valuable paper on mezereum in the *Medical Era* for April, in which he rehabilitates its ancient repute as an anti-syphilitic, finding it to act where mercury is unavailing, and to excel nitric acid in cases where mercury has already been given freely. Comparing with the latter, he says that its bone-pains are on the surface, while those of mercury feel deep-seated; and that while sweats are present in either, those of mezereum relieve, while those of mercury do not. A

characteristic for mezerium is a sensation as if the teeth were too long (*not* loose or tender).

**Mother-of-Pearl.**—"Six cases of a very rare disease—the so-called periostitis of mother-of-pearl workers—have lately come to Berlin for treatment. The symptoms are very painful swelling of the bones of the extremities, accompanied by fever, continuing for weeks and even months, but rarely leading to suppuration. The cause is thought to be the constant breathing of mother-of-pearl dust (consisting of about 95 per cent. carbonate of lime and 5 per cent. concholine, an organic substance) mixed with the water that is used in polishing, turning, &c."—*Monthly Hom. Review*, April.

**Myrrh.**—No use for this ancient medicine has yet been found in homœopathic therapy. Now that it has been ascertained, however, that its use may quadruple the number of white corpuscles in the blood, it ought to find employment in some forms of leucocytosis. The claims recently made for it in the treatment of diphtheria of the "mixed" type may be of this significance. It is pyogenic bacteria whose presence causes the mixture in such cases, and leucocytosis is a well-known symptom of the presence of pus in the system.—*N. Engl. Med. Gazette*, April, p. 174.

**Ornithogalum Umbellatum.**—This plant, a species of garlic, is Dr. Cooper's latest adoption into medicine on "arborivital" principles. He relates two cases of "ulceration of the stomach, apparently malignant," in which marvellous improvement seems to have been wrought by occasional doses of the juice.—*Hom. World*, April.

**Phosphorus.**—Dr. Jousset has been experimenting with this drug in his laboratory. Two rabbits slowly poisoned by it showed lowered temperature, diarrhœa and albuminuria. At the autopsy identical lesions were found in both. The liver was enlarged and fatty; the kidneys much congested, their capsule adherent to the cortical portion, ecchymoses also were present. The lungs presented manifest patches of congestion; on section the tissue of these patches was homogeneous, nevertheless it floated on water. The trachea and the primary bronchi were very red.—*L'Art Médical*, March.

Dr. Howard Crutcher relates a case of collapse after operation for appendicitis, in which phosphorus seems to have saved the life. The indication for it was the open and paretic condition of

the anus, while greyish-white fæcal discharges, watery and offensive, passed constantly.—*Hom. Physician*, Feb.

Dr. Von der Luhe had a case of excessive perspiration of the fingers in a young lady. It was of six to nine months' standing, but phosphorus 30 cured it in two weeks, and there had been no recurrence for years.—*N. Am. Journ. of Hom.*, April.

**Plumbum.**—Dr. Fuller states, from microscopical investigation, that the seat of the nerve-degeneration induced by lead is the white substance of Schwann—the axis cylinder itself being starved secondarily only.—*Hahn. Monthly*, May, p. 62 of appendix.

**Proto-nuclein.**—Dr. Porter S. Kinne relates a case of septic fever in child-bed, and speaks of two others, in which the action of this substance proved very satisfactory.—This is in the *Homœopathic Journal of Obstetrics, &c.*, for March.

**Psorinum.**—In the *Medical Century* for April, Dr. W. O. Young gives a study of this nosode, which is a useful summary of what is known about it. From what he says it would appear that the preparation employed in America is that made by Hering, in the dubious manner described in our last number (p. 172).

**Sabal Serrulata.**—Dr. Hale communicates to the *Homœopathic Recorder* for March a proving of the saw palmetto made since his monograph on the drug appeared. "It has," he writes, "one characteristic symptom, 'fear of going to sleep,' which may prove of value."

**Salol.**—An involuntary proving of this disinfectant (a salicylate of phenyl) may be found in the *Homœopathic World* for March. Headache, and rheumatic pains and stiffness in the joints, were the main symptoms elicited.

**Sanguinaria.**—Mr. Frederick Kopp gives, in the *Homœopathic World* for March, an account of the head symptoms induced in a proving of sanguinaria, in which he took ten drops of the tincture eight or nine times a day for two weeks. [When we read among them, however, "headache of a paroxysmal character, occurring once a week, or even at longer intervals," it seems as if clinical matter has found its way into Mr. Kopp's symptomatology.—ED.]

**Silicea.**—Mrs. H., age 28, blonde, big-boned, rather thin, has suffered since her last confinement (seven weeks ago) from

great anxiety proceeding from the heart, anxiety when she attempts to think of anything, she fears to be alone in the house. Violent headache, which proceeds from the nape and occiput to the crown; the pains are indescribable and attended by vertigo. Eyes weak; when she looks at anything attentively she becomes giddy. Memory rather weak. Any excitement brings on palpitation of heart. Sleep bad owing to confused dreams. Anorexia, constipation, uses purgatives. Has had two confinements in one year. Does not suckle her children. Menses normal since last confinement. Silicea 20 caused steady improvement. A slight recurrence of the anxious feeling was relieved by a few doses of silicea 30.—Dahlke, *Arch. f. Hom.*, vii., 39.

Miss Kunert, age 39, brunette, thin, has suffered for some months from feeling of anxiety in the cardiac region, and headache, which begins in the nape and extends to the forehead. Vertigo on stooping. Sleep bad. Easily startled. Very cross and depressed. Feeling of fullness in the scrobiculus cordis. Constipation. Catamenia regular, scanty. No leucorrhœa. Subject to cold feet. Silicea 20 one dose daily. After three weeks the head and heart troubles gone, sleeps well, is more tranquil. The medicine was continued for six weeks. At the end of this time all the previous ailments were gone, but she often wakes up at night in a fright with palpitation, and she knows not where she is. She got argent. met. 20, which relieved these new symptoms, but the former symptoms returned. Silicea 20 again removed those.—*Ibid.*

**Stramonium.**—In a case of influenza, the patient complained of fearful pain in the middle of the head; therewith he was feverish, restless, talking nonsense, starting when spoken to or touched; and he said that all things and persons looked black. The last-named symptom was considered the key-note, and led to the choice of stramonium, which—in the 30th dil.—speedily removed the nervous phenomena.—*Monthly Hom. Review*, April.

**Sulphur.**—Dr. Sturtevant lives in a neighbourhood where the drinking water is strongly impregnated with sulphur. Hæmorrhoids, rheumatoid stiffness of the legs, eczema, general pruritus, gastric derangements with eruptions on the tongue and within the mouth, and pelvic congestions, are morbid conditions which he has observed as refusing to yield to treatment until the use of such water has been interdicted.—*The Clinique*, May.

**Thea.**—Dr. Kenneth Campbell, of Edinburgh, reports a case of amblyopia in a vigorous man of 46, in which, after other

possible causes had been eliminated in vain, it was found that he drank copiously of strong tea. A suspension of this habit led to a speedy recovery.—*L'Art Médical*, April.

**Thlaspi.**—Dr. Willis J. Chapman, writing on the shepherd's purse, states that a member of the Woman Provers' Association took 5 drops of the tincture three times a day for ten days. This was followed by a great increase of urine and a menstrual flow lasting fifteen days. Another took 10 drops three times a day for five days, when the quantity of urine and brick-dust deposit was so unusual that her interest in scientific investigation suddenly ceased.—*Hom. Recorder*, March, p. 119.

**Thuja.**—The editor of the *American Medical Monthly*, in his April number, commenting on a proposed treatment of ingrowing toe-nail by perchloride of iron and cocaine, says that for a long time he has had quite as good results from the application of tincture of thuja, which hardens and shrinks the tissues surrounding the edge of the nail. "We at the same time order the nail scraped, a crescentic piece cut out of its end, and a pledget of absorbent cotton soaked in thuja tincture inserted under the edge of the nail; and in a short time the patient has ceased to suffer."

**Thyroidin.**—*The Journal Belge d'Homœopathie* for March—April, shows thyroidin in a new light.

(1) A series of experiments were made on eight subjects of mental disease, each taking 1-3 five-grain doses daily of the fresh gland. The experimenter observed emaciation, tachycardia, cardiac weakness, and mental or motor excitement, in all; but two presented also a generalised infiltration analogous to myxœdema.

(2) Dr. Mersch had a case where the symptoms of exophthalmic goitre were accompanied with myxœdema of the lower extremities. Low triturations of thyroidin aggravated the cardiac and nervous symptoms; but when higher dilutions were given, not only did the tachycardia subside, but the myxœdema disappeared also.

**Tuberculin.**—Dr. Heber Smith has joined the ranks of those who praise tuberculine (Koch's) in broncho-pneumonia. He uses a 3x trit. He relates two cases in which, the patients being 88 and 60 respectively, unhopèd-for recovery occurred under its use.—*Amer. Med. Monthly*, March.



**Vipera.**—The poison of the viper, inoculated into a rabbit, has been found to produce the physiological troubles and the anatomical lesions of polio-myelitis and poly-neuritis simultaneously.—*Journ. Belge d'Homœopathie*, March—April.

**Xanthoxylum.**—Dr. Majumdar reports a case of uterine fibroid in a woman of 56, in which, guided by neuralgic pains in the right ovary, and a history of dysmenorrhœa during the catamenial life, he gave xanthoxylum 3x. After taking this for about six months the health had cleared up and the tumour had disappeared.—*Indian Hom. Review*, February—March.

### THERAPEUTICS.

**Addison's Disease.**—Dr. Beclère presented in February last to the Société Médicale des Hôpitaux an undoubted case of Addison's disease, in which a definitive cure of three years' standing had been effected by hypodermic injection of a fluid extract of the supra-renal capsules. Ingestion of these as fresh food had been previously tried without success.—*L'Art Médical*, March, p. 216.

**Carbuncle.**—Dr. S. G. A. Brown relates a case of carbuncle, in which after operation by crucial incisions the mischief went on spreading until a solution of succus calendulæ, 1 in 6, was applied. "The effect was marvellous. Pus began to disappear rapidly, the inflammatory extension ceased instantly, and temperature dropped."—*Hahn. Monthly*, March.

**Coxitis?**—N., a girl, age 10, has complained for six weeks of pains in right knee-joint that made her limp. The pains were at first slight but have gradually increased. They are aggravated by movement, but rest does not remove them. Sleeps well, and otherwise her health is good. Nothing abnormal could be seen in the knee. A suspicion of commencing coxitis was borne out by painful sensitiveness of the trochanter major when pressed. Father was a neurasthenic. Mother's family were neuropathic, several of whom were victims of mental disease; one of her children had died of brain fever, one of pneumonia, the youngest child—6 years old—was congenitally imbecile. Prescribed rest in bed, rhus 3 twice a day. In three weeks the child was well.—Taube, *Zeitsch. d. Berlin. Vereins*, xvi., 490.

**Enterorrhagia.**—A clerk, age 54, consulted me at the end of July, 1897. For more than a month he had suffered from severe

diarrhoea, with pain in the bowels, which had resisted all domestic remedies. He was very weak, and perspired freely. Twenty years previously he had, as he said, been threatened with consumption, but since then had enjoyed good health. There was some dulness in the right infra-clavicular region, bronchial respiration and dry crepitating râles there. Skin moist and disposed to perspiration; pale complexion; much thirst; abdomen sensitive to pressure; evacuations watery. I gave arsen. 5x three times a day. After ten days the diarrhoea still persisted, and he noticed bloody streaks in every stool. Phosph. 5, four times a day, and acorn coffee. In a few days the blood disappeared from the stools, and in three weeks the diarrhoea ceased. He had profuse night sweats, for which he got every evening a cup of salvia tea. The first and second night the perspiration was much increased, but with the third cup the perspiration entirely ceased.—Stäger, *A. h. Z.*, cxxxvi. 50.

A schoolmistress, who for many years had been affected with pulmonary disease, for the last six months had been affected with bloody diarrhoea. She had taken many domestic remedies and allopathic medicines without benefit; indeed, she got constantly worse. Latterly she had severe cough with bloody expectoration. I gave phosph. 5 four times a day, and a cup of acorn cocoa once a day. The blood disappeared from stools and sputa. The number of diarrhœic stools decreased daily, and in a month the motions were normal, the cough ceased, and the patient's strength and weight increased.—*Ibid.*

**Epistaxis.**—A saddler, age 18, came to my consulting-room with profuse epistaxis, which had been going on for two hours. There was a large coagulum on the left nostril, beside which blood was dripping. Previous to the bleeding he had complained of severe frontal headache. I gave him there and then 5 drops of hamamelis tincture three times in succession, whereupon the epistaxis ceased and did not recur.—Stäger, *A. h. Z.*, cxxxvi., 34.

**Erysipelas.**—Countess R., age 56, had suffered for years from erysipelatous swelling of the face, the eyes bunged up. This came on every time she was long exposed to the open air, especially during cold winds. She was tortured by great itching. Aggravation every spring, but the disease lasted till the winter, when it occurred more rarely. The itching was alleviated by washing with salt water, but she could not bear sea-bathing; otherwise she was well. She had tried all sorts of treatment. Rhus 6 night and morning for four days caused the redness and

itching to disappear, and she was able to sit out in the open air all the evening. She was directed to continue rhus 30 every fourth evening for three weeks, after which she was, and remained, quite well.—Waszily, *Arch. f. Hom.*, vi., 337.

**Exophthalmic Goitre.**—Dr. Criquelion relates a well-marked case of Graves' disease in a woman of 43. Complete recovery ensued under a course, first of cactus 3x and arsenicum 6 (diarrhœa was present), and then of belladonna 6 and iodine 6.—*Revue Hom. Belge*, March.

Dr. Halbert records another case where lycopus, in 3-10 drop doses of the mother tincture, proved curative, with some ferrum phos. for the anæmia.—*The Clinique*, April.

**Hæmoptysis.**—A statuary, age 29, consulted me, February 25, 1897, on account of spitting of blood, from which he had suffered for three weeks. He had dry cough, and was losing flesh. Sometimes the sputum was only tinged with blood, sometimes it consisted entirely of blood. His gums were healthy. Examination showed dulness on both sides in supra- and infra-clavicular region, with dry, small vesicular râles; bronchial respiration on both sides. It was evidently a case of pulmonary tuberculosis, and the blood came from a small cavern on the right side. I prescribed arsen. iod. 4, one grain three times a-day. When I next saw the patient one week afterwards he had neither hæmoptysis nor cough. His appetite, which had been very bad, had returned. Percussion still showed dulness on both sides, but there were no râles, only bronchial respiration. The same medicine was continued, and the patient recovered and had no more spitting of blood.—Stäger, *A. h. Z.*, cxxxvi., 36.

S., man, age 38, who had been under my care previously for phthisical cough, on October 25 had suddenly a slight attack of hæmoptysis, which recurred frequently. Arsen. iod. and confinement to bed immediately stopped the bleeding, and the cough, which had returned a few days previously, disappeared at the same time.—*Ibid.*

**Hay Fever.**—A youth, age 18, had the following symptoms (how long not stated): photophobia, lacrimation, great injection of conjunctiva, coryza with constant watery discharge from nose, dyspnœa, râles in air passages and violent cough. *Allium cepa* 30 cured him gradually, though he was unable to alter his mode of life.—Lutze, *Arch. f. Hom.*, vii., 45.

Another case, where the disease had lasted for years; photo-

phobia with scalding tears, dry coryza, cough and asthma. Arsen. 30 cured quickly and permanently.—*Ibid.*

**Hyperchlorhydria.**—Dr. Hayem asserts, from his experience, that large and continued doses of alkalies, far from benefiting, actually increase and may even originate the excessive production of acid in the stomach.—*L'Art Médical*, May, p. 368.

**Ileus.**—A married woman, age 39, two children, previously good health. Five years ago was said to have carcinoma of rectum and was dosed with morphia. After prolonged observation in a hospital was found to have simple stricture of rectum which was operated without effect. Since then has been subject to discharge of mucus and blood from the bowel. Stool always hard and long-shaped. For a long time has suffered from tremor, palpitation of heart and emaciation. Since eight days no appetite, vomiting, sleeplessness, spasmodic pain in bowels, pain in sacrum, pressure downwards, increasing heat. April 29, 1897.—Extreme emaciation, lungs and heart sound, orifice of vagina very narrow, uterus normal, its left appendages swollen to size of an apple. Six cm. above sphincter ani a constriction in the form of a ring, very sensitive. May 6.—No stool for seven days, great pain in sacrum, no appetite, palpitation of heart. Dose of morphia lessened, instead some codeia. May 10, 8 a.m.—Vomiting, constant urging to stool, evacuation of hard faecal lumps, no flatus. Three powders of opium 2 in sugar. Noon.—Constant vomiting and urging to stool. Peristaltic movements of bowels seen beneath the thin abdominal parietes, this is especially noticeable on the right side below the navel. Abdomen all over very tender. After bilious and green vomiting had lasted some hours it was replaced by empty retching. Bloody stools continue. Injections cannot pass the stricture, pulse small. Continue opium powders. 4 p.m.—Same state. Merc. corr. 5, arsen. 3, bellad. 3, at quarter-hour intervals. 10 p.m.—Vomiting diminished, less restlessness. The bloody stools have ceased. Atropin 4, opium 3, at half-hour intervals. Indican in urine. May 11.—No vomiting, no stool. Injection retained, no flatulence. Air was blown into rectum by a tube, and after several attempts the ileum was seen to be distended considerably. After a quarter of an hour, flatus passes. The pulse gains in strength. May 12.—Night quiet, much flatus passed. Some pain, no stool, no vomiting, no appetite. Nux vom. 3, colocynth 3. May 13.—Continued improvement. May 14.—Soft stool. Further progress favourable. — *Giscoins, A. h. Z.*, cxxxvi., 162

A young man, age 21. Was formerly treated for several attacks of perityphlitis which terminated favourably under merc. sol. 3 and bryonia 3. Has always suffered from constipation and slight pain in cæcal region. January 28, 1898.—Had for this carduus 1 and natr. cholonic. 3, and suitable diet. January 30.—Transgressed his dietetic rules and took a long journey contrary to orders. January 31.—Cæcal region swollen as large as two fists. Colic, green vomiting. Atropin 5, bryonia 3. Copious enema of water and oil. February 1.—Swelling somewhat diminished, pain below the swelling. At night vomiting, thirst; temp. normal, pulse 80. Cont. med. February 2.—No flatus. Whole of right side of abdomen meteoric, half of it having dull percussion sound. No peristaltic movement perceptible in the distended part of the abdomen, nor can any defined outline of the bowels be distinguished. Pains below the swelling down to rectum. Every movement is painful. Anuria. The fuliginous tongue lies like a board in the mouth. Lips dry. Expression hippocratic. No sleep for several nights. Temp. normal, pulse 90, small. Air was injected as in the former case. A small quantity was forced up with much suffering to the patient, which was relieved by bran poultices. After half an hour flatus is passed. Merc. sol. three times a day. Atropin 5, nux v. 3 and colocynth 3 as intermediate remedies. In the evening flatus passed, pain diminished. Stool followed enema. February 3.—Abdominal distension gone, no pain. February 4.—Abdomen quite soft, kidneys on both sides tender. Urine one-quarter of normal, of brown colour, containing a quantity of red blood corpuscles, albumen in large quantity, no indican. Canth. 5, nitr. ac. 4, alternately every two hours. February 8.—Urine clear, more copious. February 11.—No blood in urine, very little albumen. The further progress was favourable.—*Ibid.*

**Influenza.**—In a very practical paper on this disease, relating his own experience, Dr. Burwood writes *inter alia*: “For the special neuralgias, gelsemium 1x, 20 drops in half a tumbler of water, a teaspoonful every five or ten minutes, acts like a charm.” And again: “Belladonna has not been a satisfactory experience for the laryngeal cough, while rumex crispus 1x, spongia 1x, or hyoscyamus 1x, have triumphed gloriously.”—*Monthly Hom. Review*, March.

**Meningitis.**—Lina M., age 2, had been treated allopathically for meningitis, and as the physician had given an unfavourable prognosis, the child was put under homœopathic treatment on April 1, 1897. Dr. Cramer found the patient unconscious—she

had previously had convulsions—with dilated pupils and inflamed conjunctiva. Under sulph. 6 twice a day and bryonia 4 every hour, with cold compresses, consciousness returned on the second day, and the child asked for a drink, and passed urine and fæces normally. On the third day she answered questions properly, but had a stiff neck, and the left conjunctiva was red. Sulph. 6, bell. 4. On the fourth day, the stiff neck still persisting, severe iritis came on. Sulph. 30, one dose, then bell. 4 and merc. cor. 6, each twice a day alternately.—Fifth day, the iris clear, hypopion, stiffness of neck gone; merc. cor. 6, hep. 8, alternately.—Seventh day, synechia posterior, blindness, atropin locally; sulph. 30, bell. 4, and merc. cor. alternately.—Eighth day, an oculist called in consultation only suggested instillation of atropin-cocain. The homœopathic remedies were continued.—Tenth day, the adhesions on left side gone, the right eye remained as before; considerable photophobia; sulph. 30, one dose, then merc. cor. 6, three times a day; the atropin-cocain instilled four or five times a-day.—Twelfth day, sight of left eye restored, great photophobia, the synechia of right eye remains, and that eye is blind; same medicines, warm compresses.—Fifteenth day, owing to irritation caused by the atropin, it was instilled only twice a day; continued sulph. and merc. cor.—Seventeenth day, the pupillar occlusion continues; atropin, merc. cor.—Nineteenth day, the same, bryonia in place of merc. cor.—Twentieth day, the right synechia relieved, pupil dilates; continued bryon.—Twenty-fourth day, vitreous dull in both eyes. Sight very defective. Almost all trace of iritis gone; sulph. 30, merc. cor., atropin.—Twenty-sixth day, conjunctiva normal, pupils dilated, can distinguish the hand held up to window; sulph. 30 every three days; kal. chlorat. 6, three times a day.—Twenty-ninth day, sight improved; phos. 6, twice a day, atropin instillation continued.—Thirty-eighth day, the oculist diagnosed commencing capsular cataract in both eyes; phos., atropin.—Forty-seventh day, child can distinguish near objects well, distant objects imperfectly. The capsular cataract has gone off. The child has hot hands and feet, restless, anxious sleep, will always throw off clothes, desires light, is cross, has flat red patches on both thighs; opium as antidote to the atropin; continued phos.—Fifty-sixth day, sight improved; has had no atropin instillation for three days; phos. 6 twice a day. A quarter of a year afterwards the child was seen and was still quite well.—CRAMER, *A. h. Z.*, cxxxvi., 41.

**Nephritis.**—An interesting case of nephritis complicating recovery from cholelithotomy is related in the *North American* VOL. VI.—NO. 3.

*Journal of Homœopathy* for March. The action of *cantharis* in the acute stage, and of *aurum muriaticum natronatum* in the chronic condition which supervened, was very gratifying.

**Ovarian cysts.**—(1) M. B., age 18, has for several years, almost since she began to menstruate, suffered from pain in the right side of the abdomen. At the same time she noticed a gradual swelling of the abdomen, at first on the right side. As time went on the whole abdomen increased in size, and the increase occurred chiefly at the menstrual period, after the cessation of which a slight diminution was observed. In the last months she was unable to retain the urine. She had been treated by various medical men for several years. At last she was advised to have an operation. But as she was unwilling to submit to this, she put herself under homœopathic treatment on October 13, 1896. She was of a slight figure, and her greatly enlarged abdomen was very striking. The dull percussion sound was 95 cm. and extended to a convex line superiorly and was not altered by any change of posture. The right iliac region was sensitive to pressure. All other organs were healthy; no albumen in urine. Diagnosis, ovarian cyst. She got *apisin* 5 dec. trit. three times a day. Dry food, and a pretty tight abdominal bandage. November 3, the swelling was diminished by 6 cm. In the ensuing month the swelling continued to decrease, only the decrease ceased at the monthly period, or there was even a slight increase. February 17, 1897, the swelling was 84 cm., and was now limited to the right iliac origin. The remainder of the swelling gradually disappeared. The incontinence of urine and the pain on right side of abdomen ceased. Now, after a year, she has remained perfectly well.

(2) A woman, age 45, had been operated on for a right ovarian cyst two years previously. For several months past another cyst on the left side had appeared, and enlarged rapidly. Another operation was proposed, but she tried homœopathic treatment. *Apisin*, dry nutriment, and abdominal bandage caused the tumour to disappear in three months.—*Bourzutschky, Zeitsch. d. Berlin. Ver.* xvii., 173.

**Ovarian neuralgia.**—A Hindu woman, age 22, had been suffering for two days from pains in the right ovarian region, which was tender to touch. Pain was paroxysmal, lancinating, and constrictive. *Apis* 30 every half-hour removed them after a few doses.—*Calcutta Journ. of Medicine*, March.

**Oxaluria.**—Dr. Clifford Mitchell writes upon "The Therapeutics of Oxaluria." Besides the traditional nitro-muriatic acid

(which he esteems most in young men), and oxalic acid itself in potency, he praises lysidine (ethylene-ethenyl-diamine). He gives 10 minims thrice daily of a fifty per cent. solution.—*Hahn. Monthly*, May.

**Paget's Disease.**—In this painful and serious affection of the breast no homœopathic experience has yet been recorded. Dr. Nyssens, however, presented a case at a clinical meeting in Brussels, in which the internal use of clematis seemed to be effecting a cure.—*Journ. Belge d'Homœopathie*, March—April.

**Pertussis.**—Dr. Weaver writes interestingly of his experience with whooping-cough. It has led him to prefer naphthalin to any other internal remedy. He gives it in about the 1x strength.—*Hahn. Monthly*, May.

**Retinitis.**—Dr. Linnell, in a paper on "The Eye Symptoms of Chronic Nephritis," relates a case of albuminuric retinitis, in which the action of remedies—especially plumbum 30—was very satisfactory.—*N. Am. Journ. of Hom.*, April.

**Shingles.**—Dr. R. A. Bayley writes in high commendation of carron oil (equal parts of linseed oil and lime-water) as giving great relief to the burning and other painful sensations accompanying the eruption of shingles.—*Amer. Med. Monthly*, April.

Dr. J. P. Rand finds that the application of nitrate of silver, either in stick to each vesicle, or as a lotion over the whole surface, exerts a blighting effect on this and other forms of herpes.—*N. Engl. Med. Gazette*, April.

**Stomatitis.**—A boy, age 5, blonde, pale complexion, had febrile symptoms and sore throat. His mother gave him acon. 30, but as, after two days, he was worse, he was put under my care on November 25. The little patient was pale, depressed, and lay on his back in bed. Skin dry; pulse quick. The tonsils, especially the right one, were bright red and swollen. The mucous membrane of mouth and throat was in the same state; mouth dry. Tongue also dry, with a grey coat; its centre was quite devoid of epithelium to the extent of a florin. The gums pale, swollen, and bleeding on being touched. The vermilion of the lips, the upper more than the under, showed many vesicles covered with a black crust. A fœtid odour came from the mouth. No appetite; thirst, but he feared to drink on account of the pain it gave him; would not take any solid nourishment; bowels constipated; urine scanty, dark coloured. At night the febrile heat became intense, so that his body felt burning hot.



I gave nitric acid 30 every three hours. After this the nocturnal fever ceased, the tongue became clean, the tonsillitis declined, so that he could drink comfortably; bowels relieved by enema. The restoration of the epithelium on the tongue proceeded slowly. As the morbid symptoms on the lips and gums continued, he now got carbo veg. 30. In a week the child was so far restored that he could get up, and all his functions became normal.—Mossa, *A. h. Z.*, cxxxvi., 57.

**Subcutaneous swelling.**—A woman, age 45, has suffered for nine months from the following symptoms: The abdomen swells, becomes hard, also the sacrum, hips and lower extremities. The skin becomes hard, but not œdematous, as it does not pit on pressure; frequent urging to urinate, urine fetid and causes excoriation with scalding when passed; not albuminous; no thirst, throat dry, swollen cervical glands. Frequent headaches with swelling of scalp; left cheek often red and hot in the evening. The attacks last from eight to fourteen days, and occur every six or eight weeks. Apisin 6th trit. four times a day cured. Mau, *Arch. f. Hom.*, vii., 45.

**Typhus.**—A young girl had profuse epistaxis—the blood bright and malodorous—which was only checked by tamponing the nostrils; this was attended by great weakness. A few days after this she fell into a typhoid state, rose-coloured spots appeared, high fever, swollen spleen, tongue brownish-black in the middle, sordes on the teeth, urine and diarrhœic stools very fetid. Baptisia 30 was given every two hours. The next day great amelioration, which continued, so that the typhus seemed to be averted. After another fortnight hasty drinking of cold water brought on such a severe relapse that the worst was feared. Epistaxis, great weakness, watery, *greenish*, very fetid stools, chiefly in the morning. Podophyllum 30 caused slow recovery.—Junge, *Arch. f. Hom.*, vi., 336.

**Verruæ.**—“A man came to me with warts on the back of his right hand. I counted eighty of the largest I had ever seen. The number of small ones it was impossible to count—the back of the hand and fingers was completely covered. I gave him calc. carb. 30. In a week all the large warts had turned black and shrunk, showing a red rim around each at the base; within a fortnight they had all fallen off, and his hand was perfectly free from any trace of warts.”—Heale, *Amer. Homœopathist*, May 2.

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THE COUGH OF PULMONARY DISEASES.<sup>1</sup>

BY D. MACNISH, M.A., M.B., EDIN.

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As coughing is due to an irritation of the fibres of the vagus nerve which supplies the heart, lungs, and stomach, coughing is one of the most prominent symptoms of pulmonary diseases. A cough may be defined as a sudden expiratory explosion whereby any substance, solid, fluid, or gaseous, in contact with the respiratory mucous membrane, is ejected through the mouth. The centre is in the medulla oblongata. Certain parts of the respiratory mucous membrane, viz., the true vocal cords and the trachea as far as the bifurcation, are said not to discharge coughs.

The respiratory mucous membrane is covered normally with a thin layer of mucus which protects the glands from irritating agents. In catarrhal conditions this mucus is increased in quantity and altered in quality. It is essential

<sup>1</sup> Presented to the section of Materia Medica and Therapeutics, April, 1898.

for the welfare and comfort of the patient that this secretion be removed as expeditiously as possible. Where the pulmonary organs are in an active condition the processes of coughing and absorption speedily remove the secretion. In all pulmonary diseases where there is this increase of secretion, coughing is a natural process, and must be encouraged, not suppressed. The strength and vigour of the cough is a safe guide to the condition of the pulmonary organs.

Though coughing is invariably a symptom in pulmonary diseases, it is in many cases a subsidiary symptom, and does not necessitate special treatment. The drug homœopathic to the general condition of the patient is essential, and the cough treated as a subsidiary symptom. In certain pulmonary diseases, especially of the very young and the aged, cough is absent, and the diagnosis of the disease obscured. With this class of patients, whenever ill, it is a safe plan to always examine the lungs.

For practical purposes coughs may be divided into dry and moist. The modalities of coughs are most numerous and most varied. The minute differentiations portrayed in many text-books I have found of practically no value whatever—frequently quite the opposite. In many of the pulmonary diseases the patient usually complains of pain, or nausea, or shortness of breath, &c., and considers the cough quite subsidiary and a natural concomitant of his disease. In such cases no special treatment is desirable or necessary. Again, in a large number of cases the cough cures itself, and in our differentiation of drugs it is necessary to remember the natural tendency to cure. Coughing, like acute pain, exhausts itself, and a temporary abatement or cessation occurs, which must not always be attributed to the effects of the drug. In cases under my treatment, unless the medicine employed effects a complete cure, or a most pronounced amelioration, of the cough within twenty-four hours, I do not consider that the drug has been of any practical value in the case. At the same time, the external treatment should either be *nil*, or some other preparation of the drug, as liniment, inhalation, or ointment.

For clinical purposes I divide coughs into primary and secondary. The primary cough removes the secretion from the respiratory passages and stimulates its absorption. After it has completed its work, there is often left behind a cough due to the irritation of the secretion and the primary cough. This secondary cough is not concerned with the removal or absorption of the mucus, but is often of a nature harassing, irritating, and distressing both to the patient and his friends, and often producing nausea and vomiting. Obviously this secondary cough ought to be checked as speedily as possible.

Every one of us has treated numerous cases of the different kinds of pneumonia. The cough in many cases was a useful adjuvant in hastening the cure, and required no special treatment. The indications of such remedies as bryonia and phosphorus are too well known to necessitate any references on my part. We have all proved their efficacy in pulmonary coughs. Other medicines, as antimonium tart., ipecacuanha, senega, acid. nitric., kali bichrom., &c., I may dismiss with a short reference.

Kali bichrom. 3x I have found useful in cases of atrophic bronchitis and bronchiectasis.

Lycopodium 1x in the dyspnoea of pneumonia, especially if accompanied by distension of the stomach.

Acid. nitric. 3x in chronic lung diseases, especially where the secretions are offensive, and there is a want of reaction in the patient.

Laurocerasus 3x in tuberculous disease, where the cough neither gets better nor worse and an alterative is necessary.

Arsenic iodide 3x in post-pneumonic coughs and gastric coughs of anæmic girls.

Antimonium tart. 3x in the initial stages of broncho-pneumonia, especially when the smaller tubules are affected. Where the large tubules are affected and the râles very loose, I find ipecacuanha 1x more useful.

Acalypha indica 3x is of great value in hæmoptysis of tuberculous origin, and especially where the hæmorrhage accompanies a severe bout of coughing.

Manganum 200 in one case relieved a cough which was

ameliorated by lying down. Other drugs, as *pulsatilla* 3x, *opium* 1x, *codeia* 2x, *iodine* 3x, *bromine* 3x, &c., are also of service.

I shall now give particulars of some cases lately under treatment:—

CASE I.—B. S. S., aged 8. On March 21, 1898, the patient was suffering from tonsillitis, which was relieved by *belladonna* 1 and a compress. On the 26th she developed a temperature 101°, with coughing, sneezing, and nausea. On examination, moist râles were heard all over both lungs. Her chief complaint was the nausea; for this *ipécacuanha* 3 was given. On the 28th the temperature was 99°; there was no nausea; the cough was troublesome. On examination, râles were heard over both lungs, and a well-developed nasal catarrh was noticed. *Arsenicum iod.* 3x, gr. i. 3hs., was prescribed. On the 31st cough was most troublesome, both night and day, and it was aggravated by lying down. *Verbascum* 1, m. i. ¼hs., was given. On April 2nd the patient was well, and her mother reported that the patient had not coughed once since taking the third dose of the medicine. Râles were still heard over both lungs, but on April 4 no râles were audible, and the patient was about as usual. She had had no return of cough. In this case the *verbascum* 1 appeared to cure the cough.

CASE II.—A. L., aged 60, was first visited February 4, 1897. He had been ill for two weeks, complaining of tightness of the chest, cough, and pain in left upper chest. The temperature was 99°, pulse 72; moist râles were heard over right lung; there was no dulness on percussion, nor any definite change in resonance or fremitus. He further complained of nausea and giddiness—there had been an attack of vomiting on the previous day. *Bryonia* 3x was prescribed. Next day the temperature was 98·6°, pulse 66; there was no nausea or vomiting; no pain in chest. Vocal fremitus was increased over right lung; râles were heard all over right lung. *Bryonia* 3x was repeated and *lin. bryoniæ* bis die ordered. February 6: temperature 98·4°, pulse 72; cough very troublesome; phlegm frothy white; nausea, with vertigo; physical examination as on previous day; *nux vom.* 3x. On the 8th there was no cough or nausea, and the patient felt quite well. He has been free from cough since the attack.

This patient suffered every winter with similar attacks; and the cough had previously persisted for months. The

nux vomica appeared to remove the cough at once. Though there were sufficient physical signs in the chest to produce such a cough, I considered the cough really of gastric origin, and as nux vomica was the most likely simillimum, prescribed it. This case is one of a series of cases where I have found great benefit from treating the totality of the symptoms and the primary cause of the cough.

In pertussis, which by arrangement comes under my classification, I have been greatly disappointed with drosera, a drug which I have usually prescribed in  $\phi$ , 1x and 3x potencies. I cannot remember any cure with this remedy. The patients got well, but after careful consideration and comparison with the cases which I have treated allopathically, they would have got better as soon, if not sooner, without the use of this medicine. Lately I have treated two cases of this disease and found great benefit from other medicines.

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CASE III.—J. P., aged 4, developed pertussis on January 24, 1898. Drosera 1x,  $\eta$ . i. 4hs., was given and continued till March 14, and at different times inhalations were used. There was no improvement during this period; the cough was now very troublesome at night. On March 14 I gave coccus cacti 1x,  $\eta$ . i. 3hs., and on March 21 the mother informed me that the patient had only whooped once since taking the medicine. It was repeated on March 25; there was no whoop or cough, and the patient seemed quite well. On April 14 he remained quite well, and there had been no recurrence of the cough.

CASE IV.—G. F., aged 7. The illness began with fever and cough on January 15. The disease developed into bronchitis and whooping cough on January 22. On this date the temperature was 102°; there were severe bouts of coughing, accompanied by nausea and vomiting and great prostration. I gave drosera 1x,  $\eta$ . i. 2hs. On February 2 the child was no better; the cough was most troublesome, and the whoop well marked. Corallium rubr. 6,  $\eta$ . i. 3hs., was prescribed. By February 7 the patient was much better, and whooped once a day only. February 21: an occasional whoop. On March 14, as the child still whooped occasionally, the corallium was changed to coccus cacti 1x,  $\eta$ . i. 3hs. On March 21 the whoop had ceased and there was no cough. The child was quite well. April 13: patient still remained well.

These are the only two cases of pertussis where I have found that the medicines acted promptly, and distinctly shortened the disease. I have given both *coccus cacti* and *corallium rubrum* in numerous other cases without any benefit to the patient. Where the whoop persists for months, one usually finds adenoids present; and until these are cured there is always a tendency to the recurrence of the whoop.

I have only touched superficially on the large subject of pulmonary coughs, with a view of eliciting valuable suggestions and information during the discussion.

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## REFLEX COUGHS.<sup>1</sup>

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### ANATOMY.

THE centre for coughing is placed a little above the inspiratory centre in the medulla oblongata.

The *afferent* paths to this centre are the sensory branches of the vagus. It may be noted by the way that the depressor nerve of the heart is one of these. It comes from the cardiac plexus, and its stimulation causes pain with diminution of the blood pressure.

The *efferent* paths from the coughing centre lie in the nerves of expiration and in those that close the glottis.

Branches of the vagus implicated in coughing:—

- (1) Meningeal branches.
- (2) Auricular branch.
- (3) Connection with spinal accessory.

<sup>1</sup> Presented to the Section of Materia Medica and Therapeutics, April, 1898.

- (4) Pharyngeal plexus.
- (5) Laryngeal nerves, superior and inferior.
- (6) Depressor to heart.
- (7) Cardiac branches and plexus.
- (8) Pulmonary branches to pulmonary plexus.
- (9) Œsophageal plexus.
- (10) Gastric plexus (left vagus).
- (11) Cœliac plexus (right vagus) to liver, spleen, pancreas, duodenum, kidney and capsules and other abdominal organs, such as the bladder.
- (12) Connection by means of hypogastric plexus of sympathetic with uterus and ovary.
- (13) Indirect connections with nerves of the skin.

Coughing is known to be caused by :—

- (1) Stimulation of the auricular branch of the vagus, particularly of the branches to the deep part of the external auditory meatus.
- (2) Stimulation of the sensory branches of the vagus to the tracheal mucous membrane and also to the bronchial mucous membrane.
- (3) Stimulation of the pulmonary tissue when altered pathologically.
- (4) Pathological conditions of the pleura.
- (5) Changes in the stomach.
- (6) Changes in the liver and spleen.
- (7) Stimulation of the skin, especially of the upper part of the body, as in the case of cold air striking the body.

Coughing is also attributed to changes in the heart, uterus, ovaries, liver.

#### THERAPEUTICS.

It is not proposed to follow in detail the relation of all these anatomical facts to reflex coughs and their treatment. Only the more common and interesting will be dealt with, and that as briefly as possible. Pulmonary coughs will be dealt with in the other papers of the evening.



*Ear Coughs.*

Reflex cough from the ear is well authenticated, and is most commonly due to the presence of wax or a foreign body. When this is removed and the irritation of the skin at the bottom of the external auditory meatus has passed away, the cough ceases. Therefore in this case no procedure beyond that of removing the cause is necessary. I am not aware of any morbid condition of the external auditory meatus causing cough, but if there is, no doubt our ear and throat specialists will be able to give us some information regarding it. The relation of the vagus to the ear is an interesting anatomical fact.

*Heart Coughs.*

When, in organic heart disease, we have what is evidently a reflex cough, a result of stimulation of the numerous branches of the vagus supplied to the heart, such a condition would point to the use of *hydrocyanic acid* or one of its derivatives. This is borne out by clinical evidence.

*Stomach Coughs.*

Of the existence of so-called stomach coughs no one seems to have a doubt. Anatomically we might expect it when we know that the major part of one vagus is devoted to the innervation of the organ. Of medicines which have marked stomach symptoms associated with cough there are many, but I shall only single out a few, and give some slight indication of their particular influence and use.

*Kali bichromicum* has so many pulmonary symptoms, as well as gastric, that it would be difficult to say definitely whether its cough is ever purely gastric. All we can say is that the cough may at times "seem to start from the epigastrium."

*Natrum mur.* has one form of cough which arises from a "tickling in the pit of the stomach," is accompanied by bursting headache, by occasional involuntary spurting of urine, and by stitches in the liver.

*Nux vomica* has among several kinds of cough a gastric one which is brought on after eating and is accompanied by soreness in the epigastrium. In other respects it is particularly a stomach medicine.

*Phosphorus* also has many coughs, but is useful in stomach or hepatic cough, coming on after the patient eats and starting from tickling at the pit of the stomach. Other nervous or reflex coughs belong to phosphorus, and these I shall mention under the nervous system.

There are three medicines which produce cough followed by eructation of wind. This symptom is probably connected in some way with the process of digestion and the action of the gastric muscles. The medicines are *ambra grisea*, *acid. sulphuric.* and *veratrum album*.

*Zinc* has a cough aggravated by eating sweet things. This reflex might arise either from the buccal or the gastric mucous membrane.

*Bismuth* is a thoroughly stomach remedy and has among its symptoms a cough which is worse when the stomach is empty.

#### *Hepatic and Liver Cough.*

Of medicines associated with symptoms that might point to a liver origin, one only may be noted. It is *natrum mur.*, which has stitching pains in the liver along with its cough.

*Phosphorus* might also have an hepatic origin for its cough.

#### *Bladder or Urinary Coughs*

may be found in those of *causticum*, *scilla*, *natrum mur.*, *senecio*, and *zinc*. The first three, *causticum*, *scilla*, and *natrum mur.*, have occasionally related to their respective coughs "an involuntary spurting of urine."

This symptom might often be expected in children, owing to the fact of the intra-abdominal pressure being increased during a cough. But the three remedies mentioned are particularly associated with the occurrence.

*Senecio* produces a cough and has as well certain genito-urinary symptoms, of which one is "pain at the neck of the

bladder with burning and dysuria." As this occurs in females and is related to the menstrual functions, it falls more properly under the head of uterine coughs, where it will be again noted.

*Zinc* has a peculiar symptom sometimes accompanying its cough, more particularly in children, who, when they cough, "hold their hand over the genitals," as if that part of the anatomy was particularly affected.

#### *Uterine and Ovarian Coughs.*

It is difficult to draw any sharp distinction between the coughs of the two organs, so they may be considered together. These organs, as already pointed out, are not within the direct sphere of the *vagus* and are only connected with it by the abdominal and hypogastric plexuses of the sympathetic, or by a route through the sacral spinal nerves, the spinal cord and so to the centre of the medulla. Certainly, it is a fact beyond dispute that pathological changes in structure or position of the female genital organs will produce among their many other ills a definite cough. On the other hand, there are certain drugs which have a specific relation to uterus and ovary and have an associated cough—I shall only mention five of them: *actea*, *ambra*, *apis*, *senecio*, and *zinc*. There are others, but these will suffice to indicate the relation of cough, organ, and remedy.

*Actea* has a dry, teasing cough, worse at night, with little or no sputum, and associated with spinal irritation. There is sensitiveness in the region of the cervical vertebræ, the patient will not lean back in her chair on account of the uneasiness produced, and this symptom is usually found to be reflex from uterine or ovarian irritation.

*Ambra grisea* is said to be associated with a specific action on the female genitals, in which there is atony of the uterus with profuse menstruation. Excitement increases the flow and aggravates the cough, which latter is distinctly of a nerve reflex character.

*Apis* is another well known cough remedy, suggested by utero-ovarian symptoms. The cough is such as one might

expect to be due to a distant reflex. There is teasing with little or no mucus, a feeling of tightness over the chest, numbness down the thigh and right side of the body, with burning and stinging pain. There may be tenderness of the right ovary. These and other symptoms may be directly referred to the uterus and ovary.

Some of the uterine and ovarian symptoms attributed to *apis* would point to its appropriate use in girls at puberty, where there is a nervousness connected with the onset of menstruation. Such symptoms, accompanied by a cough, would meet the definition of the late Sir Andrew Clark, "the barking cough of puberty."

*Senecio* has already been referred to as having, along with cough, disturbance of the genito-urinary tract. It suits nervous, excitable women who are sleepless from uterine discomfort.

#### *Skin Coughs.*

Cold air striking the skin, and particularly that of the upper part of the body, is said to produce cough. Whether this is due to stimulation of spinal nerves or of the sympathetic it is difficult to say. However, we find two medicines at least which are credited with this symptom.

*Lachesis* has a cough, associated, it may be, with intolerance of touch, even of clothing, about the neck. In this connection one might think of the spinal accessory as the afferent nerve to the medullary respiratory centre.

*Rhus* produces a coryza and redness of throat with a dry cough, worse when the body is uncovered, probably due to stimulation of cutaneous nerves.

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THROAT AND NERVOUS COUGHS.<sup>1</sup>

BY J. R. P. LAMBERT, M.D.,

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Homœopathic Hospital.*

BEFORE proceeding to the branch of the subject allotted to me, it may be well for me to define what I understand by throat and nervous coughs, and I may say at once that I am not prepared to draw a fine distinction between a throat cough and a nervous cough. The sort of cough that I intend to take up is that class of cough which is not accompanied by any gross pathological lesion, and not known to be reflex. Such coughs are usually characterised by a great deal of irritation which may be felt anywhere from the pharynx down to the epigastrium; they are as a rule accompanied by very little expectoration, and are of two main types. First, there is the paroxysmal type, which is often very loud and dry, or it may be more wheezy in character; such coughs usually shake the patient a great deal and often cause headache or pain in the sides. The second type is hacking, which is as a rule less severe, but may be very constant and troublesome. These coughs have one more feature in common, and that is, they are often very difficult to relieve, as in the case of the cough which so often follows influenza, or accompanies measles.

In dealing with this subject I propose taking first a medicine which has a characteristic cough of the kind described, and that medicine is *rumex crispus*, and to illustrate its action I will quote the following case:—

Mrs. T., aged about 35, consulted me on January 12, 1895, for a very troublesome cough from which she had suffered every winter, with one exception, since she was five years old. (In the winter in which she was exempt from the cough, she gave birth to a child, and that child suffers from a similar cough every time it

<sup>1</sup>Presented to the Section of Materia Medica and Therapeutics, April, 1898.

gets a cold, and is the only one of her nine children which is affected in that way.)

She described the cough as an incessant, dry hacking, or barking, which description was quite accurate, as I had opportunity to observe. The interval between the cough was only a few seconds while I saw her, and she said it continued thus day and night while awake, being aggravated after going to bed so that she had to sit up for some time. It was also increased by frosty weather and lessened in a warm room. The cough was induced by a tickling behind the upper end of the sternum, and was accompanied by a sharp pain in the side of the neck and chest, and in the hypochondria. She also suffered from dyspnoea at night. Her mother was asthmatic. Physical examination revealed nothing. She had taken bryonia, spongia, drosera, and other medicines without relief. I gave her first hyoscyamus 3x, three powders to be dissolved in half a tumblerful of water, and a dessert-spoonful to be taken every four hours. Five days later, she said she had been better since the frost ceased, but had a worse night than ever on the 12th. This aggravation I attributed to being out in the cold, not to the medicine, and gave her rumex 3x, three powders to be taken in the same way. A month later she told me the cough was practically cured, and she had been free from it through the worst weeks of that severe winter's frost.

The key-note of rumex is well described by Dunham as great sensitiveness of the tracheal mucous membrane, so that cold air, any irregularity in breathing, pressure on the trachea, &c., excites cough; so great is this sensitiveness that the patient covers his mouth with the bed-clothes at night to prevent inspiration of cold air.

The cough of rumex is described in the provings as hacking, or in one case as dry and spasmodic, and occurring in paroxysms. It is excited by a tickling sensation or irritation, which is felt either in the episternal notch, or behind the upper or middle part of the sternum, or it may be felt only on the left side of the sternum. Behind the sternum is, however, the characteristic site.

Before leaving rumex I must mention some valuable accessory symptoms which it produces in connection with the respiratory system, I allude to thoracic pains, which indeed are more prominent in the provings of rumex than is

the cough. These pains have a decided affinity for the left side of the chest and are variously described as "acute," "piercing," "cutting," "transient stitches," "fine stitches in substance of the left lung," and also as "burning" or "stinging." The left-sided pains are ameliorated by lying on the left side and aggravated by lying on the right, thus resembling bryonia. It also produces soreness down the left side of the sternum and a sensation of a thread tied round the neck just below the ears. These symptoms may be valuable aids to the diagnosis of the remedy, as may also such symptoms as the morning diarrhoea, or itching of the skin whilst undressing, for not every case where rumex is indicated will present Dunham's key-note, and of the other symptoms I do not think any are pathognomonic of rumex.

Passing on now to allied remedies, the most similar, in my opinion, are phosphorus and causticum.

Both of these medicines are more often indicated where there is a definite bronchial or pulmonary lesion than is rumex, but they are nevertheless often called for in coughs of a nervous character.

In common with rumex both produce a dry spasmodic cough, and both produce likewise tickling or irritation, which is felt in the episternal notch, or in the larynx, or, with phosphorus, lower down behind the sternum.

Now for the differences. In the first place, they both produce a more violent and hollow cough than rumex. They lack, as do all other remedies so far as I know, the great sensitiveness of rumex, though phosphorus has aggravations on change from warm to cold air.

The causticum tickling is produced by a tightly adherent bit of mucus, and is relieved when this is shifted. It has also a characteristic sensation that he cannot cough deeply enough "to shift it." Another important symptom is a streak of soreness behind the sternum in middle line, where every cough pains. Contrary to the rumex aggravation from cold air, causticum has aggravation from warmth of the bed at night and relief from a swallow of cold water. The cough of causticum may be accompanied by involuntary discharge of urine. Phosphorus has one distinguishing symptom, which

I have found a very good indication, and that is tightness across the upper part of the chest or a feeling of a pressure over that region. It also produces a feeling of rawness in the larynx and trachea.

Both phosphorus and causticum have more action on the larynx than has rumex, and both produce more or less complete aphonia. Rumex, however, does affect the larynx, producing rawness and tickling there and tickling in the throat, but acts more characteristically lower down the respiratory tract.

Lachesis has a superficial resemblance to rumex in the sensitiveness which it produces about the neck, but with lachesis it is a sensitiveness of the *skin*, so that the least touch of clothing about the neck is unpleasant, and this symptom may occur quite independently of cough. It also has painfulness of the larynx to pressure and on bending head backwards.

The lachesis cough is worse after sleep, and is accompanied with tickling either in the throat, the trachea, or the epigastrium. The increased tendency to cough after sleep and peculiar sensitiveness to touch are quite sufficient to indicate lachesis.

Another group of medicines I must mention are belladonna, hyoscyamus, and conium. These all act more upon the larynx, and produce a tickling which is felt high up. Hyoscyamus and conium have marked aggravation on lying down at night; the conium cough is supposed to come at that time. I have had very little experience with this medicine. Hyoscyamus I have used (and with good effect) for a purely nervous cough of hacking, irritating character, belladonna more for cough due to cold or accompanying phthisis. It has a dry, spasmodic, hollow cough, and a dry sensation in the larynx. We need the differential indications for these three drugs.

Another drug which I have used a little is sticta, but I can give you no reliable indications for it. The provings are very scanty. The cough symptoms attributed to it are chiefly clinical; they are dry, incessant, racking cough, tickling in the larynx and bronchi, increased in the evening, and on lying down. This is a medicine which needs proving.



All the remedies we have considered produce irritation or tickling somewhere from the larynx to the bronchi. The same sensation lower still is produced by *veratrum alb.*, which has it at the lower end of the sternum, and with it deep, hollow cough, as if from the abdomen. *Lachesis* sometimes produces irritation to cough in the epigastrium.

In dealing with nervous coughs (any cough, in fact) it is a good plan always to ask if the cough is relieved by lying down. This symptom is not uncommon, and is very characteristic of two medicines—*ferrum* and *manganum*—specially the latter. *Ferrum* I generally give in the shape of Schüssler's *ferrum phosphoricum* (a very valuable drug), and the following case is illustrative :—

Mrs. C. complained of having had a bad cold for two weeks. It began with sore throat, and left a troublesome cough, described as loose and rattling, the rattling being felt low down in the chest. It was accompanied by a splitting headache, and only troubled her by day, ceasing on lying down at night. There was no expectoration, and physical examination revealed nothing. I put about a grain of *ferrum phos.* 2x in a tumblerful of water, and ordered dessert-spoonful doses every two hours. Its action was so prompt that she considered herself cured in twelve hours.

The indications for *ferrum phos.*, as given by Schüssler, very closely resemble *causticum*. The cough is described as a short painful tickling from irritation in the windpipe. Spasmodic cough with involuntary emission of urine. Hard dry cough with soreness in the lungs. Hoarseness and loss of voice, irritation and pain in the larynx.

Several other medicines I might have mentioned, but I have restricted myself to those which I have used more or less, and I think I have said enough to elicit a good deal of discussion.

In closing, I should like to express a wish that those gentlemen who take part in this discussion will not say "I have found *senega* a good medicine for nervous coughs" or some other medicine, but will give us the indications for the medicines. It is of the utmost importance to know the exact indications which we may expect a drug to relieve.

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Dr. HUGHES (in the chair) said Dr. MacNish had suggested that the success of *nux vomica* in curing a troublesome cough was probably because of its action on the stomach, but *nux vom.* had a great relation to all coughs and other spasmodic phenomena dependent on reflex irritation. For instance, the vomiting of pregnancy was a good illustration of the value of *nux vom.* It there controlled the reflex circuit from the uterus to the spine, and acted similarly here upon the respiratory organs on which the cough depended. He thought *drosera*, used without sprays, would give very good results. It would not do to limit it to the first decimal dilution; nearly all the brilliant results obtained with *drosera*, from Hahnemann downwards, had been from the medium or higher dilutions. Dr. Jousset, who had published over a hundred cases illustrating its value, pointed out that the dilutions were preferable to the mother tincture. His (Dr. Hughes') own experience with whooping cough had been very encouraging. He expected a case of whooping cough to have about a fortnight's ordinary cough, about four weeks in the spasmodic stage, and perhaps another fortnight for the decline. At the end of that time there was very little trace of cough. He agreed that *coccus cacti* and *corallium*, when indicated, would act more vigorously than *drosera*, but as a standing remedy, if no other was indicated, *drosera* in medium dilutions might be used with great advantage. Mr. Johnstone had mentioned a good many rather surprising effects of drugs, among others that *ambra* caused hypertrophy of the uterus with menorrhagia. He strongly suspected that he founded that statement on the many apocryphal symptomatologies abounding in homoeopathic literature.

Mr. JOHNSTONE said it was found in Farrington.

Dr. HUGHES said Farrington's was a "Clinical Materia Medica," and not limited to pathogenetic effects. He agreed with Dr. MacNish that one should not treat coughs, but the pathological condition on which the cough depended. That was a counsel of perfection, but as very often that pathological condition could not be found, the cough had to be treated itself. Where cough occurred with undue frequency, undue violence, or greatly disturbed the patient at night, cough medicines had to be used. In such cases he had found the following medicines of benefit. When the cough was either violent, spasmodic, or convulsive, if it was moist, *ipecacuanha* or *coccus cacti*; if it was dry, *corallium* or *nux vom.*, according to the special indications. If its frequency was the morbid condition desired to be reduced, then *corallium*, *rumex*, or *senega*. If the recurrence of the cough at night was

the great trouble, hyoscyamus, if dry; pulsatilla was simply invaluable where a loose cough was troublesome at night.

Dr. DYCÈ BROWN said nitric acid was one of the most valuable medicines in pulmonary diseases, including bronchitis, pneumonia, and phthisis. After the acute stage of bronchitis, nitric acid acted most beautifully in removing the remains of the cough, diminishing the expectoration, and removing the general lassitude and weakness and want of appetite. Also after the acute stage of pneumonia, where the convalescence was tedious and the patient was exceedingly weak, and where there was a fear, from a slight rise of temperature at night, that there might be mischief of a serious kind brewing, he found nitric acid cleared up the case directly. In phthisis it was equally of value in the more chronic cases, where the temperature rose slightly at night and the patient was losing appetite. To get the full benefit of the nitric acid it should be given in the first or second decimal dilution, the second decimal, in doses of three to five drops, answering beautifully. Quite as often he gave the first decimal in doses of two to three drops three times a day. Hyoscyamus given at night acted like a charm in removing the tickling cough so often found in convalescence. He had been always most successful with drosera in whooping cough, and he thought Dr. MacNish's failures were due to the dilutions used. The twelfth dilution acted beautifully. Often when 1x, 2x, or 3x had had no effect, a change to 12 would immediately produce a difference. Drosera he considered to be one of the most reliable medicines we had. When the drosera stage was over, veratrum album, cuprum and nitric acid were of great value, the indications being well known and reliable. He expected a case of whooping cough to be round the corner in a fortnight, and practically well in three weeks or a month. There was no doubt a stomach cough, but they were mostly cases of catarrh of the stomach. In every stomach cough the pharynx would be found to show catarrhal symptoms, the whole of the back of the pharynx red and relaxed, with large follicles, and that condition of the mucous membrane was present in the stomach also. The tongue was also generally coated and the appetite poor. The medicine he found of greatest use in such cases was first, biniodide of mercury, with one dose of belladonna at night, the biniodide of mercury being given three times a day. After the main stage was over, lycopodium was of much value, and nitric acid was of use in finishing up.

Dr. GOLDSBROUGH did not, as a rule, use drosera in the higher dilutions, but in the 1x, or a few drop doses of the mother tinc-

ture. If *drosera* did not have any effect in about a week he usually turned to some other medicines. Of these cuprum was the first in importance, and the indications for it were a particularly dry spasmodic condition of the cough, especially if accompanied with a tendency to cyanosis and hæmorrhage. He regarded six weeks from the commencement of the cough as about the limit of expectation for the patient to recover—a fortnight preliminary to the onset of the whoop, a fortnight's bad whooping, and a fortnight for convalescence. His late colleague, Mr. Harris, when his children were suffering from a severe attack of whooping cough, turned on the gas in the room in which they were living, and it certainly seemed to moderate the cough very much. He (Dr. Goldsbrough) had given *strophanthus* on one or two occasions in the out-patient department, in cases of severe cough with bronchial catarrh as a result of weakened action of the heart. He suggested that where a case was troublesome the heart should be looked to with regard to the possible use of *strophanthus*. Nitric acid was also useful when the cough was aggravated by lying down at night. In the barking cough of puberty he (Dr. Goldsbrough) had found *pulsatilla* of service, and in coughs of a decidedly paroxysmal nature, *rumex*. Nothing had been said about coughs in pregnancy. His experience was that if a patient contracted a cold in pregnancy, it was extremely difficult to get rid of. He had found *sepia* of use in the early months and *pulsatilla* and *nux vom.* in the later, but certainly not with as satisfactory results as could be wished. He had found a gargle of sulphurous acid useful in cases of large or congested uvula, and also *hepar sulph.* Nervous coughs, he thought, were very much under the control of the will, and that they also arose readily from suggestion. *Drosera* was a valuable remedy in coughs of a spasmodic character, of nervous origin, resembling whooping cough.

Dr. ROBERSON DAY generally gave *drosera* in the 1x dilution or the third, and he always prescribed glycerine with it, which he found distinctly an advantage. He considered succinic acid to be distinctly homœopathic to the suffocative cough of whooping cough. He had used it with great advantage applied locally in the form of a liniment made up as follows:—Oil of amber ʒij., oil of cloves ʒij., and olive oil ʒss. He thought it was almost impossible to state the duration of whooping cough, because the disease varied immensely in severity. Sometimes there was only one whoop, and sometimes no whoop at all, during the whole course of the disease. At other times the whoop would persist

for months, and go on long after al infection had ceased; and whenever the patient had an ordinary cold, the nervous system having acquired the habit of whooping, the whoop would repeat itself, even after an interval of more than a year.

Dr. VINCENT GREEN spoke on the subject of reflex coughs. It would not do only to examine the ear, but the meatus should also be examined with a probe, as sometimes a sensitive spot was present which was the cause of the cough. In that case a solution of 5 per cent. of menthol in olive oil would very often cure the case. Mr. Johnstone had mentioned that the afferent path for the coughing centre was in the vagus. He did not know whether Mr. Johnstone meant that it was in no other nerve, because in the nose, which was not supplied by the vagus, a cough was sometimes produced reflexly, and when examining the nose for a cause it was always advisable to touch the mucosa with a probe, as sometimes a sensitive spot might be found here which would give rise to a cough. Touching the sensitive area with chromic acid or a galvanic wire usually effected a cure. Another condition of the nose which sometimes produced a cough was catarrh of the upper turbinated bones, the fluid trickling down into the larynx and falling on the inter-arytenoid fold, which was the most sensitive part of the larynx, and irritation of which invariably caused coughing. Gouty pharyngitis was another condition producing a cough. When the pillars of the fauces were of a dull fiery red, perhaps a little bluish, guaiacum in low dilutions had an almost magical effect. In studying the etiology of coughs, it should not be forgotten that sometimes the earliest symptom in locomotor ataxia was a cough.

Dr. DUDGEON said it would be a very great advantage to be able to attack the anatomical seats of different coughs, but in practice it was not always possible, and the only course was the original plan of Hahnemann of seeking the corresponding symptoms in the *Materia Medica* as a guide to the best cough medicines. He believed that the *Materia Medica* would furnish more hints for the treatment of the cough than any pathological or physiological theories respecting its cause. Sometimes a cough was readily curable by one remedy which would fail to touch an apparently similar cough in another patient.

Dr. NEWBERY found naphthaline in trituration or in tablets valuable in all stages of whooping cough. As soon as any suspicion arose that a child had been infected with whooping cough he began with a tablet of naphthaline immediately after each fit of coughing, using the second decimal, unless it was

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a very young child, when he gave the third. He generally finished up with sulphur, which not only prevented the frequent recurrences of the cough, but obviated also the recurrence one was apt to meet at the same season for two or three successive years afterwards. Another remedy for breaking up the peculiar spasmodic character of the whooping cough was bromide of potassium.

Dr. GALLEY BLACKLEY said: As a means of giving relief in whooping cough, *drosera* was only one out of a good many drugs which were useful. The circumstances and surroundings of the patient accounted for a very great deal in the matter of the success of treatment, and accounted for such differences in the duration as the six weeks mentioned by Dr. Dyce Brown and the six months mentioned by others. He himself had seen a case lasting eighteen months, but that was in very poor patients in the poorest of surroundings. He did not think homœopathically chosen drugs had any influence upon the actual progress of the disease. He believed whooping cough behaved like all other specific infections, and the most that could be done was to treat symptoms as they arose, and surround the patient with all the hygienic means that will conduce to recovery. He suggested that Dr. Newbery's reference to naphthaline was very much the same in principle as the turning on of the gas in the bedroom, mentioned by Dr. Goldsbrough, because gas contained a large quantity of free naphthaline. He had tried during the last three years spraying a dilute solution of formalin about the bedroom, and he certainly thought it had relieved the paroxysms, but of course it was not homœopathy.

Mr. JOHNSTONE, in replying, said it was certainly the fact that the *Cyclopædia of Drug Pathogenesis* said nothing about the wonderful effects of *ambra* in causing uterine abnormalities, but he had seen it in homœopathic print and put it down for what it was worth. With regard to the question of *drosera*, he had tried it both high and low on a case of whooping cough which had lasted for eight months, but the cough still remained. With reference to reflex cough from the nose, there was a direct communication between the fifth nerve and the jugular ganglion of the vagus, so that probably the stimulus passed up the fifth nerve as far as the ganglion and so affected the respiratory centre. In answer to Dr. Dudgeon, he did not think the anatomy and pathology of disease could be done away with. Things must be looked straight in the face, and with a germ disease such as erysipelas and typhoid, one must not expect to do much more than modify and relieve the symptoms by the use of medicine.

Dr. LAMBERT also replied, joining issue with Dr. Hughes and Dr. MacNish with regard to treating a cough, because people very often from apparently the same causes got an infinite variety of different coughs, and if those cases were to be treated homœopathically, the peculiarities of the different coughs must be taken into account, and in his opinion it was just the minute indications thus obtained which were of the greatest value in hitting on the simillimum of any particular case. He would by no means ignore pathology. If a particular cough was produced by a reflex, that at once gave a second symptom and limited the choice of medicines. He had found arnica of use in whooping cough. A very valuable indication for arnica was the crying of the child before the cough came on, due to the painful nature of the cough. He had also found coccus cacti very useful. He mentioned the case of a lady of 45 or 50, who, a year ago, had an attack of whooping cough, and afterwards had an attack of coughing every morning with a distinct whoop, and bringing up thick phlegm. He gave her coccus cacti 6, and in three or four days the cough was completely cured. He had seen a case diagnosed as one of commencing whooping cough completely cured by coccus cacti. He agreed with Dr. Dudgeon that better results were obtained by treating coughs by symptomatic indications than by going into the pathology of the case.

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## MEDICINES OF USE IN SEPTIC CONDITIONS, WITH ESPECIAL REFERENCE TO ULCERA- TIVE ENDOCARDITIS.

BY BYRES MOIR, M.D.

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UNTIL recent years the majority of septic cases were to be found on the surgical side of a hospital, but in consequence of the revolution that has taken place in surgical treatment that is not the case now, and certainly in this hospital few, if any, septic cases are seen on the surgical side.

We still see a great many on the medical side and the question arises, What can be done for septic cases by medicines when there is no question of surgical interference?

The condition which I wish to bring before you this evening, more especially, is infectious or ulcerative endocarditis, which is a true *septicæmia*; and by septicæmia I mean a disorder caused by the entrance of living micro-organisms into the body, and their growth and multiplication therein. The poison is being continually produced inside the body. In *sapræmia*, on the other hand, the poison is produced in the wound, that is to say, outside the body, and is absorbed from that part, and by removal of the original source of infection the disease will as a rule come to a favourable termination.

Ulcerative endocarditis is often, though not always, *pyæmic*, that is, secondary abscesses are formed by septic emboli in which living pyogenetic micro-organisms are carried to various parts of the body. We have then in ulcerative endocarditis a growth of micro-organisms on the valves, and a general infection of the system in consequence.

The most commonly found organisms are the staphylococcus pyogenes aureus, the streptococcus pyogenes, and the diplococcus pneumoniae. The bacilli of tubercle, of diphtheria, and of typhoid fever, as well as the diplococcus of gonorrhoea, have also been found associated with the pyogenetic organisms.

Many cases run their course without there being true pyæmia, and this must depend upon the character of the micro-organisms present. More work will have to be done in deciding the symptoms due to different micro-organisms, if the serum treatment is to be made effectual; for it is evident that though some few cases have benefited from the anti-streptococcic serum, the failures have been many, and it may be that it will only be of use where the streptococcus is alone present, and not where there is a mixture of several toxins.

The first case which I will mention is that of a man aged 36, who had, as we see in very many of these cases of ulcerative endocarditis, already got damaged valves from a



previous attack of rheumatic fever. The temperature chart begins on June 30, 1897, and ends with the death of the patient on February 16 last. Even that is not all, because there was a history of at least two months' feverishness before he was laid up at all. During the whole of the time from June 30 till February 16, there has not been a normal temperature for twenty-four hours. One of the most striking points in this case, I think, is the comparatively few symptoms. Time after time I saw this case, he was lying in bed, and you could not tell he was suffering; he looked well, he did not lose much flesh, and one would not think at first that there was much the matter. His breathing was not altered, and it was not till you took the temperature and examined the heart that you could tell how ill the patient really was. Later on, of course, there is no difficulty, there is evidence of infarcts in the spleen, kidneys, and other organs, causing a great deal of pain, and near the termination of the case there are often convulsions. There was no evidence in this case of the source of infection, but there was a clear history of his having had rheumatic fever. I did not see him till late in the case, after he had been under numerous doctors. The only way in which I can account for it is that a few weeks before his acute illness began he had been yachting, and had been lying in Margate harbour. Anybody who has been in that harbour knows there is a good deal of sewage pollution about, and he may have got some of the germs in that way. I will refer to the treatment which was adopted in that case later on. (To show the frequency with which these cases may be met, and the actual lesions which have to be treated, two specimens were exhibited from patients admitted into the hospital in the same week. One was the heart from the first case, showing where the aortic valves were affected.)

On March 9 of this year a man of 45 was admitted with a history of rheumatic fever, and probably there were damaged valves. Six weeks before admission he had had stricture, and had a silver catheter passed, which caused great pain and hæmorrhage, followed by a discharge. This was evidently the source of infection, and two weeks after

the catheterization there was a rigor and headache. Five days before admission there was plugging by embolism of the right femoral artery. Here is a case where you can distinctly point to the cause of the mischief. I believe there was a long shivering fit soon after the catheter was passed, and then the mischief set in with headache and feverishness. The heart symptoms were not marked. There was a systolic murmur, which was heard loudest at the apex, with an accentuated second sound at the base. On March 11, two days after admission, he had an attack of dyspnoea with cyanosis, and he died within five minutes. (The specimen showed that the embolism and the plugging was complete.) The whole leg was becoming gangrenous. There was no evidence to point to any such grave cardiac mischief as that from which the man was suffering at the time. (The largest nodule in the valve has been cut across, so that you can see the size of it. It must have been a very rapid growth.) A large embolus was found in the right femoral artery extending down as far as the origin of the profunda artery, evidently derived from the vegetations on the aortic valve. In the spleen there was a very large hæmorrhagic infarct partly broken down into a pulp.

The next case is that of a woman of 23, without any previous history of illness till this attack set in. She was evidently moribund at the time of admission, and lived for five days in the hospital. She gave a history of three weeks' illness, but beyond a mitral systolic murmur there was nothing to point to the nature of the disease from which she was suffering, as her collapsed condition resembled more the end of a case of typhus. At the *post-mortem* infarcts were found in the kidney and spleen. (The state of the mitral valve can be seen in the specimen.)

I will now give a few notes of the case of a boy I had waiting here to be examined, but it was so late that I sent him away, but passed round the chart which was taken whilst he was in the hospital. He is 14 years of age, and was an in-patient last year from March 16 to October 2. The abstract of his case is as follows:—Mitral obstruction and incompetence, with some pericarditis, accompanied for

months by a hectic temperature. There was marked anæmia with leucocytosis. For a time there was general anasarca and extreme ascites. He was tapped three times, and his condition improved wonderfully, and the temperature became normal. On admission the murmur was presystolic, a systolic bruit at the apex was next heard, and another one in the tricuspid area. The heart showed great hypertrophy. The medicines which appeared to benefit most were spigelia, strophanthus and naja. The boy is now able to go out in all weathers, and does not seem to suffer. There is a considerable enlargement of the heart, and of course the question comes whether it really was the infective form or not. From the temperature chart I certainly came to this conclusion, and lectured upon the case, in this place, last year, as an instructive case of ulcerative endocarditis; but when you see him cured you begin to doubt, and I wonder now whether it really was so. Certainly I cannot account for the condition of the heart in any other way; he has still a very hypertrophied heart. The temperature is not the temperature of pericarditis, and the boy has not got adherent pericardium. No simple endocarditis would have shown a similar temperature for that length of time, so that I came to the conclusion that it was a case of ulcerative endocarditis, which has been stopped.

The next case, in which I have to thank Dr. Epps for the use of his notes, has another rather alarming temperature chart, and was in this hospital last year. It is that of a girl, aged 18, who was admitted for acute rheumatism; but the state she developed certainly seemed to me to be that of infective endocarditis. A systolic murmur developed with very rapid pulse, profuse sweats, and rigors. In the temperature-chart you will notice a sudden fall of temperature on July 29, with rise of pulse. She became suddenly worse, the pulse rose to 240, there was dyspnœa and cyanosis, with complete collapse. The temperature fell to 95°, she had four rigors, and her condition appeared absolutely hopeless. Strophanthus, 2 m. every two hours, was given, and caused wonderful relief. She went out in three-and-a-half months nearly well. The

medicines given were strophanthus, arsenic, and naja 6. (In the first chart I showed you you will see at the end that the temperature goes down gradually, and from looking at the temperature alone you might have hopes that the case was improving, but at the same time the pulse went up steadily, and when you get the two lines separate, the temperature going down and the pulse going up, you may be sure there is trouble before you.) In this case of Dr. Epps' I should have said that there was no hope whatever. With a pulse of 240 and a temperature falling rapidly to 95°, anybody would give the case up at once. But there she is, and Dr. Epps can give an account of how she is at the present time.

Now, with regard to treatment. When first I began studying these cases I had a good many in the hospital, and I wrote to Dr. Hughes to ask what he considered were the best remedies for this state. He suggested aconite, the ordinary mother tincture, or the arseniate of quinine, and I gave them a fair trial in many cases. Aconite certainly has many of the symptoms; even in the provings it produced vegetations on the valves of animals where it was given, but I consider that it will only meet a simple, or somewhat simple, endocarditis, and not a true infective one. In only one case, that was of the infective form, did it seem of much use; the patient went out apparently cured, and died a year or two afterwards from a second attack. At the *post-mortem*, on the wall of the left auricle there was a large scar, that looked like the result of the old ulceration which had healed over. I have tried aconite in many other cases, but have seen no results since, and from the arseniate of quinine I have derived no benefit at all.

Of late years, the anti-toxins have been largely tried. The anti-streptococcic serum has certainly answered in puerperal conditions, but has failed in most of the cases of infective endocarditis. One or two cases have been reported as cured, but it is quite exceptional to get any improvement with it. In the first case I mentioned, five or six injections of anti-streptococcic serum were given, but it had not the slightest effect on the temperature or the

general condition. Another remedy which is very much used in America in all septic conditions is nuclein, or nucleinic acid. In this form it is prepared from a sterilised yeast extract, and the view taken is that it increases the natural resistance to disease by giving to the blood a germicidal element, corresponding to the nuclein of the white corpuscles. Its power to cause leucocytosis has been proved by experiment. Nuclein contains a high percentage of phosphorus. In the first case nuclein was used hypodermically, and the temperature fell while it was being used, but the case had gone on too long to expect anything but a fatal issue. With regard to leucocytosis, it would certainly be a very favourable condition to have, if the cells attack the germs in the blood, and so overcome them. There was well marked leucocytosis in the boy who was here to-night. He had a perfectly white, blanched condition, and it was during that time that the improvement took place. Nuclein might help us in that direction.

The other medicines which I have turned to of late have been among the snake poisons; and there, I think, we have much more hope of doing good than from anything else. With regard to lachesis in septic conditions, we now know the use of it in poisoned fingers and wounds, and in infections spreading by the lymphatics. In these cases I have over and over again convinced myself of the use of lachesis. *Crotalus* is another medicine which I have seen used in septic conditions. In both of the cases which got better, the two medicines which did most good have been *strophanthus* and *naja*. The boy has been taking *naja* for some time, and seems to do well under it. Now comes a difficulty, how are we to diagnose this state in the early stage? Have we got a simple endocarditis, or the ulcerative form, to deal with? The blood does not, in most cases, show any indication. In several of the cases we have had the blood carefully examined for micro-organisms, and I do not think in any case they have been detected. Now and then you can find the streptococcus, but this is rare. When the mischief to the valves is going on, a few weeks may cause great destruction. And in the early stage it is not easy to say that the case is really of the infective form.

Dr. EPPS said, with regard to the case of his mentioned by Dr. Moir, that it was nine months now since she left the hospital, and that she was still living and had been fairly well.

Dr. CARFRAE asked if Dr. Moir would state the dose of snake poison which he had given. He thought these remedies were comparatively inert when taken into the stomach, and should be used subcutaneously.

Dr. GALLEY BLACKLEY said that nuclein caused a very acute leucocytosis, but it was quite a novel suggestion that it might be made definite use of in trying to get the upper hand of some of those septic conditions. One's feeling was that leucocytosis produced by a drug would probably not be of much service, but of course it might prove to be otherwise, and if that were so, there might be something in "phagocytosis" after all.

Mr. DUDLEY WRIGHT said it had been shown by Professor Fraser, of Edinburgh, that the snake poisons, when taken into the body, were acted upon by the bile when they got into the alimentary tract, and that the bile was an antidote, or there were certain substances in the bile which were antidotes, for the snake poisons. It was quite possible that the harmlessness of the poison, when swallowed, was due to the fact that before it could be absorbed it was acted upon by those various antidotal substances contained in the bile. He asked, Might not the various methods of dilution, by which they prepared tinctures, enable the stomach to absorb those poisons before they had got so far as the duodenum and so be acted upon by the bile? because clinical experience taught one that the snake poisons did have a beneficial effect upon certain conditions of the body. He had always looked forward to the time when they would, by means of demonstrating the particular form of germ which was causing any disease, and by predicating the exact symptoms which were likely to occur in that particular disease, be able to select a drug which was likely to be an antidote of the poison produced by those special germs. For instance, they knew that erysipelas and cellulitis were produced by streptococci; they knew that certain conditions of the lungs were the outcome of the pneumococcus infection; and if they could say that a particular disease was caused by one of those particular germs of which he was speaking, and knew that a certain drug had a particular action for the poisons of those particular germs, he thought they would be a long way on the road to cure cases as they occurred.

Dr. EDWIN A. NEATBY (the President) asked Dr. Moir if he had had any experience of giving, not the anti-toxin, but the

toxin, in infinitesimal doses in cases of that kind, or if he had any opinion as to the probabilities of the usefulness of such a method. It seemed to him that if they got to know the particular germ which was acting, they ought to get a more truly homœopathic action in that way than by giving the anti-toxin.

Dr. MOIR, in reply, said with regard to the doses of snake poisons and the way they acted, he had written to Dr. Hayward, of Liverpool, as being the greatest authority, and it was really through looking over his cases of malignant scarlet fever that made him consider the subject. They were the most striking cases which one could read. It was not till he put a blister on the neck and applied the medicine to the wound that the cases did so well. Dr. Hayward had said that there was no use in treating the cases hypodermically, they did just as well by the mouth. With regard to the dose of the snake poisons, the naja he used in the 6th dilution. He had used crotalus hypodermically. Dr. Hayward advised him to use it in the 3rd dilution mixed with a few drops of distilled water. With regard to nuclein, he had to thank Dr. Blackley for having drawn his attention to it. The Americans were using it very much in tuberculosis, and he believed it was well worth a fair trial. He had used it hypodermically in the case mentioned, and there was no question of the result. The old teaching on infective endocarditis was that one had pus forming in every case, but that was not so. There was no sign of pus about the cases he had mentioned. In other cases he had had abscesses all over the body. They must be due to different germs, and that was the reason why he believed there was often no result from the use of the anti-streptococcic serum.

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SIMPLE DYSPEPSIA.<sup>1</sup>

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THE subject of dyspepsia is a large and somewhat vague one, as it embraces symptoms arising from a great variety of causes, and denoting many different states. But as my paper is on simple dyspepsia, I can at once exclude all cases of organic disease such as malignant growths, ulcerations, &c., and also all cases secondary to such causes as kidney disease, or heart or lung complaints, and confine my attention to the class of cases which apparently arise from some functional disturbance of the normal physiological working of the digestive process.

It will be convenient, at the outset, to rapidly survey the principal facts in the physiology of digestion. The food, on being received in the mouth, is comminuted by the teeth and mixed, in the act of mastication, by the movements of the tongue and buccinator muscle together with the muscles moving the lower jaw, with the saliva, which is poured forth, partly under the stimulus of the smell and idea of food, and partly by the contact of the food in the mouth. The saliva comes from the parotid, submaxillary, and lingual glands. It is an alkaline fluid containing a diastatic ferment called ptyalin, mucin, probably traces of pepsin, serum albumen and globulin, and some earthy salts. The ptyalin is secreted principally by the parotid, the mucin by the submaxillary gland. The parotid is under the control of Jacobson's nerve and the sympathetic, the former principally stimulating the watery, the latter the solid constituents, including the ferment. The submaxillary is controlled by the chorda tympani, and here again the sympathetic fibres of the nerve are most concerned in the production of the mucin and ptyalin, while the cerebral fibres govern the watery secretion. The action

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of the saliva is to convert the starch in the food into maltose, but this action is only begun in the mouth. The alkaline saliva, mixed with the food, then passes down the oesophagus to the stomach, where it is a powerful stimulant of the gastric juice, the secretion of which is still further stimulated by the contact of the food and the muscular movements of the stomach walls. The food remains in the stomach, roughly speaking, about five hours, during which time, by the action of the gastric juice and the kneading movements of the stomach walls, it is converted into a perfectly liquid substance, the chyme. Small portions are, however, constantly passing the pylorus, or being absorbed as peptones through the stomach. The changes effected in the food in the stomach are—(1) the conversion of starch into sugar, begun in the mouth, is carried a stage further; (2) much of the proteid material is converted into peptones; (3) fat by the digestion of its cell walls is partly emulsified; and (4) milk is curdled. These changes take place by the agency of hydrochloric acid and the ferments, pepsin and rennet. The pepsin and rennet are fairly constant, but the amount of hydrochloric acid may vary considerably, being present in excess in all cases of hyperacidity, and generally in ulcer of the stomach, and deficient in catarrhal inflammation, carcinoma, anæmia, and neurasthenia. There are also a number of micro-organisms to be found in the stomach which give rise to fermentative action in the food, with production of gases, and of lactic, butyric and acetic acids, but they are kept in check by the action of the hydrochloric acid, which in the proportion of 0·07 per cent. of free acid arrests their action. All kinds of albumen have such an affinity for H.Cl. that, for the first forty minutes or so, they absorb all the free acid as fast as it is poured out, so that none can be detected in the stomach, and during this time it is normal for a certain amount of lactic acid fermentation to take place. After forty minutes free H.Cl. begins to appear and this process is checked. The contents of the stomach become more and more acid till they are poured out into the duodenum, when their acidity at once causes a secretion and outpouring of the biliary and pancreatic secretions in sufficient volume

to neutralise the acid chyme and to render it alkaline. In this alkaline medium the pancreatic ferment, the trypsin, does its work, converting albumens and proteids into alkali albumen, and eventually into peptones with the manufacture of some by-products, the chief of which are leucin, tyrosin, skatol, and indol. The fats are emulsified and saponified, and the conversion of the starch into sugar is completed. Absorption takes place principally in the large intestine, where the movement of the food onwards is slow. As a rule it takes from five to eight hours for food to pass from the stomach to the ileocæcal valve, but it takes sixteen hours to pass through the large intestine to the anus.

This is the normal process of digestion. A breakdown at any point may derange it all, and give rise to the various symptoms grouped under the name of dyspepsia. A deficiency or alteration in the saliva may produce nausea and want of appetite, and may reflexly interfere with the proper secretion of the gastric juice, which will in turn cause delayed digestion and give increased time for micro-organisms, always present in the stomach, to set up fermentative and putrefactive changes with the resulting symptoms of flatulence, heartburn and pain. Or there may be a deficiency in the biliary excretion; the acid chyme is not sufficiently neutralised, and the starchy elements of the food are not converted into sugar as they should be, but undergo fermentation with development of gases and the production of borborygmi, distension, colic, and diarrhoea or constipation. Or the same result may be obtained by atony of the muscular wall of the stomach, whereby its contents are not properly churned, and remain much longer in the stomach than they should do, and become over-acid, and by their irritation cause vomiting, or, if they pass into the intestines, set up secondary disturbance there.

The chief symptoms of dyspepsia are furred tongue, a bad taste in the mouth, alterations in appetite—whether simple want of appetite, loathing of food, or ravenous hunger, nausea, oppression of the chest, weight at epigastrium or a sinking there, various pains, flatulence, acidity, eructations, pyrosis, constipation or diarrhoea.

The state of the tongue is often taken as a rough guide to the condition of the stomach, and the character of the coating suggests to us the use of different remedies. The coating consists chiefly of epithelium with masses of micro-organisms, and depends on the state of the salivary secretion and on the kind of food taken, as well as the condition of the teeth. If the diet is soft or liquid the fur collects, and the coating is thick, white and creamy; if in addition there is much fever and diminished salivary secretion, the upper layers will become dried, brown, and hard, as with the typical typhoid tongue. If the food is solid and well masticated the fur is rubbed off; sometimes only on one side if the teeth on one side are bad and all the chewing is done on the other. A tongue with slight coating and easily indented edges, or a sodden-looking tongue, we associate with an atonic condition of the stomach; while one that is furred only in the middle with red edges and tip is a usual concomitant of an irritable condition. With regard to the medicines suggested by the appearance of the tongue—a thick, moist fur, creamy white in colour, indicates antimony; while a dryer tongue of the same character calls for pulsatilla, and a thin, white coating, through which the enlarged papillæ show, indicates belladonna. A yellowish stripe down the middle indicates hydrastis; a thickly coated, yellow-brown tongue, with red edges, kali bichrom.; a yellow coating to the base while the fore part is clean, nux vom. or mercurius iod. flav.; a dry tongue, brown down the centre, and shining red edges, baptisia; a dry, brown tongue, with a red, cracked tip, indicates lachesis; a coated tongue, with moist, clean tip, bryonia; the same, with a triangularly shaped red tip, rhus tox. A beefy red tongue, or a tongue with two brown or yellow streaks with red centre stripe and edges, indicates arsenicum; a white coating, with tendency to formation of black crusts, phosphorus. Mercurius sol. also has a thick moist coating, the upper layers tending to be blackened in patches. A mapped tongue suggests taraxacum or natrum mur. The sensation of a hair on the back part of the tongue is given as a reason for the administration of kali bichrom.; on the fore part, of silicea; indifferently,

of *natrum mur.* I have had cases which have confirmed these three indications.

Like all other symptoms, these appearances of the tongue must not be taken for more than they are worth, but they are valuable as far as they go.

The disagreeable taste in the mouth which often exists in dyspepsia may be due to decomposition of food set up by microbes which have their nidus in decayed teeth, or to regurgitation from the stomach, but also to substances secreted in the saliva. A bitter taste may not be, and probably in most cases is not, due to the presence of bile in the mouth; many bitter substances are formed during digestion, as we may see from the bitter taste of milk which has been over-peptonised artificially, and these are absorbed by the alimentary tract, and may sometimes be secreted in the saliva, and so give rise to a bitter taste in the mouth.

The indications for medicines arising from altered taste are not very distinctive. *Pulsatilla* has under its pathogenesis a foul, putrid taste, a bitter taste, a taste of food eaten; also food tastes too salt, and there is a flow of sweetish saliva in the mouth. *Antimonium crudum* has much saltish saliva in the mouth; *nux vomica* a sour taste, and so on; but I do not think much importance can be attached to the taste, or that much aid can be derived from it in the selection of remedies for dyspepsia.

The appetite seems to be associated with the condition of the circulation in the stomach, which stimulates the gastric nerves, giving rise to a sensation which may be compared to a tickling of the skin. A craving appetite is associated with a red and irritable mucous membrane, and when the circulation through the stomach is slow and obstructed, as in portal obstruction, appetite fails. Many substances which stimulate the capillary circulation of the stomach promote appetite, such as the various condiments, dilute alcohol, and minute doses of arsenic. If given in too great a quantity so much irritation is set up as to cause nausea and vomiting. In dyspepsia we may have a craving appetite, a loss of appetite, or a depraved appetite. It is important to remember that poisons manufactured in the

intestines may be excreted by the stomach, and their presence there may disorder the appetite.

The abnormal cravings arising from disordered digestion, the aversions and increased or diminished appetite, are symptomatic of many different drugs, with a list of which I need not weary you: they may be found in any repertory. I will merely state a few which I can confirm from my own experience. The craving appetite in the middle of the night, of cinchona, and that in the evening preventing sleep, of ignatia, I have met. We must have all of us noticed the hunger, twenty-four hours or so before an acute bilious attack, of nux vomica. I can confirm the value of a desire for eggs as an indication for calcarea, of a wish for food to be cold, for phosphorus and silicea, and of an aversion for milk, for pulsatilla. The desire for cold drinks, little and often, is a leading key-note for arsenicum, and an equally valuable key-note for bryonia is a desire for large quantities of fluid, preferably warm.

Vomiting, which is a frequent accompaniment of dyspepsia, is effected by a squeezing of the stomach between the diaphragm and the abdominal walls, with at the same time a dilatation of the cardiac sphincter; if the sphincter remains closed retching only is produced. The nerve centre which governs these movements is situated in the medulla oblongata, in close association with the respiratory centre. It may be stimulated directly by poisons which act on it, as apomorphia, or tartar emetic, but more commonly reflexly by irritation starting from the brain or various parts of the body. The vomiting of dyspepsia is usually reflex from irritation of the stomach, either on account of the food being too large in quantity or of its having by decomposition developed in the stomach irritating products, as may be the case in tainted meat or over-ripe fruit, or as may happen if food is delayed too long in the stomach, as when the food is not sufficiently comminuted, or when there is obstruction of the pylorus. Dr. Lauder Brunton thinks that in cases of migraine there is a transient condition of dilatation of the stomach with contraction of the pylorus, whereby the food is detained in the stomach and

undergoes decomposition with formation of irritating products and the consequent vomiting which often ends the attack. The mucous membrane itself may be hyperæsthetic, and so the stomach too easily induced to reject its contents. In alcoholics an irritable state of the stomach is produced, which causes the morning vomiting—the vomited matter being principally ropy masses of glairy mucus, which are really the saliva that has been swallowed and coagulated by the acetic acid fermentation which goes on in the stomachs of these people. The number of drugs which cause vomiting is legion. One class seems to act by irritating and inflaming the mucous membrane, as arsenic, argentum nit., kali bichrom.; another by altering the secretions and so causing food to be imperfectly digested and to ferment, as pulsatilla, antimonium crud., and bryonia. Another class irritates the vomiting centre direct, as antimonium tart., apomorphia, veratrum album, and digitalis; and yet another appears to favour vomiting by rendering the muscular apparatus more irritable, as nux and ipecacuanha. These divisions are meant merely as types to which some medicines appear to more closely conform than others, but in most cases the action of our drugs cannot be limited to any one division, but overlaps the others. As an instance of the irritable or inflamed mucous membrane class, I will mention a case, that of A. M., a housemaid, aged 18, who on the morning of October 22, 1897, felt quite well, but after a meal of fish and pudding at 12 o'clock, was suddenly seized with a dull pain across the lower part of the stomach and upper part of the abdomen, and vomited her dinner. From that time she continued to vomit everything she took immediately it reached the stomach for five days, though she kept at work. When I saw her on the fifth day she felt weak, was slightly, but not excessively, anæmic, was in no pain, but tender at the epigastrium, and the tongue was red and irritable. She was sent to bed, and given argentum nit. 3x in two-drop doses every three hours. After the first dose she never vomited again, and in three days was up and able to take her usual food.

Typical of those cases where the vomiting centre seems to be unduly irritable was that of H. C., a young married lady, two to three months pregnant with her first child, who suffered from constant nausea and frequent vomiting of food. The tongue was clean, and the vomiting could be staved off to some extent by keeping her lying perfectly still, but if she began to move it would come on at once; suddenly and without effort the last meal would be thrown back. After various drugs had been tried and failed, apomorphia 3x cured.

We next come to the symptoms of oppression and pain, so common and for which as a rule the patients come to consult us. The feeling of oppression is largely due to depressed cardiac action, caused by a flatulently distended stomach, and is referred usually to the sternal and cardiac areas. But as well as this local oppression, there is often a general oppression, a sense of heaviness and prostration, often of sleepiness, which is probably due to the absorption of ptomaines or other injurious products into the general circulation. This general oppression is a marked indication for nux, bryonia, or lycopodium, and if sleepiness is prominent, for the two latter medicines.

The pain usually has its seat above the umbilicus in a lozenge shaped area, the four corners of which are situated at the ensiform cartilage, the umbilicus, and the rounded lower margin of the costal cartilages; but it may extend into the hypochondriac regions, and is very often situated over the lower end of the sternum, whence it less often radiates to between the shoulders or to the left shoulder-blade. Pain at the nape of the neck or down one of the arms may be an accompaniment, but can hardly be considered as an extension of the principal focus of pain, but rather as an associated symptom like pain over the eye or in the calf.

The pain is of various kinds. It may be burning, due to great acidity of the gastric contents; the burning is usually felt at the cardiac orifice and referred to the cardiac region or lower portion of the sternum. It is perhaps caused by the acid fluid irritating the lower end of the œsophagus, being brought

into contact with it, either by regurgitation, or by a relaxed oesophageal membrane protruding into the stomach through the cardiac orifice. The hyperacidity is not often due to excess of hydrochloric acid, though that may sometimes occur, but more generally to the presence of organic acids, lactic and butyric, from fermentation of food.

There may also be an epigastric and stomach burning from a cause which can hardly be included amongst the dyspepsias, although allied, in the condition known as gastralgia. This burning does not have much relation to the digestion of food and is usually associated with nervous depression. A case of this kind once made a great impression on my mind, as I met with it at the time when I was first beginning to consider homœopathy. It was the case of a middle-aged man, a labourer, who had worked hard. For several weeks he had had attacks of severe burning pain, quite agonising while it lasted, the pain being referred to the lower end of the sternum and the epigastrium. Food made very little difference, but he sometimes vomited, more I think from severity of pain than because the food disagreed. I was assistant to an old school practitioner, and all the usual dyspeptic remedies had been given to no purpose. I had shortly before obtained Hughes' "Pharmacodynamics" and had recently been reading the article on arsenicum, and it occurred to me that here was a good chance to test the value of arsenic in a case which seemed to be suitable. So I put two drops of liq. arsenicalis into an eight-ounce bottle of water with a little infusion of calumba, with directions that a table-spoonful was to be taken every three hours. On visiting him again next day I found that he had had no more attacks of pain, and they did not recur.

The pain in dyspepsia is often that of an aching soreness, suggesting *pulsatilla* or *antimonium crudum*; or of a heavy weight, as in *bryonia*; or spasmodic and cramp-like as with *nux*, or a sharp cutting stitch as with *argentum nit.* A common symptom is a sinking at the epigastrium, and this is a characteristic of many drugs—*ignatia*, *hydrastis*, *sepia*, *baptisia*, *actea*, *phosphorus*, *sulphur*, *petroleum*, *pulsatilla*, and *viburnum*.



In many forms of dyspepsia or gastralgia the pain in the stomach is relieved by food—this is the case usually when there is hyperacidity, the fresh food for the time neutralising the acid secretion. But the pain is often a gnawing, craving pain, and is relieved when something is given to the stomach to work upon. Some drugs also have this symptom.

With *anacardium* the symptoms disappear during dinner and appear again after two hours. With *pulsatilla* there is weight as from a stone an hour after eating, relieved by eating again. *Graphites*, *petroleum*, *chelidonium* and *ignatia* are all useful for gastralgia relieved by eating. I have also met with this symptom in a case of mitral and aortic regurgitation in a heart damaged by rheumatism, but with good compensation. An acute, painful, hungry feeling would come on after any slight exertion, immediately relieved by a little food or in a longer time by lying down. A drop dose of *digitalis* would relieve this symptom for several days. This case shows how the sense of hunger is associated with the condition of the gastric circulation, the painful hungry feeling being doubtless due to slight temporary congestion from embarrassed cardiac action.

Pyrosis, or waterbrash, is a common symptom of dyspepsia. Gastric irritation gives rise reflexly to increased secretion of saliva, which either runs from the mouth, or is swallowed and collects in the lower part of the œsophagus till expelled, at least, it probably collects there when it is tasteless, as it very often is; but when it is acid or burning it, perhaps, is swallowed into the stomach before being regurgitated. We have all tested the value of *nux* in tasteless or sour pyrosis, and *pulsatilla* in that which tastes of the food taken. I can confirm the indication for *phosphorus* when portions of the food are regurgitated.

Flatulence is due to an increased amount of gas in the stomach; this may be due to increased ingestion of gas, or it may be manufactured on the spot. A small quantity of air is swallowed with the food. A good deal of air is swallowed with saliva, so that when irritation of the stomach leads to frequent swallowing of saliva a large quantity may be

collected in the stomach. This air when not again brought up is partially absorbed, the oxygen especially leaving nitrogen in the stomach and intestines. A more frequent and prolific source of wind is decomposition of the food, especially of the carbo-hydrates, which gives rise to the formation of marsh-gas. Both sugars and starches give rise to this, but it is produced in larger quantities still from cellulose, so that vegetables and fruit are apt to cause flatulence. When sulphur is present, as it is in cabbage and most of the cruciferæ and in eggs, sulphuretted hydrogen may be formed. The gases when formed mainly in the stomach give rise to belching and eructations, when in the intestines, to borborygmi, colic, distension, and probably constipation.

The quantity of wind apparently belched forth by some patients is enormous, and seems out of all proportion to the possibility of its manufacture. But I think it is a case of "much cry and little wool," and is caused by the rapid swallowing and belching again of air by œsophageal movements under the influence of a disordered nervous system. There is no doubt, too, that borborygmi are largely under nervous influence. Some women can produce them at will. One hysterical patient of mine used to produce the most extraordinary noises in the intestines and greatly alarmed her friends; but when I explained to them in her presence that they were of no consequence whatever, and did not indicate any disease of the stomach, they quickly ceased. I have a patient at the present time suffering from dyspepsia, and in whom borborygmi are a troublesome symptom, but they occur only at those times when she especially wishes to avoid them, such as when she is at church or the theatre, or at a dinner party.

There are a great number of medicines useful for flatulence, but six stand out pre-eminently, viz: Carbo veg., bryonia, lycopodium, china, argentum nit., and nux vomica. It will be useful to differentiate a little between them.

With carbo vegetabilis there is much distension and full feeling, so much so that the stomach feels very heavy and as if hanging down, and the abdomen full and bursting. The

flatulence seems equally distributed to stomach and bowels, and large quantities of flatus are passed both upwards and downwards, without effort and with relief; there is not usually much colic or pain—the flatulence does not by its presence excite painful spasmodic action in the gastro-intestinal muscular walls.

With china, the bloated, distended feeling of the stomach is accompanied by eructations which are bitter, or taste of food, and by belching, which does not relieve; and there are spasmodic constrictive pains in the abdomen. The bloated feeling is relieved by motion (the reverse of bryonia). China is especially useful in cases caused by excessive tea drinking, or by depletion of the system, and the spasmodic pains are usually worse at night. It seems to be more related to an exhausted nervous system than the other flatulent remedies.

With *argentum nitricum* the flatulence is mainly confined to the stomach; there is belching after every meal, but it occurs with difficulty, as though there were a resistance to be overcome at the cardiac orifice, which is finally overpowered with the discharge of flatus in large volumes and with great violence.

With bryonia there is much distension and great sensitiveness of the abdomen, confined mostly to the upper part; there are stitches and other pains, which hinder respiration; the symptoms are worse from any movement, however slight; hiccough and eructations come on immediately after food; the eructations relieve.

With *lycopodium* there is not much flatulence in the stomach, but a great deal in the intestines, especially in the colon. It becomes incarcerated, and causes pressure upwards on the diaphragm, with a sensation as if a cord were tied round the waist, and downwards on the rectum and bladder. There is much rumbling of wind in the splenic flexure of the colon, and great fermentation in the abdomen, with rumbling and croaking, colic, and a discharge of quantities of flatus per anum. It is on the whole our most useful remedy for intestinal flatulence.

With *nux vomica*, the epigastrium becomes bloated, but not till two or three hours after a meal, and there is a

pressure as of a stone there ; there is also some pressure under the short ribs. There may be a good deal of spasmodic colic and pressure downwards and ineffectual urging to stool. There is more colic and less distension than in lycopodium, which it most closely resembles.

In the treatment of dyspepsia the first thing to be done is as far as possible to remove the cause. The causes are many, and may concern either the food or the general condition and habits of the patient. The food may be taken in quantities larger than the digestive organs can manage ; the right quantity varies with the individual, and with the same individual at different times ; thus a person all day in the open air can eat and digest much more than one in a sedentary employment indoors. Dyspepsia may result from insufficient food, leading to general debility and atony of the digestive system. Many people, finding food to disagree, almost starve themselves, and so make their dyspepsia worse. It is in these cases and others, when the general health is feeble, that a small quantity of dilute alcohol at the beginning of meals is often beneficial. It acts as a gentle stimulant to the secretion of gastric juices, and starts the digestion on its way, and as the food begins to be absorbed this itself acts as a stimulant, and, the process once started, a fair meal can be partaken of. Irregularity of the time of meals, or crowding all the principal meals within a few hours, are frequent causes of indigestion. The stomach should always be allowed to dispose of one meal before being called upon to attack another.

Insufficiently comminuted food, whether from bad teeth, a habit of bolting food, or hurry at meals, causes dyspepsia by an insufficient mixing of the saliva with the food, and by presenting too large pieces for the gastric juice to act upon. The gastric juice can only act on the surface of the food presented to it, so the finer it is divided the more readily the gastric secretion can digest it. For this cause, meats with fine fibre, like mutton or breast of chicken, are more digestible than those with tougher and larger fibres, like beef, and those made tough and hard by salting or by the tannin of strong tea. Flesh food or fish that has become tainted is

indigestible from the presence of poisons formed by the decomposition of albuminous substances, and may provoke violent local disturbance in the alimentary canal, or cause general poisoning sometimes of a serious or even fatal character. The digestibility of farinaceous foods varies directly with the ease with which they are disintegrated—thus new bread and rolls and underdone pastry are extremely indigestible, while stale bread and toast are very easily digested. Fats do not undergo digestion in the stomach, but sometimes they are split up, perhaps by the action of microbes, and fatty acids such as butyric acid are set free, which are very irritating. Raw vegetables and unripe fruits which contain a quantity of cellulose are very apt to cause flatulence, especially in the intestines. New beer and acid wines are liable to undergo further fermentation in the stomach and to cause acute indigestion.

A fertile source of dyspepsia, especially in women, is the prevalent habit of tea drinking. One or two cups of fairly strong tea will be taken an hour or so after a nitrogenous meal, the tannin hardens the fibre and makes it more hard to digest, and at the same time the gastric juice is diluted and made less powerful to act upon it, while the tea also stimulates the brain, and in that way withdraws blood from the stomach. All this at the critical period of digestion, which is thus delayed, time is given for fermentation to take place, and flatulent dyspepsia is the result. The best antidote to this condition, when caused by tea drinking, is china  $\phi$  or  $1x$ .

The food may be of proper quality and quantity and taken at proper times, but dyspepsia may result from digestion being inhibited by depressing emotion or business cares and worries. This is a very common cause of dyspepsia in business men, and experience has led them to adopt the custom of only taking a light meal in the middle of the day, reserving the principal meal till the evening, when the day's work is over. But for this plan to act well it is necessary that a proper breakfast should be taken. Frequently bed is not left till the last moment, a slight hurried breakfast is taken, immediately followed by a rush to catch the train.

The faintness which naturally supervenes about 11 or 12 is checked by a biscuit, or some stimulant; there may be an afternoon cup of tea; and the man arrives home at 6 or 7 o'clock, tired out and exhausted, to sit down to a heavy meal, in which he has to assimilate the greater part of the nourishment for the twenty-four hours. It is not astonishing if these people become confirmed dyspeptics, and later on nervous and hypochondriacal. Happily, if taken in time, they are readily cured by rest, change, regulated diet, and the indicated homœopathic remedy, which will often be *nux vomica*.

We, as homœopaths, are very fortunate in having at hand a number of drugs of great value to assist us in the treatment of dyspepsia. As in all our treatment, the totality of the symptoms should be our guide in choosing them, and a choice is often determined by symptoms outside the bounds of the alimentary tract. Half the drugs in our Pharmacopœia may have their use at some time or other in our treatment of indigestion, but I expect that most of us do not go beyond a dozen drugs to select from in the treatment of nine-tenths of our cases. It is only when we get an intractable case, or one presenting an anomalous symptom indicating some especial drug very markedly, that we go outside the usual range.

Perhaps our most frequently used drug, and one which meets a large number of cases, is *nux vomica*. This drug is so well known by our patients that they have very probably tried it before coming to consult us for dyspepsia. But I am sure we make a mistake if on that account we omit to give it in a case in which the indications for it, which I need not repeat (they are so well known), are decided. Few patients who dose themselves do so with any regularity or persistency—they may have taken two or three doses of *nux* one day, but they have probably tried *pulsatilla* the next day, and *mercurius* the day following, and so on—and a week's steady course of *nux* will do much to counteract the other medicines and make the case plain, even if it does not prove to be the *simillimum*.

It would be tedious if I attempted to go through the

the first fortnight there was considerable improvement, but the patient relapsed while continuing the medicine. I then discontinued the lycopodium and gave bryonia 3x, when the case got well at once, in the magical way which we often see when our medicines are properly selected.

CASE VIII.—This was a plainer case, but one in which I nevertheless made a wrong choice at first. M. M., aged 25, a housemaid, complained of constant pain under the ribs on the left side, as if enlarged and forced out, which had lasted for more than twelve months. The food seemed unable to pass this painful place. This pain, which had also a feeling of weight with it, felt as if it pulled down the left eye and throat and all down the left side, and there was actually some ptosis of the upper eyelid, *i.e.*, the lid drooped. The catamenia were regular. She was low-spirited and tired. The bowels were very constipated, being never opened without artificial means, and there was a moist, itching, tender eruption at the anus of eczematous character. No doubt pulsatilla was the better indicated remedy, but I gave lycopodium on account of the eruption at the anus. The result was that the constipation was much relieved and the eczema round the anus completely cured, but the other symptoms not affected at all. On changing to pulsatilla, they got better at once.

One cannot help wondering whether if pulsatilla had been given first the eruption at the anus would have been cured or whether it would have needed a subsequent administration of lycopodium to get rid of it. It is not a pulsatilla symptom, though pulsatilla has painful protruding piles. I think we meet with many cases where one drug alone, however carefully chosen, does not suffice, but needs supplementing by the subsequent administration of another drug to clear away symptoms not covered by the first one.

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Dr. GALLEY BLACKLEY was struck by one important omission in the paper, *viz.* :—that in the act of mastication the mere mechanical pressure of the jaws and teeth upon hard food was of prime importance, for it forced out the saliva mechanically. With hard food it was necessary, not only to have good teeth, but to use them energetically. The more perfect the salivation, the readier the change of starch into dextrose. He had confirmed the action of apomorphine in the vomiting of pregnancy. It was generally considered to be a cerebral remedy, but he did not entirely hold

that view. It was cerebral to an extent in its action, but it also caused vomiting by reflex action.

Dr. ORD said that there were such an enormous number of symptoms found under *nux vomica* in Hahnemann's *Materia Medica Pura*, and in the *Encyclopædia*, that there were very few cases left to which *nux vomica* was not applicable. A colleague of his carried it so far as to use it much in the same way that Hahnemann recommended that sulphur should be used in skin diseases, and put all chronic dyspeptics on *nux vomica* for the first week; that was not pure homœopathy, but it showed how generally useful *nux vomica* was. With regard to the multiplication of stomach symptoms in their provings he would give one word of warning. Almost the first thing a prover noticed on taking a drug was a symptom connected with the stomach and dyspepsia. It was to be remembered that nearly everybody was liable to some gastric disturbance, and those who had indigestion at all frequently would know that it often presented the same symptoms, whatever the exciting cause. An example of that is shown in one of Hahnemann's provers—Gross—who was very liable to intestinal flatulence after every medicine he took. Therefore, in proving a drug and observing the gastric symptoms, they wanted a large number of provers before they could be absolutely certain which were really the symptoms peculiar to the drug action, and which were the symptoms peculiar to the provers, which they would probably have got under any kind of drug which upset the digestion. Another interesting point was the relation between the chemical action and the homœopathic action of a drug when taken into the stomach. As an example he referred to the use of alkalies. Everyone knew how bicarbonate of soda would chemically counteract acidity and give relief, but it did not cure, and in chronic acidity it increased the trouble. People who took a large quantity of alkalies found that they produced extreme acidity when continued for a time, and yet on the other hand, in minute doses, the alkalies acted homœopathically in curing the acidity. That was very curious, because it suggested that their chemical action and their homœopathic action were in the same direction and of the same kind. Another interesting drug was *carbo veg.* What was the connection between the action of large and small doses of *carbo veg.*? Teaspoonfuls of charcoal and charcoal biscuits were often most useful, and yet the 3x, 6x trit., or 12x tincture of *carbo veg.* in many cases were more advantageous. Did they act physiologically and homœopathically in the same direction, or had they the same dynamic action?



One very valuable aid to treatment in chronic dyspepsia was the use of Salisbury minced beef and hot water, which, taken in small quantities at a time, could be digested in a stomach which had rejected every form of nourishment for days. It supplied every need of the body.

Dr. W. ROCHE said one of the best general practitioners he had ever known had said that almost his sole remedy for dyspepsia was nux and starvation. In his experience, as a rule, the difficulty was to prevent patients eating too much and very unwisely. A short course of preparatory starvation and a few doses of the Hahnemann suggestion as to sulphur being carried out in the nux direction, would not be at all a bad thing. With regard to charcoal, he had frequently obtained very useful results from Bragg's biscuits, particularly with old patients, whose flatulence was due to feebleness of digestion and in whom there was a large mechanical accumulation of wind. He had obtained good results from argentum nitricum, especially where there was a good deal of somewhat acute pain and burning connected with the indigestion. He never gave it as a rule lower than about the 6th dilution.

Dr. E. B. ROCHE agreed as to worry being a fruitful cause of indigestion. He was convinced of the value in many cases, for a time at any rate, of hot water. There was nothing he had found more necessary than to stop all cold drink. He was interested to hear Dr. Stonham's remarks about bryonia 12, as he had seen more aggravation from bryonia than from any other medicine. That fact had led him to desire to diminish the strength rather than to continue it in the stronger tinctures, and he had obtained better results by that practice.

Dr. GOLDSBROUGH said that in the vomiting of alcoholics he usually gave capsicum  $\theta$ , and found that great benefit resulted. *Apropos* of alcoholism nux vom. was *par excellence* the tonic for the dyspeptic state. In these cases he gave the drug in the mother tincture or the 1x dilution. In other cases, unless a patient was addicted to free living and an indulgence in alcohol, nux in the lower dilutions caused constipation as a rule, except, perhaps, in elderly people. When the habits of the patient were very moderate and care was exercised in diet, this drug required to be given in the higher dilutions, from 6 to 12, or even higher. Two drugs which had received little attention at the hands of Dr. Stonham, kali bichromicum and plumbum aceticum, he (Dr. Goldsbrough) had found very serviceable in dyspepsia of the duodenum and perhaps the upper part of the small intestines.

When pain was rather lower than the epigastrium and not of a very severe type, coming on about two hours after food, kali bichromicum should be thought of. Plumbum aceticum is useful where there is a considerable amount of irritation of the mucous membrane of the stomach, with a coated tongue, especially if the coating is dark, verging on black, and if gastralgia is severe, accompanied by constipation. He thought this latter drug was worthy of an extended study and trial in gastric affections as distinct from abdominal. He had recommended patients who suffered from acidity to keep a small stock of acid or lemon drops by them, one being sufficient usually to cut short an attack. It was quite a mistake to use alkalis in cases of acidity; they might perhaps relieve the patient for the moment, but the acidity came on again worse than ever. The point made about starvation was very important; patients starved themselves, lost weight, got low, and then wondered that they still had dyspepsia. Medical men should consider how much dyspeptic patients could conveniently take and digest, and allow them that much. In cases of gastralgia rest in bed for a few days was a very valuable measure.

Dr. EPPS said that many of one's women patients drank four or five times too much tea, and that was the first thing one had to stop. With regard to flatulence, the great point in these cases was to make the patients' meals as dry as possible. He always told them to take their food without taking anything to drink at all, and in consequence they did not suffer half so much from flatulence. With regard to the Salisbury treatment, many people drank half a tumbler of warm water during a meal. That was a great mistake; it diluted the gastric juice and impeded digestion. If hot water were taken at all, it should be *hot*, and taken as Salisbury advised, an hour before or two and a-half hours after food. Dr. Salisbury advised that the meat should be taken in three meals, not several times a day. Three-quarters of a pound of minced beef was to be taken three times a day—no other food—and the hot water was taken an hour before or two and a-half hours after. For the noisy flatulence he thought the remedy was *ignatia* in 2x or 3x. Dr. Goldsbrough had spoken of *argentum* and *arsenicum*. The position of the pain indicated the remedy in some cases. If it were on the left side of the stomach it was *argentum*, if on the right, *kali bichr.*, and if it were general, and of a burning character, it was *arsenicum*. He had found that distinction useful.

Dr. GOLDSMITH (*Cincinnati*) said there were three remedies

which had not been mentioned which he had found useful—iris, hepar sulphur., and cina. Magnesia phos. was a most useful remedy in gastralgia, as also strychnia phos. With regard to food—mutton and beef, for instance—he would ask whether the cooking of the food had not often as much to do with it as the food itself. He thought English cookery was better than American; in America meat was fried up and made hard. In his opinion, scraped meat was better than minced meat because there was a certain amount of fibre left out. He thought that the fear of food in the case of dyspeptics had a certain effect—patients fancied they would have pain if they ate certain foods, and, finally, they did have it. If that fear could be got rid of, some good might be done. He asked if the extensive habit of tea drinking had not something to do with dyspepsia. Tea was not consumed to a very large extent on the other side of the water, but coffee was, and they had over there a distinct coffee-dyspepsia. In those cases no cure could be effected until coffee was discontinued. He agreed with the statement that food should be taken dry, and that cold drink especially should not be taken with food.

Dr. LAMBERT thought it a mistake to limit the use of lycopodium to intestinal flatulence. He did not doubt its value in intestinal flatulence, but he was sure that many cases of purely gastric flatulence would be relieved by lycopodium. The feeling of sudden satiety while eating was a proof of the flatulence being in the stomach, and he had found many such cases relieved by lycopodium, generally in the 30th dilution. In flatulence in heart cases he thought that carbo veg. was particularly useful. He had known a case where charcoal biscuits utterly failed to relieve, in which the 12th trituration relieved very promptly.

Dr. EDWIN A. NEATBY (the president) said he always told his patients that it did not matter so much what they ate as how they ate it. With respect to raw meat, scraped meat, or meat passed through a sieve, it was an invaluable help in the treatment of many forms of dyspepsia, especially where there was real gastric irritation.

Dr. STONHAM, in reply, said he quite agreed with what had been said as to the inadvisability of giving alkalies in bulk, at any rate for any length of time, in cases of acid dyspepsia. Saliva was an alkaline fluid, and was a powerful stimulus to the secretion of the gastric juice; and any other alkali also seemed to increase that secretion. There was no doubt that the Salisbury treatment was very useful in cases of chronic dyspepsia; the raw meat which was given did not produce flatulence. Patients by

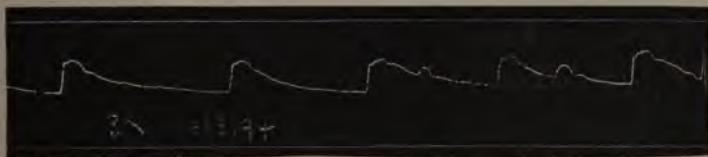
that means got rid of the flatulence, and the hot water taken an hour before meals, when the stomach was empty, flushed out the lymphatics and put them in a more healthy condition. He thought that was really a treatment of rest, while at the same time giving sufficient nourishment to the patient.

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PATHOLOGICAL SPECIMENS, CASES, &c., SHOWN  
AT VARIOUS MEETINGS.

*Cases of Bradycardia.*<sup>1</sup>

CASE I.—M. B., aged 77, first consulted me in March, 1891, for some slight ailment, when his pulse was 72. In March, 1894, he consulted me again for a bronchial cold, the result of getting wet after violent exertion on the 9th. He complained of a very frequent cough when in the cold air. On examination the respiration was normal, the heart sounds very soft and distant, the pulse 33, and irregular.



The appetite was poor. Bowels regular. Sleeps quite well. Prescribed ars. iod., and conium 1x for cough. In December, 1894, patient came for another cold. The pulse was 64, heart sounds not so distant, second sound "clipped." Said he soon got well in March. In May, 1897, patient again came for a cold, pulse still 64, and regular.

<sup>1</sup> Notes of cases presented by Dr. WASHINGTON EPPS, Clinical Evening, June 2, 1898.

CASE II.—Mrs. L., aged 60, married at 33, widow seven years; no children. June, 1894, patient has never been very strong, and suffered from abscesses in her youth. For the last five years she has suffered from difficult and short breath, has great difficulty in going upstairs. The shortness of breath is accompanied with spasms, when she has a perfect fight to get breath. She has much wasted during the last three months. Patient has never fainted but once, when 18 years. On auscultation a very curious squeaking sound was heard with the first and second sounds at apex and base. Pulse 30, regular; ordered cact. 1.



June 8, 1894, patient came to my house again. Says the medicine, cactus, has tried her, that it has caused a feeling of contraction in heart. She has short breath at times, cannot walk any distance without stopping. Not slept so well, awakes with pain in chest. Pulse 30.

June 12.—As the patient was too weak to attend as a dispensary patient, and refused to come into the hospital, I lost sight of her. On this day I visited her at her house in Whitechapel. She was feeling very much weaker, being hardly able to walk across the room. Her sphygmogram was still much the same in character.

CASE III.—(With albuminuria and curious pulse-respiration ratio.) M. R., aged 83, nervous temperament, pulse usually 84, but easily raised. Suffered from uterine displacement. Is very liable to attacks of diarrhoea. In December patient suffered from attacks of weakness and faintness. Heart and breath sounds normal, except for feebleness and slight irregularity. Pulse only 40 to 42. Patient rapidly improved under strophanthus, and was able to go to Folkestone.

In February patient complained of much the same symptoms, with coldness and slight oedema of the lower extremities. In the latter days of the attack, which proved to be fatal, the urine contained a trace of albumen.

February	2	4	6	7	8	9	10	11	12	13	14	15
PULSE	40	36	28	28	29	31	43	42	44	60	68	80
RESP.					32	32	32	30	28	24	25	
TEMP.	(Sub-Normal or Normal.) (Raised.)											

The above table shows the curious pulse-respiration ratio. Pulse 29 to respiration 32.

The following pulse tracing was taken February 12.



### *Congenital Malformation of Heart.*<sup>1</sup>

The heart is very small, and the greater part of its bulk consists of a greatly hypertrophied right ventricle; the left ventricle is comparatively small and ill-developed. There is a considerable sized opening between the two ventricles, caused by a defect in the upper part of the interventricular septum. The aorta is large and arises from the upper part of the *right* ventricle. The pulmonary artery is very small, and its orifice only just admits an ordinary probe; it is guarded by a single rudimentary cusp; the pulmonary orifice is situated at the upper part of the right ventricle, close to the aortic orifice. The ductus arteriosus is patent and forms a large communicating channel between the aorta and pulmonary artery. The foramen ovale is patent. The mitral and tricuspid orifices and valves are normal.

*Clinical History.*—The child suffered from cyanosis and dyspnoea from birth, and died suddenly at the age of six weeks.

There was no cardiac murmur or thrill.

### *Adhesive Pericarditis.*<sup>1</sup>

The anterior surface of the pericardium is turned down in the form of a triangular flap. Both the visceral and parietal layers of the pericardium are seen to be covered by a layer of

<sup>1</sup> Shown by Dr. J. T. BODMAN, November 4, 1897.

rough, shaggy lymph, by which the two surfaces were glued together till the flap was turned down. The heart itself is considerably hypertrophied. There is a slight amount of endocarditis of the mitral and aortic valves.

*Clinical History.*—The patient, a girl aged 9, was admitted to the Hospital in a critical condition, and was found to be suffering from pericarditis, following a second attack of acute rheumatism; for two or three weeks her condition slowly improved, but one day, when apparently well on the road to recovery, heart failure rapidly developed and proved fatal in a few hours.

#### *Friedreich's Disease.*<sup>1</sup>

Charles Landon, aged 5½; father aged 39, mother aged 33; both healthy. Patient is the fourth in the family—the other four children (girls) are healthy. No history of paralysis in family.

*Present Illness.*—Always backward in walking and talking—onset gradual and insidious. First seen June 3, 1896. Fine boy, with intelligent expression. Unable to walk owing to great staggering. Also inco-ordination of upper limbs, and continual nodding of head. Reflexes all intact, superficial and deep. Sensation not affected. Fundi oculorum normal. *Principal medicine*—Gels. s. 1x *ter die*, and bell. 3x at night occasionally. He has steadily improved.

#### *Pseudo-hypertrophic Muscular Paralysis.*<sup>1</sup>

Lilian Wright, age 6; father aged 49, mother aged 47; both healthy. Patient is the eleventh in family; seven others are living and five have died, but none suffer or have died from paralysis.

*Present Illness.*—Began gradually; parents first noticed her weak on her legs.

*Present State.*—Marked hypertrophy of calf muscles and glutei, especially on right side. Lordosis is marked, and abdomen very prominent. Knee-jerks feebly present on both sides. Gait: on running liable to fall, and has great difficulty in lifting her feet as seen on going upstairs. Has taken phosph. 6 *ter die* and cod liver oil.

<sup>1</sup> Case shown by Dr. ROBERSON DAY, Clinical Evening, June 2, 1898.

*Intra-Cranial Tumour.*<sup>1</sup>

John Stansborough, aged 4; father aged 52, mother aged 46; both healthy. Patient is the youngest of a family of eleven, and all the others are said to be healthy.

*Present Illness.*—Began Easter, 1896, with vomiting and staggering gait. Admitted to this hospital June 9, and on June 15 seen to have double optic neuritis.

*Treatment.*—Ars. iod. 3, grain i. *ter die*, steadily continued.

*Present State.*—Still unsteady in walk, though much better. No optic neuritis; rarely vomits. There has never been any headache.

*Convulsions of Cerebellar Origin.*

Dr. JOHN D. HAYWARD referred<sup>2</sup> to a female child, aged 5, who had died that day after an attack of eclampsia lasting three days. A marked symptom of the attack was, that while almost unconscious, the child continually threw itself violently over towards the left, and if not prevented, would rotate several times in that direction. Constant vomiting was an early symptom of the attack, but no cause for this could be detected. The fits came on suddenly on awaking in the morning after the child had gone to bed quite well the night before. Two years ago the child had suffered from a convulsion, but otherwise had been quite healthy. There had been no injury. From the prominent symptom, inflammation, possibly tuberculous, in the region of the cerebellum, was suspected. No *post-mortem* was allowed.

Dr. EDMUND CAPPER narrated the case of a man, aged 21, whom he saw February 18, 1892, complaining of headache and frequent vomiting. He had been at drill the day before. In addition to the above symptoms he had constant revolving in the bed. He died four days later. Cerebellar hæmorrhage was the diagnosis made, and it was confirmed at the *post-mortem*, when a clot as large as a man's fist was found in the cerebellar substance, which was very much torn and lacerated.

*Vermiform Appendix.*<sup>3</sup>

Appendix removed from a girl, aged 13, who had a severe attack of peritonitis in 1892. Off and on since she has had

<sup>1</sup> Case shown by Dr. ROBERSON DAY, Clinical Evening, June 2, 1898.

<sup>2</sup> Liverpool Branch, October 14, 1897.

<sup>3</sup> Shown by Mr. C. KNOX SHAW, December 2, 1897.



slight attacks of relapsing perityphlitis, causing her to lie up for a few days. In the early part of this year she had an attack, keeping her at home for a week. In August last, a severe attack of perityphlitis, accompanied with, according to the statement of the physician who attended her, the formation of abscess and discharge of pus per rectum. The appendix was removed on November 1, the patient making a rapid aseptic recovery.

The appendix had a short meso-appendix, and was found in the sub-cæcal fossa bound down with many adhesions. It measured three inches in length; its canal was patent to within five-eighths of an inch of its extremity, where there was a marked stricture. The tip was bulbous and dilated, and perforation had probably taken place at its extreme end. The mucosa was thickened and in places greatly injected.

#### *Vermiform Appendix.*<sup>1</sup>

Specimen of a vermiform appendix, removed *post mortem*, from a girl, aged 6 years, who died forty-two hours after the onset of peritonitis. At the *post-mortem* there was found, on opening the peritoneum, a quantity of sero-purulent fluid with flakes of lymph attached to the intestines. The appendix, a very long one, was fixed by adhesions to the peritoneum covering the psoas muscle; there was no localised abscess nor swelling. The appendix was not distended, its middle third was of a dark, livid colour, and in the centre of the free surface of this there was a very small punched-out perforation, not larger than a pin's head. From this there had evidently been a leakage of the contents of the appendix into the general peritoneal cavity, inciting a rapidly fatal peritonitis.

#### *Vermiform Appendix removed for Relapsing Catarrhal Appendicitis.*<sup>2</sup>

This appendix was removed from a patient, aged 17, who had his first attack of appendicitis in October, 1897, since then he has had two sharp recurrences. The patient made an uninterrupted recovery. The appendix was of considerable size, and unusually free from adhesions. It had a very short meso-appendix, which caused it to be acutely flexed upon itself. It was distended with

<sup>1</sup> Shown by Dr. BYRES MOIR, February 3, 1898.

<sup>2</sup> Shown by Mr. KNOX SHAW, April 14, 1898.

fluid, which was prevented returning to the cæcum by a constriction at its cæcal extremity. The mucosa was unusually soft, swollen, and hypertrophied.

*Gall Stone successfully removed by Cholecystotomy.*<sup>1</sup>

Miss S., age 66, twenty years ago had an abdominal attack which was thought to be due to gall stones, and she was jaundiced for two or three weeks. She remained free till seven years ago, when she had periodic attacks of what she thought was malarial fever. The attacks occurred once a month for sixteen months and then ceased. Since then she has been very liable to attacks of severe abdominal pain and flatulence. For the last twelve months the pain was more definitely situated in the liver region. The attacks were of a cramp-like, colicky nature, and were relieved by going to bed and applying warmth. Recently she came under the care of Dr. Byres Moir, who discovered an enlarged gall bladder, and as the pain was now getting constant, and there was a regular evening rise of temperature, advised operation. The operation was performed on May 23, and a gall stone found plugging the cystic duct. The gall bladder was much thickened and inflamed. The temperature immediately fell, and the patient is making an uninterrupted recovery.

*Ovarian Dermoids—Ruptured Multilocular Cyst—Left.*<sup>2</sup>

Miss W., aged 38.—Patient had noticed gradual abdominal enlargement for eighteen or twenty months, following an attack of peritonitis. Menstruation scanty.

*Ovariectomy.*—Peritoneal cavity filled with clear "colloid" material (11 pints); multilocular and dermoid cysts removed from left side, dermoid (small) from right. Recovery good; subsequent peritonitis.

*Right Ovary.*—The upper preparation consisted of a dermoid cyst of the right ovary laid open. Its pultaceous contents have been removed, but portions of skin, teeth, bone, and hairs are visible.

*Left Ovary.*—The lower preparation was a multilocular cystic tumour of the left ovary, embedded in which was a small dermoid cyst, bearing a tuft of dark hair. The loculi of the tumour were filled with colloid material.

<sup>1</sup> Shown by Mr. KNOX SHAW, June 2, 1898.

<sup>2</sup> Shown by Dr. EDWIN A. NEATBY, June 2, 1898.

*A Dilated Fallopian Tube, from a case of Double Hydro-Salpinx.*<sup>1</sup>

Mrs. B., aged 37, had suffered from peritonitis when 18, and two years ago had an attack of pneumonia. For the last nine years patient has suffered from more or less constant pelvic pain, and especially at the monthly time. All her pain has been worse since she was married, three years ago, and her ability to do ordinary household work has steadily lessened, so that she has had to give up washing, lifting, &c. Dyspareunia has also been present throughout.

Patient had attended Dr. Neatby's clinique for several months. Pelvic examination revealed in Douglas' pouch a softish elastic globular swelling, at first about the size of a walnut. This mass was chiefly on the right side. It appeared to taper off on the left, and the left ovary was felt low in the pelvis on that side. On the right it was indistinguishable from the larger mass, which enlarged during the time patient was under observation to the size of a Tangerine orange. The patient had no pyrexia.

*Operation.*—On opening the abdomen, both tubes were found to be dilated, the left one being very closely adherent to the pelvic wall, so that the broad ligament had to be opened and the tube shelled out. The right was larger—as described; both were full of pale serous fluid. The operation was tedious and prolonged, and the patient suffered considerably from shock. A flat and flaccid abdomen throughout demonstrated a satisfactory condition from the surgical aspect, and the patient made a complete recovery.

*Uterine Tumour removed by Abdominal Hysterectomy.*<sup>2</sup>

The specimen showed:—

- (1) An old-standing fibro-myoma.
- (2) A recent rapidly-growing myoma, with commencing cystic change.
- (3) The dilated uterine cavity.

Mrs. F., aged 43, began to suffer from too profuse and too frequent menstruation twelve months ago. Once or twice it amounted to "flooding." Since the date mentioned an abdominal enlargement has arisen. She has recently become anæmic and short of breath.

<sup>1</sup> Shown by Dr. EDWIN A. NEATBY, November 4, 1897.

<sup>2</sup> Shown by Dr. EDWIN A. NEATBY, June 2, 1898.

Examination showed an abdominal tumour, smooth, elastic, and globular, extending above the umbilicus. The flanks were clear.

Bi-manual examination showed that the tumour was intimately connected with the uterus, which was crowded up to the right side of the pelvis by another tumour—hard, and probably of long-standing. This was also united to the uterus and to the abdominal tumour. The bladder was well drawn up in front of the tumour.

*Heart.*—Hæmic bruits at base; no dilatation. *Urine.*—No alb.; quantity varies from 20-45 ozs. per diem.

#### *Uterine Fibroids, showing Hard and Soft Tumours.*<sup>1</sup>

E. W., aged 47, had been aware of a tumour since 1893, but did not suffer *in any way* therefrom. Since October, 1897, the growth had increased in size, and more bleeding had occurred. Pain on walking developed. Some anæmic and cardiac hypertrophy were present.

April, 1898.—Tumour removed by abdominal hysterectomy (retro-peritoneal method). Recovery uninterrupted.

The specimen showed two large interstitial fibroids in the wall of the uterus. In the recent state the upper tumour appeared much softer, probably due to œdema. But after immersion in formalin there was no appreciable difference in their appearance.

#### *Pedunculated Uterine Myoma removed by Abdominal Hysterectomy.*<sup>2</sup>

Jane W., aged 42, had a slowly-growing abdominal tumour of three years' standing. Menorrhagia of three years' duration. Examination revealed a central tumour reaching to umbilicus, clearly connected with the uterus. Above and to the left of umbilicus was a large movable tumour, which could be easily moved from left hypochondriac region to right hypochondriac region without causing central tumour to move. The patient suffering great distress, and being unable to follow her employment, operation was undertaken. She is making a most satisfactory recovery. Operation March 29, 1898.

<sup>1</sup> Shown by Dr. EDWIN A. NEATBY, June 2, 1898.

<sup>2</sup> Shown by Mr. KNOX SHAW, April 14, 1898.

The central tumour was a large fibroid occupying the anterior wall of the uterus. The movable tumour was an equally large sub-peritoneal fibroid with a narrow pedicle.

*Pessary in situ Eighteen Years.*

Dr. HAWKES exhibited to the Liverpool Branch, October 14, 1897, a pessary he had lately removed from a case of cancer of the uterus, and which had evidently remained *in situ* eighteen years. He said it was necessary to keep an account of the pessaries as introduced, and to see that they did not remain in too long or get lost. The possibility of subsequent cancer should be borne in mind.

*Lymphangioma.*<sup>1</sup>

Gladys Fenson, aged 6; father, 51, suffers from nervous debility; mother, 41, suffers from pelvic trouble. Patient is 7th in the family. There are two others delicate, and four have died.

*Present Illness.*—The swelling in the back part of the left arm was first noticed when three months old. She has been under observation since January 23, 1896. Electrolysis has been used and silica 3 given internally, also apis 3x, kali mur. 3x, and thuja 12.

*Present State.*—A large, fusiform, translucent tumour occupies the position of the lymphatic vessels as they leave the arm for the axilla. It is painless and soft and cystic to the touch. It is covered in parts with small, warty, translucent bodies, which vary in size and position. These are very characteristic of this kind of tumour. Occasionally blood extravasates into parts of the tumour.

*Congenital absence of the Right Forearm.*<sup>1</sup>

An instance of the so-called spontaneous intra-uterine amputation. Child is perfectly well otherwise.

<sup>1</sup> Case shown by Dr. ROBERSON DAY, Clinical Evening, June 2, 1898.

*Salivary Calculus.*

Mr. DUDLEY WRIGHT showed, June 2, 1898, a salivary calculus removed from the right sublingual gland. Its presence had excited suppuration, and the calculus was found lying in the abscess cavity.

*Vesical Calculus.*<sup>1</sup>

Phosphatic calculus removed from the bladder of a man by suprapubic operation.

Section of the vasa deferentia was afterwards performed to reduce a large prostate.

Weight of stone 650 grains.

*Gumma of the Neck.*<sup>2</sup>

Dr. BERNARD THOMAS showed a patient with a swelling in the neck. The patient was a young married woman of 25. She had noticed the swelling for two years. It was situated above the left sterno-clavicular articulation, and behind the sterno-mastoid. It was somewhat indefinite in outline on account of its deep situation, but did not seem to be connected with the clavicle. There was also enlargement of the axillary glands, which could be easily felt on this side; and the left arm and hand were reddened and cold, giving rise to sensation of numbness due to pressure on the large veins. She stated that she had a miscarriage two years ago, and about three years ago suffered from temporary alopecia, rash and sore throat. The case was thought to be tertiary syphilitic gumma, and this view was confirmed at the meeting.

For a little over three weeks she had been taking aurum met. 3 trit., and it was thought the swelling had decreased in size. If after a little while there was no marked improvement potass. iod. would be given.

*Paget's Disease of the Nipple.*<sup>3</sup>

The section was removed from a patient who presented the typical appearance of Paget's disease: "A florid, intensely red, finely granulated, raw surface" covering the nipple and areola.

<sup>1</sup> Shown by Mr. DUDLEY WRIGHT, June 2, 1898.

<sup>2</sup> Before the Liverpool Branch, November 11, 1897.

<sup>3</sup> Microscopical section, shown by Mr. KNOX SHAW, June 2, 1898.

The section showed much inflammation of the corium, and down-growths of epithelium were to be seen in the subcutaneous tissue. There was absolutely no induration of the breast proper beneath the florid surface. The axillary glands were enlarged, and affected with scirrhus carcinoma. (See below.)

*Scirrhus Carcinoma of Axillary Glands.*<sup>1</sup>

The section showed an axillary gland infiltrated with scirrhus carcinoma. The gland was removed from a patient suffering from Paget's disease of the nipple, without apparent infiltration of the breast proper. A section of the nipple disease was shown in an accompanying slide.

*Surgical Diagnosis by the Roentgen Rays.*<sup>2</sup>

Mr. GERARD SMITH gave an explanation of some recent advances in surgical diagnosis by the Roentgen rays. The most encouraging point, he said, at the present time, is the remarkable unanimity of several prominent workers with X rays, as to the main principle on which we should work towards accomplishing the essential, but as yet incompletely elaborated, means of recording and indicating by mechanical methods the precise localisation of foreign bodies embedded in deep structures or cavities of the body.

The plan first tried, and which has been, from the first, mistrusted by many of the more cautious and sceptically minded experts (amongst these Mr. Gerard Smith begged to include himself), was to take two separate X-ray photos on two plates, one from above, the other from the side of the *supposed* situation of the foreign body; and this obviously weak plan has long since been discredited, with no little injury to the reputation of the X rays in diagnosis in the minds of those surgeons who judge hastily and without due knowledge.

For a method for localisation which must be used after localisation by guess is made, and which is used in reliance on that guess, is not a method of localisation at all. That a process or method cannot be the cause of its own antecedent conditions is a well established law or rule in philosophy, and the weak point in the application of X rays in surgery and medicine has been that the localising of an object situated beyond the reach of touch

<sup>1</sup> Microscopical section, shown by Mr. KNOX SHAW, June 2, 1898.

<sup>2</sup> Clinical Evening, June 2, 1898.

and sight, although its silhouette is distinctly thrown on the fluorescent screen or photo plate, may be situated at any plane in relation to that surface, both horizontally and vertically, because such a shadow is formed at every point within the field on which the X rays fall, but is thrown on different points in accord with the shifting of the vacuum tube over the object.

And the shadow appears quite clear and definite, its outline seems distinct and the evidence of the photo reliable, whereas it has been now frequently proved that the diagnosis may be utterly falsified through such reliance, both the impression as to the form and position of the object discovered being displaced and distorted in the X-ray image on account of the fact that the source of the rays, the anti-cathode "target" of the vacuum tube, the surface of the photo plate and the axis of the concealed object have not been arranged in absolute parallel planes in relation to each other, these being the essential conditions for producing a true image by the X rays.

The new method will enable this absolute parallelism to be attained, and then the taking of the two pictures may of course act as a test to verify the localisation. Briefly, the main basis of the method is founded on the fact that every shadow formed of an object, by means of any rectilinear form of radiation, must be that of some object situated between the source of the rays and the surface on which the shadow is viewed, and a line drawn from the radiating centre to the centre of the shadow must therefore pass through the centre of the actual object, if the original relative positions of the radiant and photo or other surface are retained.

The method, roughly defined, is to take two or more shadow records on one plate at the same time, and with the limb or part of the body and the photo plate retained in the same relative positions to each other; but the vacuum tube, the radiant, placed at varying and opposite positions, these being mechanically recorded, as are the other relative data, by lines on the patient's skin left by some dye on a wire frame, the shadow of which is photographed at the same time.

Then, lines drawn from radiant to photo plate through the patient from each of these positions must all cross each other, *as they pass through the centre of the shadowed object*. This point is at the precise point in the horizontal plane, as measured from the surface of the photo plate up through the body of the patient.

This is far more simple to do than the description appears to



apparatus, which must be accurately and permanently erected and all the delicate adjustments fixed, this requiring considerable skill, and ample time, and quiet.

*Skiagram of a Needle in the Hand.*<sup>1</sup>

The needle had been present several months. Two attempts had been made at another hospital to remove it, but the incisions had been made too high. It was successfully removed here.

*Skiagram of a Needle in the Palm of the Hand.*<sup>2</sup>

The needle had been in the hand seven years, and was seen to be lying in front of and a little below the head of the 4th metacarpal bone. An attempt had been made by a surgeon outside the hospital to remove the needle by an incision at the back of the wrist.

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REPORT OF THE INDEXING COMMITTEE OF  
THE BRITISH HOMŒOPATHIC SOCIETY.

*Presented to the Annual Assembly, June 30, 1898.*

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THE Committee are glad to report that the careful analysis and excerpting they have undertaken from the mass of British homœopathic literature is now nearly completed. For this purpose, every volume of the *British Journal of Homœopathy*, of the *Monthly Homœopathic Review*, of the *Homœopathic World*, of the *Transactions* of this Society, of the *Annals of the London Homœopathic Hospital*, of the *Homœopathic Times*, and of the *London Homœopathic Hospital Reports*,—every volume in these periodicals has been diligently read through, and every case reported as cured or benefited by homœopathic medication has been noted.

<sup>1</sup> Shown by Mr. DUDLEY WRIGHT, Dec. 2, 1897.

<sup>2</sup> Shown by Mr. KNOX SHAW, December 2, 1897.

Thus, to illustrate. If the disease is "Nephritis," in this work will be indexed every case of nephritis in these serials reported as benefited by remedies. And further, on turning to "Cantharis," under this heading will follow a citation of every case of nephritis successfully treated by cantharis; or again, if anyone is desirous to know exactly the kind of hepatic troubles that chelidonium will disperse, in this volume, under "Chelidonium," will be references to every case in British homœopathic literature where chelidonium has acted well.

The essential difference between this projected volume and the *Materia Medica* may be thus stated: The *Materia Medica* sets forth what remedies may be calculated to do; this new work will give orderly references to every case of what any remedy has actually done.

To render this a practical working volume, the Committee have worked with only those serials contained in the Society's library.

For two preceding years the Society has directed the sum of twenty pounds in each year to be set aside from its finances for the current and ultimate cost of this work. The Committee have striven to work as economically as possible, so that only an actual outlay of some three or four pounds for clerical expenses has been made. They ask that the Society would direct that a further sum of twenty pounds be added during the next session to the balance of the monies directed by the Society last year to be retained for this purpose.

The Committee suggest that to the Sub-Committee (Drs. Dudgeon, Washington Epps, and Burford) be delegated the necessary authority for the printing and publishing, in as economical a form as possible, of this work. They expect that during the next twelve months this volume would be ready for distribution.

Because of the great practical value of this index, the Committee suggest that a nominal charge of two shillings be made to each member for its receipt, and that the published price to others be seven shillings.

R. E. DUDGEON, *Chairman*.  
GEORGE BURFORD, *Secretary*.

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## REPORT OF THE COUNCIL.

THE Council in presenting their annual report have regretfully to refer to the unusual number of members that have been removed by death : Mr. Hugh Cameron, to whose death reference was made in the early part of the session, was one of the original founders of the Society ; Dr. Rhodes Reed, of King's Lynn, had been a member since 1862 ; Dr. C. B. Ker, of Cheltenham, since 1879 ; Mr. Ockenden, of Brighton, since 1892 ; Dr. Woodgates, of Exeter, since 1893 ; and Dr. G. P. Richards, who died at Beira, since 1894. Two new members have joined the Metropolitan Society, and one member has joined the Society through the Liverpool Branch. One member has resigned. Dr. Dewey, of Michigan ; Dr. Pemberton Dudley, of Philadelphia ; and Dr. Eugene Porter, of New York, have been elected corresponding members. The roll now numbers 211.

Dr. Edwin Neatby delivered the Presidential address at the opening of the session, and seventeen papers have been presented to the various sections. The Secretary of the Surgical and Gynæcological Section organised a most successful clinical and microscopical evening on the night previous to the Homœopathic Congress, held in London this year. The average attendance at the meetings has been thirty-three.

An International Committee has appealed for subscriptions to enable it to remove the body of Hahnemann to a more central position in Père la Chaise Cemetery and to this the British Homœopathic Society has responded with a donation of £10. Dr. Hughes was present when the grave was opened in May last and witnessed the ceremony of re-interment.

During the past year the first two instalments of the Repertory to the Cyclopædia of Drug Pathogenesis, compiled by Dr. Hughes, have been presented to members, thus bringing near to completion the monumental work undertaken conjointly by the American Institute of Homœopathy and the British Homœopathic Society.

The Treasurer's statement shows that the balance usually found at the close of the Session has been seriously curtailed ; this is due to the expenses in connection with the Repertory, and to the Society being called upon to find £50 of its guarantee towards the publishing expenses of the International Homœopathic Congress.

BRITISH HOMOEOPATHIC SOCIETY.

RECEIPTS AND EXPENDITURE FOR THE YEAR ENDING JUNE 30, 1898.

RECEIPTS.		EXPENDITURE.	
	£ s. d.		£ s. d.
To Balance in hand .. .. .	.. .. . 150 6 8	By Printing (less advertising) .. .. .	.. .. . 174 14 6
" Subscriptions .. .. .	.. .. . 198 9 0	" Reporting .. .. .	.. .. . 17 17 0
" Sale of Publications .. .. .	.. .. . 9 8 9	" Postage and Stationery .. .. .	.. .. . 6 11 0
" Dividends on £199 4s. 8d. Consols .. .. .	.. .. . 5 6 0	" Honorarium to Editor .. .. .	.. .. . 10 10 0
" Half cost of Plates .. .. .	.. .. . 0 3 6	" Rent .. .. .	.. .. . 25 0 0
" Sale of old Bookcases .. .. .	.. .. . 7 5 0	" Refreshments .. .. .	.. .. . 5 10 0
" Refunded for extra reporting .. .. .	.. .. . 1 1 0	" Library .. .. .	.. .. . 10 2 11
		" Petty Cash .. .. .	.. .. . 2 0 0
		" Hire of Microscopes, Tables, &c. .. .. .	.. .. . 6 10 0
		" Indexing of Periodicals .. .. .	.. .. . 2 18 6
		" Cheque returned .. .. .	.. .. . 1 1 0
		" Subscription to Hospital .. .. .	.. .. . 10 10 0
		" Subscription to International Transactions .. .. .	.. .. . 50 0 0
		" Subscription to Hahnemann's Grave Fund .. .. .	.. .. . 10 0 0
		Balance .. .. .	£383 4 11
			.. .. . 38 15 0
			<u>£371 19 11</u>
			<u>£371 19 11</u>

C. J. WILKINSON, Auditor.

JNO. G. BLACKLEY, Treasurer.

## A REPORT OF THE WORK OF THE SOCIETY FROM SESSION 1892-1893 TO SESSION 1897-1898.

PRESENTED TO THE ANNUAL ASSEMBLY JUNE 30, 1898,  
BY C. KNOX SHAW, HONORARY SECRETARY.

THE Annual Assembly of the Session 1891-1892 was a momentous one in the history of the British Homœopathic Society. After prolonged and careful consideration certain important alterations were made in the laws of the Society with a view to the "further advancement and extension of its work." The formation of the Council was altered and its powers extended, members, as well as fellows, were admitted to its deliberations, the formation of branch societies became a feature in the work of the Society, and finally the Council undertook to publish a quarterly journal.

The new Council, at its first meeting, deemed fit to appoint me, upon the resignation of Dr. Galley Blackley to become President, Secretary of the Society, and has done me the honour of annually re-appointing me since, and now that I feel compelled to relinquish my office—a period of duty that I shall always look back upon with pleasure—I feel I should like to present to you an account of my six years' stewardship. I need not say that I greatly felt the responsibility of undertaking the post, for much of the effective carrying out of the wishes of the Council I clearly saw depended upon the efforts of the Secretary. I can also assure you that I do not lay down my office without many regrets, still I feel it is my duty to give more of my time to other work.

During the summer of 1892 the Council was busy with its work of reorganisation, and secured the services of so able a littérateur as Dr. Hughes, as editor of its *Transactions*. At the commencement of the Session 1892-1893 there were 116 active members of the Society, and as evidence that the homœopathic body was ready for reorganisation, 66 new members joined the Society during that Session; and during the past six years a total of 111 members have been added to its roll.

In November, 1892, the Liverpool Homœopathic Medico-Chirurgical Society—an old-standing homœopathic society—applied to the Council, and was duly registered as the Liverpool Branch of the British Homœopathic Society. This important

branch has steadily increased in numbers, and has risen from a membership of 15 to one of 31.

In January, 1893, the JOURNAL of the Society appeared, and its sterling value as a homœopathic medical periodical soon caused it to have a circulation outside the membership of the Society, both in this country and in America. With the journal was issued, as a supplement, an annual classified list of officers and members of the Society.

At the Annual Assembly in 1893 the method at present in vogue for the election of the Officers and Council was adopted, and a new law defining the qualifications of members for the Fellowship was passed.

In April, 1894, the Society reached its jubilee, and with its President, the late Mr. Cameron, the only surviving founder of the Society, in the chair, celebrated the occasion by a well-attended banquet.

At the Annual Assembly of 1894 the Council proposed certain new bye-laws, which were adopted. The most important addition was the division of the work of the Society into sections, three sections being formed, each with its chairman and secretary, viz. :—Materia Medica and Therapeutics, Medicine and Pathology, Surgery and Gynæcology. The varied and interesting papers, which have been the result of this division of labour, testify to the wisdom of this new step. Under the new bye-laws the old plan of "private and public business" was done away with.

In 1896 the section of Medicine and Pathology, upon the direction of the Council, undertook the formation and distribution of schedules for the collective investigation of certain diseases. The returns are slow in coming in, but when they are complete they will form a most valuable contribution to the statistics of homœopathy.

During the same year the Council appointed a Committee of the Society, under the guidance of Dr. Burford, to index British Homœopathic Literature. The staff of collaborators are steadily at work at this important task.

In July, 1896, the Council appointed a Sub-committee to arrange for the entertainment, at a banquet at the Hotel Cecil, of the members of the International Homœopathic Congress, then visiting London. Towards the end of 1896 the Council ordered the re-arrangement of the library of the Society, and instructed the librarian, Dr. E. A. Neatby, to prepare a catalogue of the books, this catalogue to be issued, in quarterly instalments, free to each member, as a supplement to the JOURNAL, and the final part

will be issued with the July number now in preparation. They further arranged for increased facilities for the loan of books to country members.

At the Annual Assembly of 1897 Dr. Hughes was able to announce that the first part of the Repertory to the Cyclopædia of Drug Pathogenesis was nearly ready, and the Society thereupon undertook to subscribe for 250 copies, and to distribute them and future numbers without charge to members; two parts have already been delivered. The work of the present Session has been alluded to in the report of the Council just presented to the Society.

During the past six years 66 meetings of the Society and 29 meetings of the Council have been held, all of which your Secretary has been able to attend. During this period 121 papers have been read, and 5 clinical and microscopical evenings have been arranged. Now, when we come in this manner to review the work of past Sessions, we find activity in all sections of the Society, whether viewed from the scientific, literary, or social aspect. Such work could not have been done without the hearty co-operation of many workers, and it clearly shows the Society to be an important factor in the life and work of the homœopathic body, and renders it the duty of every one who cares aught for the honour and advancement of rational therapeutics to rally to its support.

It may seem to some egotistical on my part to present a report of my stewardship upon giving up what is, after all, only an annual appointment, but the Council have invariably been so kind to me that I felt that I might look forward to being your Secretary again should I have desired to continue in office. There are fortunately others who will be better able to carry on the traditions of the Society, and I feel, too, I am entitled now to some rest.

I would like to take this occasion to thank you, Mr. President, the Council, and the Society in general for the opportunity that has been given me of working in a cause in which I have been so very deeply interested.

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**SOCIETY NEWS.**

At the first meeting of the Annual Assembly, June 29, 1898, Dr. Norman Webster, of Guernsey, was elected a Member of the Society.

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At the second meeting of the Annual Assembly, June 30, 1898, Dr. J. J. Gawlor Pritchard, West Park Street, Dewsbury, was elected a Member of the Society.

At the same meeting Dr. Ord, Dr. Cash Reed, and Dr. E. B. Roche were elected Fellows of the Society.

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At the Annual Assembly the President, Dr. Edwin A. Neatby, proposed that a memorial tablet be erected in the meeting room of the Society, containing the names of the Founders of the Society, and the past Presidents. After discussion the matter was referred to the Council for report.

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It was resolved at the Annual Assembly that where in the Laws and Bye-laws the word editor and secretary appear, editors and secretaries should be read.

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The following officers for the Session 1898-1899 were elected :

*President*: Dr. Arthur Clifton.

*Vice-Presidents*: Dr. Burford, Dr. Washington Epps.

*Treasurer*: Dr. Galley Blackley.

*Council*: Dr. Clifton, Dr. Burford, Dr. Epps, Dr. Blackley, Mr. Dudley Wright, Mr. Knox Shaw, Dr. Byres Moir, Dr. Goldsbrough, Mr. Wilkinson, Dr. Stonham, and Dr. A. E. Hawkes (Liverpool Representative).

*Section of Materia Medica and Therapeutics*: Mr. Wilkinson, Dr. Hughes, Dr. Epps, Dr. Ord, and Dr. Dyce Brown.

*Section of Medicine and Pathology*: Dr. Moir, Dr. Blackley, Dr. Day, Dr. Epps, and Dr. Goldsbrough.

*Section of Surgery and Gynæcology*: Mr. Knox Shaw, Mr. Wright, Dr. Burford, Mr. Johnstone, and Dr. Neatby.



*Library Committee:* Dr. Blackley, Dr. Burford, Dr. Hughes, Dr. Neatby, and Mr. Knox Shaw.

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At the second meeting of the Annual Assembly Messrs. Down, Bros., of St. Thomas's Street, gave an excellent exhibition of recent surgical instruments and appliances; Mr. Pentland, of Smithfield, and Mr. Kimpton, of Holborn, of medical and surgical books.

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The Council have appointed Dr. Hughes Editor of the JOURNAL, and Mr. James Johnstone Secretary of the Society.

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SUMMARY OF PHARMACODYNAMICS AND  
THERAPEUTICS.

“GATHER UP THE FRAGMENTS, THAT NOTHING BE LOST.”

JUNE—AUGUST, 1898.

PHARMACODYNAMICS.

**Acidum nitricum.**—Dr. Hanchett relates a case in which a young woman, in the second week of typhoid, complained constantly of a difficulty of drinking because of a sensation being induced as of a hair on the tongue. “I found it,” he says, “under nitric acid, which also covered the totality of my patient’s symptoms.” [But where did he so find it? It does not appear in Allen’s “Symptom Register,” nor is it in the copious pathogenesis of the *Chronic Diseases*.—ED.]—*Amer. Medical Monthly*, October.

**Acidum picricum.**—“Recent advocacy of picric acid in burns renders interesting this note of warning. Dr. Szczypiorski relates two cases where, thirty-six hours after local application of a 5 per cent. salve of picric acid in vaseline, there was noticed slight icterus and a rubeoliform erythema which covered the whole body with irregular patches. These were partially confluent, and did not disappear wholly on pressure. The urine was darkish red; the tongue coated; and there was anorexia with general malaise, so that the patients—adult men—were obliged to remain in the house for two or three days.”—*Amer. Homœopathist*, August 1.

**Aconite.**—Speaking, at the *Materia Medica Conference* of 1897, of the value of uniquely occurring symptoms, Dr. Korndorfer mentioned the experience of Van Helmont, who, after putting a piece of aconite root on his tongue, had an ecstasy in which all his mental operations seemed performed in the pit of his stomach. No other prover has felt anything like this, and Van Helmont could not reproduce the sensation in his own person. But Dr.

Korndorfer had a serious case of insanity which had existed for some months, and the presence of this very symptom led him to prescribe aconite tincture. Within five days the patient was restored to reason, and has had no relapse since (five years). Dr. Eldridge Price acutely suggested that such verifications would probably be as rare as the occurrence of the symptom in drug pathogenesis.—*American Medical Monthly*,<sup>1</sup> October.

A boy, aged 4, subject to laryngeal catarrh, was taken ill on January 12 with a slight cold in the head which changed towards evening to a croupy cough of a very severe character. When seen by the doctor he was extremely anxious, would not stop in bed and was carried about in his mother's arms. Face dark red, hot, anxious expression, pulse weak and small, respiration slow, inspiration and expiration noisy, interrupted by hoarse hacking cough, temperature somewhat increased. Some mucus came away with the cough. Great dyspnoea; he seemed about to suffocate every moment. Voice quite toneless, speaks with difficulty, can hardly be understood. The nose, which was running during the day, is now quite dry. Aconite 30 was given every half hour; a sponge dipped in hot water was applied to the laryngeal region. This was at 7 o'clock. When visited at 9 p.m. the violence of the symptoms had abated. He was in a state of perspiration, the dyspnoea had gone, the breathing was no longer noisy, the cough less frequent and white mucus was expectorated. The cheeks not so red, the pulse quieter, but the voice was still hoarse. He had a pretty good night and next morning appeared quite well.—*Mossa, A. h. Z.*, cxxxvii., 105.

Dr. Clifford Mitchell commends aconite in the symptoms of chronic interstitial nephritis due to the rigid arteries of the disease. He gives the 1x or 2x dilution.—*Amer. Homœopathist*, June 1.

**Actæa**.—Dr. Burford's experience with actæa in insomnia and mental disturbance following on ovariectomy (see p. 216 of this volume) has been verified by Dr. Wesner in similar symptoms occurring during the fifth week of typhoid. The 3rd dil. was used here, the 1x in the former case.—*Amer. Homœopathist*, June 1.

Two old-school physicians of France—MM. Albert Robin and Mendel—praise this drug as almost infallible in tinnitus aurium of whatever kind. They give 15 drops of a fluid extract (which must be somewhat inert, as our mother-tincture could not be borne in such doses).—*L'Art Médical*, July.

<sup>1</sup> This is the journal hitherto issued as the *Southern Journal of Homœopathy*.

**Æsculus.**—The horse-chestnut is growing in repute in France for affections of the anus. In addition to the hæmorrhoids for which we have long valued it so highly, it appears capable of subduing the irritation caused by ascarides, and effecting their expulsion.—*L'Art Médical*, July, p. 75.

**Anacardium.**—Dr. Dahlke communicates another case in verification of the indication for anacardium, that its gastralgia is relieved as long as food is in the stomach, but returns some two hours after its ingestion. The remedy was given in the 6th dil.—*Amer. Homœopathist*, September 1, p. 268.

**Anhalonium.**—Another experiment with the “mescal buttons,” related by Mr. Havelock Ellis in the *Lancet* of June 4, is extracted in the *New England Medical Gazette* for September. It confirms the chromatopsia experienced by Dr. Weir Mitchell; but, while he could only see the coloured phantasmagoria with his eyes closed, to Mr. Ellis they were plain enough in a dark room though his eyes were open. He is convinced that all the senses were in his case more or less affected.

**Antimonium tartaricum.**—Dr. Jousset has been experimenting in the laboratory of the Hôpital St. Jacques, to see whether Magendie was right in affirming, or Ackermann in denying, the power of tartar emetic to inflame the lungs. His results, especially when histological examination was added, unmistakably support the affirmative answer to the question.—*L'Art Médical*, August.

**Antitoxin.**—A healthy man was injected with 5 c.c. of diphtheria antitoxin for prophylactic purposes. Five days later he suffered from malaise, chilliness, and vertigo. He was faint, and was put to bed. Chilliness and vertigo continued; vomiting occurred. There was great prostration, and œdema of uvula and pharynx. Urine thick, high-coloured, and very scanty. At the end of the first day of the symptoms, general glandular enlargement came on, which persisted ten days. Patient was much prostrated and lost ten pounds in weight; he was unable to resume work for a week.—*Medical Era*, July.

**Arnica.**—A man, aged 60, had been troubled for four weeks with soreness of the testicles. The pain ran up to the inguinal regions and the back. Arnica (dilution not named) relieved almost immediately, and there was no further trouble.—*N. A. Journ. of Hom.*, August, p. 524.

**Arsenic.**—Uhlmann of Vienna, in a recent medical meeting, showed a case with keratosis, ulcers, and epithelial carcinomata, brought on by the prolonged use of arsenic. The patient had suffered from burning and smarting of the skin of the hands and face. Epithelioma appeared upon the forehead and head. Hebra, in the same meeting, related that from taking arsenic for neuralgia the soles of his feet became so thick and painful that walking was impossible.—*Med. Century*, August.<sup>1</sup>

A case of well-diagnosed cancer of the rectum is reported by Dr. Frank Wieland, in which arsenicum, in high potency, effected so much improvement that the stools became formed, and the patient returned to work and remained practically well.—*Amer. Homœopathist*, August 15.

**Baryta iod.**—Dr. C. B. Crosby highly commends this salt of barium in the inanition of children without ascertainable cause. He gives the 3x trit.—*Med. Era*, August.

**Borax.**—Another cure of membranous dysmenorrhœa with this drug is reported by Dr. W. J. Renwick. It was given in the 6x trit. The patient had the fear of downward motion characteristic of the drug.—*Medical Century*, August.

**Calcareo fluoric.**—Dr. George P. Hale reports a good case of parotid induration and hypertrophy disappearing under the 3rd trit. of this salt; and mentions that he has for several years prescribed it for all chronic palpebral tumours, always getting softening and either absorption or evacuation, leaving the lids perfectly normal.—*The Clinique*, July.

**Cannabis indica.**—Dr. Bicknell, from a case of poisoning with this drug, adds a new symptom—sense of extreme tension in the abdominal vessels, which felt distended even to bursting.—*Amer. Homœopathist*, June 1.

**Carbo animalis.**—From the pathogenesis of this drug, and from experience with it in continued fever where the axillary glands were swollen, Dr. Younan suggests it in the treatment of bubonic plague.—*Calcutta Journ. of Med.*, March—April, 1897.

**Causticum.**—Dr. Cowperthwaite contributes to the *Medical Era* of August an interesting study of causticum, which he regards

<sup>1</sup> Cases of peripheral neuritis and of herpes zoster produced by the medicinal use of arsenic may be read in the June No. of the *Monthly Hom. Review*.

as a potash preparation. *Inter alia*, he says :—"Some years ago I published the reports of a large number of cases of facial paralysis . . . brought on by exposure to cold winds . . . cured within a very few hours with the aid of causticum 30." [One would like to have the reference to this publication.—ED.]

**Cineraria.**—Dr. E. D. Perkins has had better results than others have reported from the use of *cineraria maritima* (instilled into the eye) in cataract. In a case he treated—"from blindness so extreme that she could scarcely distinguish day from night, having to be led every step, she wheels her little grandson in his carriage safely along the walk, and distinguishes colours and the outlines of objects in a room. There has been constant gradual improvement, which is still progressing . . . From a dull, lustreless eye, with muddy, congested conjunctiva, we have a bright, clear, healthful-looking organ."—*Minneapolis Hom. Magazine*, August.

**Crocus.**—An unmarried lady, aged 42, fat and short, had for some years suffered from profuse menorrhagia at irregular intervals, sometimes even two or three times in a week. She was very anæmic, and her heart was weak, she had frequent ebullition of blood to head, with very high colour of face. She was nervous, over-sensitive to weather changes, had frequent changes from extreme depression to exuberant spirits. Appetite good, eats much and often, and frequently takes wine. She suffers much from menstrual colic, with pain in ovaries and limbs. Sleep restless, with disagreeable dreams. At the beginning of April she had an eruption of furuncles on right cheek and nape. She treated these with collodion, but fresh furuncles constantly appeared. Latterly she developed a febrile state, rigors in the evening and heat at night. The right cheek and upper eyelid were swollen and dark red. The gums, both upper and lower, became inflamed, and her teeth, which were much decayed, became painful, the tongue thickly coated, *foetor oris*. The fever with pulse at 88 was aggravated towards evening, and she had intense thirst, compelling her to drink much water. The menorrhagia, which had lessened for some weeks, returned with profuse flow of dark fetid blood. She had also throbbing headache. Belladonna 30 did no good. Diarrhœa, with frequent stools, appeared, and she complained much of going to sleep of the limbs, especially the arms. She now got crocus 1x, 5 drops every three hours. In twenty-four hours the fever was allayed,

the redness of face and the gingivitis disappeared, the tongue became clean, the diarrhoea ceased, and in a few days the menorrhagia stopped, the furuncles healed, and after fourteen days the skin of the affected parts desquamated.—Goullon, *A. h. Z.*, cxxxvii., 2.

**Cuprum arsenicosum.**—Another old-school writer comes forward to commend this drug in the diarrhoea of children. He dissolves a  $\frac{1}{100}$  grain tablet in four ounces of water, and gives a teaspoonful of this solution frequently, *i.e.*, his dose is  $\frac{1}{4800}$  of a grain, or about 2 drops of our second centesimal dilution.—*Hahn. Monthly*, June, p. 403.

**Digitalis.**—Experiments with this drug have been carried out with pigs, five having daily doses of it, and another five being left unmedicated. The former gained weight, and their hearts were found about  $\frac{1}{2}$  oz. heavier than those of the others, the walls being thicker, firmer, and more resistant to the knife.—*Calcutta Journ. of Medicine*, July.

Dr. Pennoyer's experience would give this medicine a higher place than it usually occupies among remedies for vesical irritation. It is where this occurs chiefly at night, causing frequent desire to micturate, that he finds it most useful. If there is much catarrh, terebinthina must be conjoined with it.—*Minneapolis Hom. Magazine*, July.

**Euonymus.**—A man of 24 proved this drug upon himself, in continued small doses. His chief symptoms occurred after leaving off the experiment, and among them the most noteworthy were pain and tenderness in the liver, and great mental hebetude.—*Amer. Homœopathist*, June 1.

**Ferrum.**—An artesian well has been sunk in Garfield Park, Chicago, and its water contains a large percentage of iron to the gallon. "Nearly everyone," writes Dr. Chas. H. Evans in the June *Clinique*, "visiting the park drinks from this well, and a large number of people in that part of the city daily fill their jugs or bottles from its pool and carry it to their homes, where it is, I am told, used as a table water. In all the years of my practice I have never seen such a large number of chloro-anæmics on the streets as I have observed during the past three or four years, and I attribute a considerable proportion of such to the almost constant use of this water, which in time has established a ferric cachexia."

**Ferrum picricum** is making a reputation for itself in another sphere<sup>1</sup>—as a remedy for warts. Three cases of the kind appear in the *Homœopathic Recorder* of August, in which the action of the drug (6th dil.) was all that could be desired.

**Guaiaicum**.—Dr. Jitendra Nath Majumdar relates a case of locomotor ataxia, having a distinct syphilitic history, in which guaiacum 3x induced great relief in respect of the lightning pains, which were very severe.—*Indian Hom. Review*, April—May, 1898.

**Hyoscyamus**.—Dr. Venturi, an old-school physician, writes to praise the “globuli hyoscyami homœopathici” of the 30th dil. as remedial against insomnia. He gives two morning and evening: the results are seen generally on the third or fourth day.—*N. Amer. Journ. of Hom.*, July, p. 458.

**Ignatia**.—In a case of intense photophobia complicating “sore eyes,” and accompanied with chirping in the ears and great nervousness and restlessness, ignatia 4 brought about speedy improvement.—*Amer. Homœopathist*, June 1.

**Iodine**.—MM. Renon and Fallet report a case in which the tincture of iodine, applied to the chest, caused inflammation first of the left and then of the right parotid.—*L'Art Médical*, July, p. 47.

**Iris**.—Dr. Baruch relates a case of what seems to have been diabetes of pancreatic origin, where complete recovery ensued under the use of iris 2x, without any restriction of diet.—*Amer. Homœopathist*, July 1.

**Kali iodatum**.—In a case of blennorrhagic rheumatism treated by this drug, Dr. Jacquet saw developed on the 3rd-4th day of its administration a neuralgia of the right facial nerve, with tenderness on pressure at its emergence from the aqueduct of Fallopius. There was no motor paralysis; but this phenomenon occurred from the same drug when taken by the patient four years previously, and two years ago it excited in the patient severe dorso-lumbar pains.<sup>2</sup>—*L'Art Médical*, June.

**Kreosote**.—A short proving of this drug, taken by inhalation, is recorded in the *Hom. World* for August. Toothache was very marked among the symptoms induced.

<sup>1</sup> Mr. Dudley Wright continues to get good results from it in enlarged and irritable prostate. See *Monthly Hom. Review*, July.

<sup>2</sup> This is the second time that Dr. Jacquet has seen neuralgia of the facial supervene under the influence of the iodide.



**Methylene blue.**—This aniline colour has been much used of late in old-school practice. One of its disadvantages has been the occasional setting up of vesical irritation. Taking this hint, Dr. Henry H. Chase has tested it in catarrhal condition of the urinary tract, and with good results. He gives two grains, in capsules, for a dose.—*Med. Century*, August.

**Myrrh.**—In speaking (p. 302) of the use of this medicine in "mixed" diphtheria, we omitted to mention that the dose recommended is the 100th of a drop of the tincture, and its action is said to be "in accordance with a well-known law." This is from an old-school source.—*Hahn. Monthly*, June, p. 398.

**Oophorin.**—This substance—an extract, as its name imports, of the ovaries—has been given, on the analogy of thyroidin, for the troubles of the climacteric, and those which ensue on oophorectomy, with good effect.—*Hom. World*, July.

**Phytolacca.**—In a "symposium" on obstetrical practice, the question being asked "To resolve cake-breast, what?" twenty-five respondents placed phytolacca first among internal remedies for the condition.—*Hom. Jour. of Obstetrics, &c.*, May.

**Ranunculus.**—Dr. Cartier gives an interesting study of the two ranunculi (bulbosus and sceleratus) in the *Revue Hom. Française* of June. [In saying that "iritis" is among the pathogenetic effects of r. bulbosus, is not Dr. Cartier drawing upon Farrington's "*Clinical Materia Medica*" in a way hardly legitimate?—ED.]

Dr. Marc Jousset adds a curious experience of Polli's, that chronic sciatica may almost always be cured by the application to the heel of the affected leg of the tincture or distilled water of ranunculus.

**Salt.**—The "normal salt-solution" (*i.e.*, a teaspoonful to a pint) has been found valuable when injected into the veins not only against shock but also in sepsis and uræmia. Dr. J. C. Wood endorses this testimony from his own experience.—*Medical Century*, July.

**Secale.**—Dr. Dyce Brown has lately<sup>1</sup> called our attention to Dr. Lombe Atthill's experience with ergot as a preventive (while in health it is an excitant) of abortion. Dr. Lambrechts, *filis*, supports the practice by two well-narrated cases of his own, where

<sup>1</sup>*Monthly Hom. Rev.*, June. Dr. Brown also cites Dr. Meadows as confirming this experience.

the 3x was the dilution employed.—*Journ. Belge d'Homœopathie*, July—August.

**Somatose.**—This preparation appears to have considerable power in favouring the mammary secretion; but a case extracted in *L'Art Médical* for July (p. 51) seems to show it possessed of this disadvantage, that it may set up glycosuria.

**Sticta.**—The late Dr. Scudder, of "eclectic" fame, highly esteemed this remedy when pain in the back and shoulders, extending through the neck to the back of the head, was present.—*Hom. Recorder*, June.

**Thallium.**—The acetate of this rare metal has been found very effective against the night-sweats of phthisis, but in three cases in which it was used complete alopecia occurred.—*Amer. Homœopathist*, July 1.

**Thyroidin.**—Among the many collateral effects of the medicinal use of this animal extract is now to be ranked anaphrodisia. Two men who took it to reduce obesity found that the sexual function had fallen completely into abeyance.—*Hom. World*, July.

### THERAPEUTICS.

**Addison's Disease.**—Dr. T. E. Gilman reports a case apparently of this malady, in which recovery set in, when the patient was at a very low ebb, after a critical and most offensive exhalation. This supervened on the administration of hydrocyanic acid, but arsenicum iodatum and some of Schüssler's salts were later of value.—*The Clinique*, July.

**Diphtheria.**—Dr. George Talbot states that when anti-toxin was first introduced in the treatment of diphtheria he was enthusiastic, and had confidence in its superiority over any other treatment; but at present, after having tried it in a large number of cases with apparently bad results, he was inclined to discontinue its use altogether.—*N. Engl. Med. Gazette*, July.

**Eczema.**—Dr. Nyssens relates a curious bit of isopathy. Having some obstinate cases of eczema on hand, he took from one a crust and its subjacent exudation, made a 3rd cent. dil. of it with distilled water, and gave it to the patients with good curative effect.—*Journ. Belge d'Homœopathie*, July—August.

While a homœopathist thus uses isopathy, an old-school practitioner succeeds by dipping his hand into the homœopathic bag. A cure of eczema of nine years' standing by iris (in the

tincture) is extracted from the *Californian Medical Journal* in the *Homœopathic Recorder* of August.

**Goitre, exophthalmic.**—Dr. Halbert continues to get good results in the treatment of Graves' disease. His main remedies are ferrum phosphoricum, arsenicum iodatum, and lycopus<sup>1</sup>—the two former in the 3x trit., the latter in the mother-tincture. —*The Clinique*, July.

**Hæmoptysis.**—Dr. Herbert Clapp expresses the confidence his experience has given him in the homœopathic treatment of this accident, and shows, by quotations from old-school authorities, how little real temptation exists for hankering after the fleshpots of Egypt in this respect.—*N. Engl. Med. Gazette*, July.

**Nystagmus.**—A lady, aged 69, had suffered for years from loud roaring in ears, accompanied by cracking, which had been long treated allopathically without relief. At last she came under homœopathic treatment with good result, as the noises almost entirely ceased. But another affection appeared. Constant and severe winking and twitching of eyelids, vertigo, pressive pain in forehead extending to nose and right temple. The right eye looks smaller and sometimes closes altogether. The sight sometimes grows dim and then clears again. Appetite bad, sleeps well, weeps much. The homœopathic doctor prescribed medicines with no result, and tried water compresses at first to calves then over whole body without effect. Then he tried brom. 4, but with the same result. Goullon consulted prescribed first ignatia, then gelsemium, then sulphur and silica—all in vain. The vertigo continues, but only when she stands up. The winking and twitching of eyelids persist, the eyes itch and the right eye is almost always shut. The noises in ears are still present in minor degree. She is very nervous and fears she is going to die. Kal. brom., kal. iod. and natr. phos. did no good. She has attacks of weakness and fainting. The cracking in the ears was lessened, but there came on a weakness of throat and chewing muscles, so that she could eat with difficulty. She has not left her room for three weeks. Apis was now given. Immediately after the first dose there came on a sort of drawing feeling in lower eyelids and she could open her eyes perfectly. The giddiness and faint attacks ceased, and in a short time she was able to

<sup>1</sup> "The records of a number of cases in the Neurological Department of Hahnemann Hospital, Philadelphia, show conclusively the value of lycopus in this disease."—*Hahn. Monthly*, July, p. 478.

take carriage exercise after eight weeks of confinement to her room, and in short the cure was complete.—Goullon, *A. h. Z.*, cxxxvii., 25.

**Scarlatina.**—Dr. Lambreghts, *filis*, writes of his experience in a recent severe epidemic of scarlatina in Antwerp, in which he treated 30 cases, losing only two. In anginose cases he praises aconite alternated with apis when there is much œdema, with mercurius cyanatus if the throat presents a diphtheritic aspect. In the post-scarlatinal nephritis, he adds to the usual remedies tuberculinum (Kochii), which he gives in the 6th dilution. He relates a good case showing its efficacy.—*Revue Hom. Belge*, May.

**Sciatica.**—Dr. Jousset relates a remarkable cure of chronic sciatica resulting from the abandonment of the daily use of aloes and the prescription of iodium 30. No medicines touched the malady while the aloes was being taken.—*Revue Hom. Française*, June.

**Sneezing.**—A child of 10, ever since whooping-cough two years previously, was subject to daily attacks of sneezing, lasting half an hour or so. She had persistent nasal catarrh. Senega was chosen as the most suitable remedy, and after one dose of the 200th the sneezing disappeared in a week, and the catarrh soon followed suit.—*Amer. Homœopathist*, August 15.

Dr. O. L. Smith relates a similar case in a man of 24, where the nasal mucous membrane was acutely congested as well as hyper-sensitive. Here asafoetida 1 proved the remedy.—*The Clinique*, August.

**Stomach Cough.**—An article on this affection is translated from the German in the *Homœopathic Recorder* for June. The writer regards bismuth as its leading remedy, and places pulsatilla next.

**Typhoid.**—Delirium and jactitation were very marked in a case of typhoid which Dr. Colwell had to treat. Ordinary remedies failing, he tried the hydrobromate of hyosine in the 2x, later the 3x, trit., with speedy good effect. The congestion of the brain, obviously present, seemed to melt away under its use.—*The Clinique*, July.

**Ulcers.**—The practice of dressing indolent ulcers with bovine as a nutrient has become very general. Dr. C. Gurnee Fellows, however, has made a fresh step by carrying out this treatment in ulceration of the cornea. He relates a very severe and long-lasting case, in which the undiluted preparation was instilled daily with the happiest results.—*The Clinique*, August.

## INDEX

*To the Transactions, &c., of the Society.*

	PAGE
Appendix vermiformis: (Specimens of) .. .. .	371, 372
Arm, Congenital Absence of: (Case of) .. .. .	376
Balance Sheet .. .. .	384
Blackley, J. Galley: On the Use of some of the Principal Hæmatics ..	282
Blake, E. T.: On the Study of the Hand for Indications of General Disease .. .. .	194
Bradycardia: (Cases of) .. .. .	367
Brain Disease: On the Diagnosis and Therapeutic Treatment of, with Special Reference to Conditions requiring Surgical Interference: (Giles F. Goldsbrough) .. .. .	42
Calculus, Salivary: (Specimen of) .. .. .	377
Calculus, Vesical: (Specimen of) .. .. .	377
Cancer, Short Notes on Three Cases which closely resembled: (John D. Hayward) .. .. .	250
Children's Sanatorium, Southport, A Digest of Ten Years' Work: (W. M. Storrar) .. .. .	82
Clifton, Arthur C.: Clinical Observations and Indications as Aids for Drug Selection in Homœopathic Therapeutics .. .. .	32
Clinical Observations: (Arthur C. Clifton) .. .. .	32
Convulsions of Cerebellar Origin: (Case of) .. .. .	371
Cough of Pulmonary Disease: (D. MacNish) .. .. .	315
— Reflex: (J. Johnstone) .. .. .	320
Coughs, Throat and Nervous: (J. R. P. Lambert) .. .. .	326
Council, Report of .. .. .	383
Day, J. Roberson: The Serum Treatment of Diphtheria .. .. .	117
Death, Sudden, and Premature Burial: (C. T. Green) .. .. .	136
Diphtheria, General Medical Treatment of: (Byres Moir) .. .. .	124
— Serum Treatment of: (J. Roberson Day) .. .. .	117
— Surgical Treatment of: (E. B. Roche) .. .. .	111
Dyspepsia, Simple: (T. G. Stonham) .. .. .	345
Endo-carditis, Ulcerative: (Byres Moir) .. .. .	336
Endo-metritis, chiefly the Senile Form: (W. Cash Reed) .. .. .	242
Fallopian Tube: (Specimen of) .. .. .	374
Friedreich's Disease: (Case of) .. .. .	370
Gall-stone: (Specimen of) .. .. .	373

	PAGE
Glands, Carcinoma of: (Microscopic Slide of) .. ..	378
Goldsbrough, Giles F.: On the Diagnosis and Treatment of Brain Disease, with Special Reference to Conditions requiring Surgical Interference .. .. .	42
Green, Conrad T.: Sudden Death and Premature Burial .. ..	136
Gumma: (Case of) .. .. .	378
Hæmatics, On the Action of some of the Principal: (J. Galley Blackley)	282
Hahnemann, The Genius of: (T. Simpson) .. .. .	184
Hand, The Study of the: (E. T. Blake) .. .. .	194
Hayward, John D.: Short Notes of Three Recent Cases which closely resembled Cancer, with Special Reference to the Question of a Pre-Cancerous Condition .. .. .	250
Heart, Congenital Malformation of: (Specimen of) .. .. .	369
Hughes, Richard: On the Use of Nosodes in Homœopathic Practice ..	168
Indexing Committee, Report of .. .. .	381
Intra-cranial Disease, Some Aspects of: (Dudley Wright) .. ..	60
— Tumour: (Case of) .. .. .	371
Johnstone, J.: Reflex Cough .. .. .	320
Lambert, J. R. P.: Throat and Nervous Coughs .. .. .	326
Liverpool Branch, Annual Report .. .. .	295
Lymphangioma: (Case of) .. .. .	376
MacNish, D.: The Cough of Pulmonary Disease .. .. .	315
Mahony, Ed.: On the Therapeutic Use of Nosodes .. .. .	160
Moir, Byres: The General Medical Treatment of Diphtheria .. ..	124
— Medicines of Use in Septic Conditions, with Especial Reference to Ulcerative Endocarditis .. .. .	336
Neatby, Edwin A.: The History and Life-History of Uterine Fibro-Myomata .. .. .	1
Nosodes, The Therapeutic Use of: (Ed. Mahony) .. .. .	160
— The Use of, in Homœopathic Practice: (R. Hughes) .. .. .	168
Ovarian Dermoids: (Specimen of) .. .. .	373
Paget's Disease of the Nipple: (Microscopic Slide of) .. .. .	378
Pericarditis, Adhesive: (Specimen of) .. .. .	369
Pessary: (Specimen of) .. .. .	376
Pneumonia in Children, Homœopathic Treatment of: (F. A. Watkins)	231
Pseudo-Hypertrophic Paralysis: (Case of) .. .. .	370
Reed, W. Cash: Notes on Clinical Endo-metritis, chiefly the Senile Form .. .. .	242
Roche, E. B.: The Surgical Treatment of Diphtheria, with Special Reference to the Methods and Anatomical Relations of Tracheotomy	111
Shaw, C. Knox: A Report of the Work of the Society from Session 1892-93 to Session 1897-98 .. .. .	385
Simpson, T.: The Genius of Hahnemann .. .. .	184
Skiagrams: Needles in Hand .. .. .	381

INDEX

403

	PAGE
Smith, Gerard: The Molecular Physics of X-Radiation .. .. .	261
Society News .. .. .	95, 215, 297, 388
Stonham, T. G.: Simple Dyspepsia .. .. .	945
Storror, W. M.: A Digest of Ten Years' Work at the Children's Sanatorium, Southport .. .. .	82
Temperament, Diathesis and Dyscrasia, The Study of: (B. Thomas) ..	266
Thomas, B.: The Study of Temperament, Diathesis, and Dyscrasia ..	266
Uterine Fibro-Myomata, The History and Life-History of: (Edwin A. Neatby) .. .. .	1
— (Specimens of) .. .. .	374, 375
Watkins, F. A.: The Homœopathic Treatment of Pneumonia in Children	231
Wright, Dudley, Some Aspects of Intra-Cranial Disease Reviewed from a Surgical Standpoint .. .. .	60
X-Radiation, The Molecular Physics of: (Gerard Smith) .. .. .	261
X-Rays, Surgical Diagnosis by (Notes on) .. .. .	378
X-Ray Vacuum Tubes. (Specimen of) .. .. .	380

## INDEX

*To Summary of Pharmacodynamics and Therapeutics.*

	PAGE		PAGE
Absinthium .. ..	298	Calotropis .. ..	99
Acidum Camphoricum .. ..	96	Cannabis Indica .. ..	393
"    Hydrocyanicum .. ..	96	Cantharis .. ..	99
"    Nitricum .. ..	216, 298, 390	Carbo Animalis .. ..	393
"    Picricum .. ..	390	"    Vegetabilis .. ..	218
Acne .. ..	224	Carbuncle .. ..	306
Aconite .. ..	96	Caulophyllum .. ..	218
Actæa .. ..	216, 391	Causticum .. ..	393
Addison's Disease .. ..	306, 398	Cedron .. ..	99
Adenitis .. ..	224	Chamomilla .. ..	299
Æsculus .. ..	392	Chancre, Phagedænic .. ..	227
Ammonium Carbonicum .. ..	298	China .. ..	100
Anacardium .. ..	298, 392	Chlorosis .. ..	107
Anasarca .. ..	224	Cina .. ..	218
Anhalonium .. ..	392	Cineraria .. ..	394
Antimonium Tartaricum .. ..	392	Cinnabar .. ..	299
Antipyrin .. ..	96	Cocaine .. ..	100
Antitoxin .. ..	97, 216, 392	Coffea .. ..	218
Apis .. ..	97, 216	Colchicum .. ..	299
Aranea Diadema .. ..	216	Cough .. ..	225
Arbutus Andrachne .. ..	97	Coxitis .. ..	306
Areca .. ..	217	Cratægus .. ..	229
Arnica .. ..	97, 299, 392	Crocus .. ..	394
Arsenicum .. ..	98, 217, 393	Crotalus .. ..	300
Arsenicum Iodatam .. ..	98	Cuprum Arsenicosum .. ..	395
Arteries, Disease of .. ..	107	Curare .. ..	300
Atrophy .. ..	224		
		Damiana .. ..	100
Baptisia .. ..	217	Dengue .. ..	225
Baryta Carbonica .. ..	98	Diabetes .. ..	225
"    Iodata .. ..	393	Digitalis .. ..	395
Birch-leaves .. ..	98	Diphtheria .. ..	107, 393
Borax .. ..	217, 393		
Bright's Disease .. ..	224	Eczema .. ..	398
Broncho-pneumonia .. ..	224	Enterorrhagia .. ..	306
		Enuresis .. ..	225
Calcarea Carbonica .. ..	99	Epilepsy .. ..	225
"    Fluorica .. ..	99, 393	Epiphegus .. ..	300



INDEX

405

	PAGE		PAGE
Epistaxis .. .. .	307	Magnesia Phosphorica .. .. .	102
Erysimum .. .. .	100	Menière's Disease .. .. .	109
Erysipelas .. .. .	307	Meningitis .. .. .	310
Eucalyptus .. .. .	218, 300	Mercurius Corrosivus .. .. .	221
Euonymus .. .. .	395	,,    Cyanatus .. .. .	301
Euphrasia .. .. .	300	Methylene Blue .. .. .	397
		Mezereum .. .. .	301
Ferrum .. .. .	395	Mother-of-pearl .. .. .	302
,,    Picricum .. .. .	396	Myrica .. .. .	102
Fibroids .. .. .	226	Myrrh .. .. .	302, 397
Fucus Vesiculosus.. .. .	300		
		Naphthalin .. .. .	102
Gangrene .. .. .	226	Nephritis .. .. .	109, 311
Gastralgia .. .. .	107	Neurasthenia .. .. .	227
Goitre, Exophthalmic .. .. .	308, 399	Nuclein .. .. .	303
Gonitis .. .. .	108	Nux moschata .. .. .	221
Grindelia .. .. .	300	Nystagmus .. .. .	399
Guaiacum .. .. .	396		
Gummata .. .. .	226	Oils .. .. .	103
		Oleander .. .. .	103
Hæmoptysis .. .. .	308, 399	Opium .. .. .	221
Hay Fever .. .. .	308	Ophthalmia Purulenta .. .. .	227
Hepar Sulphuris .. .. .	218	Ophorin .. .. .	397
Hydrastis .. .. .	219, 301	Ornithogalum .. .. .	302
Hydrophobia .. .. .	109	Ovarian Cyst .. .. .	312
Hyoseyamus .. .. .	101, 396	,,    Neuralgia .. .. .	312
Hyperchlorhydria .. .. .	309	Oxaluria .. .. .	312
Ignatia .. .. .	396	Paget's Disease .. .. .	313
Ileus .. .. .	309	Pertussis .. .. .	313
Infinitesimals .. .. .	219	Phellandrium .. .. .	103
Influenza .. .. .	310	Phosphorus.. .. .	103, 302
Iodium .. .. .	219, 301, 396	Phthisis .. .. .	227
Iodoform .. .. .	101	Physostigma .. .. .	222
Iris ... .. .	101, 396	Phytolacca .. .. .	222, 397
		Pilocarpine .. .. .	222
Jaborandi .. .. .	101	Plumbum .. .. .	303
		Polymnia .. .. .	104
Kali Chloricum .. .. .	219	Progressive Muscular Atrophy .. .. .	227
,,    Iodatium .. .. .	101, 396	Prolapsus Ani .. .. .	110
,,    Nitricum .. .. .	219	Psorinum .. .. .	303
,,    Phosphoricum .. .. .	219	Pyelitis .. .. .	110
Kreosote .. .. .	396		
		Quinine .. .. .	104, 222
Lachesis .. .. .	102, 219		
Leucorrhœa .. .. .	109	Ranunculus .. .. .	397
Lichen .. .. .	226	Raynaud's Disease .. .. .	110
Locomotor Ataxy .. .. .	109, 226, 396	Retinitis .. .. .	313
Lycopodium .. .. .	220	Rhinoscleroma .. .. .	227

	PAGE		PAGE
Rhus .. .. .	104	Sulphur .. .. .	304
Sabal Serrulata .. .. .	308	Swelling, Subcutaneous .. .. .	314
Salol .. .. .	308	Thallium .. .. .	398
Salt .. .. .	397	Thea .. .. .	304
Sanguinaria .. .. .	303	Thlaspi .. .. .	305
Scarlatina .. .. .	400	Thuja .. .. .	305
Sciatica .. .. .	400	Thyroidin .. .. .	106, 223, 305, 398
Scopolamine .. .. .	105	Tinnitus Aurium .. .. .	110
Scutellaria .. .. .	105	Topical Applications .. .. .	223
Sea-sickness .. .. .	228	Tubercle in Iris .. .. .	230
Secale .. .. .	397	Tuberculinum .. .. .	106, 305
Senega .. .. .	105	Typhoid .. .. .	230, 400
Sensitiveness on Lying .. .. .	229	Typhus .. .. .	314
Shingles .. .. .	313	Ulcers .. .. .	400
Silicea .. .. .	303	Veratrum Album .. .. .	223
Sneezing .. .. .	400	"    Viride .. .. .	106
Somatose .. .. .	398	Verrucæ .. .. .	314
Spasmus Glottidis .. .. .	229	Vinegar .. .. .	106
Stannum .. .. .	222	Vipera .. .. .	106, 306
Sticta .. .. .	398	Viscum Album .. .. .	223
Stomach-cough .. .. .	400	Xanthoxylum .. .. .	306
Stomatitis .. .. .	313		
Stramonium .. .. .	304		
Strophanthus .. .. .	105, 222		

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L A W S  
AND REGULATIONS  
OF THE  
BRITISH HOMŒOPATHIC SOCIETY.

INSTITUTED IN 1844.

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Printed for the Society.

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## CONTENTS.

	PAGE
Constitution of the Society . . . . .	3
Fellows . . . . .	5
Honorary and Corresponding Members . . . . .	5
Ordinary Meetings . . . . .	6
Extraordinary Meetings . . . . .	6
Annual Assembly . . . . .	6
Offences and Penalties . . . . .	7
The President and Vice-Presidents . . . . .	8
The Council . . . . .	9
Treasurer . . . . .	9
Honorary Secretary . . . . .	10
Papers . . . . .	11
Diplomas . . . . .	11
Form of Diplomas . . . . .	13
Diploma of Member . . . . .	13
„ Corresponding Member . . . . .	13
„ Honorary Member . . . . .	13
„ Fellow . . . . .	14
„ President . . . . .	14
Bye-Laws :	
Ordinary Meetings . . . . .	15
Library . . . . .	16
Committees . . . . .	16

LAWS AND REGULATIONS  
OF THE  
BRITISH HOMŒOPATHIC SOCIETY.  
INSTITUTED IN 1844.

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CONSTITUTION OF THE SOCIETY.

I. THIS Society has for its objects the advancement and extension of the principles of Homœopathy.

II. The Society shall be divided into Fellows, Ordinary, Honorary, and Corresponding Members.

III. The Officers of the Society shall consist of a President, two Vice-Presidents, a Treasurer, Council, and an Honorary Secretary, all of whom shall be elected annually, and be re-eligible; but no President, or Vice-President, shall hold his office for more than two years in succession.

IV. All Elections shall be conducted by Ballot.

V. Ordinary Members must be Medical men, residing in the United Kingdom, registered by virtue of a diploma obtained after personal examination, under the provisions of the Medical Act, 1886; they shall pay on admission a fee of one guinea,<sup>1</sup> and an Annual Subscription of one guinea to the funds of the Society, and have a right of voting when present at the meetings. All Members residing out of the United Kingdom, or who shall be prevented by illness, or any cause that is satisfactory to the Society, from practising their profession, shall be exempt from their annual payment during such time.

VI. Every person desirous of becoming a Member of the British Homœopathic Society must be proposed by two Members. The

<sup>1</sup> See Law X.

name, professional qualifications, and place of residence of the Candidate shall be specified by the proposers. The proposal must be in the following form :—

*We, the undersigned, attest from our personal acquaintance with*  
*, of*  
*(Qualifications)* *, that he has*  
*fulfilled the requirements of Law V.; and that he is a proper person to*  
*become a Member of the Society.*  
*(Signed by two Members.)*

The proposal must be publicly read by the President of the Meeting, and shall be suspended in a conspicuous part of the Society's room during two Meetings before the Candidate is balloted for.

VII. Before proceeding to ballot for any Candidate, the Secretary shall read from the *Medical Register* for the current year the qualifications under which the Candidate is registered; or, in the event of his registration having been effected since the publication of the Register for the current year, shall produce the Candidate's receipt for his registration fee, or his diploma.

VIII. A majority of four-fifths of the Members present must be in favour of the Candidate for his election.

IX. Every person elected a Member shall, on his admission, pay the fee and subscription according to Law V., and subscribe to the following obligation :—

*By subscribing my name to the Laws of the British Homœopathic Society, I publicly declare that I will endeavour to promote the honour and welfare of the Society, and advance the doctrines and practice of Homœopathy, and that I do recognize and will observe the Laws and Regulations of the Society.*

(a.) New Members will be expected, as the turn of each comes round, to read to the Society a Dissertation or Paper, the title of which shall be announced at the Meeting previous to that at which it is to be read.

X. Members residing more than ten miles from the General Post Office shall be considered Provincial Members, and pay no admission fee.

## FELLOWS.

XI. Fellows must possess the usual qualifications of Members, with the addition of having been in practice for seven years, five of which must have been devoted to Homœopathy. They must also have been Members of the Society for at least two years, and have contributed at least three original Communications. The new Fellow shall on election pay an enrolment fee of one guinea.

(a) A Member desirous of becoming a Fellow must petition the Society through the President, who must certify that the Member has fulfilled the conditions in the preceding law, entitling him to present his petition, before it can be taken into consideration.

(b.) The election of a Fellow shall be determined by a majority of two-thirds of the Members present, after the petition has been read from the chair, and affixed in a conspicuous part of the Society's room during two Meetings.

(c.) Any Member, who in the opinion of the Society has at any time distinguished himself in science or literature, may be elected a Fellow by a majority of at least three-fourths of the Members present at the Annual Assembly.

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## HONORARY AND CORRESPONDING MEMBERS.

XII. Honorary Members must be either Medical Men retired from the active exercise of their profession, or men engaged in auxiliary scientific pursuits, and who take an interest in the advancement of Homœopathy; they shall have the right of attending the Public Meetings, and taking part in the Medical discussions.

XIII. Corresponding Members must be Medical Men of some recognized University, College of Surgeons, or Licensing Body, and engaged in the practice of Homœopathy out of the United Kingdom. They shall not be subject to any payments; nor shall they have the right to vote.



### ORDINARY MEETINGS.

XIV. The Ordinary Meetings of the Society, at which five Members shall form a quorum, shall take place once a month, during the Session, which shall extend from October to June inclusive. But the Society shall have the power of prolonging the Session, if required.

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### EXTRAORDINARY MEETINGS.

XV. An Extraordinary Meeting may be called by the President; or on the requisition of five Members.

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### ANNUAL ASSEMBLY.

XVI. An Annual Assembly of the Society shall be held in London, in the month of April, May, or June, each year, for the purpose of taking into consideration matters pertaining to the interests of the Society, and of Homœopathy in general.

(a.) The Annual Assembly shall consist of Meetings on two successive days, and on a third if necessary. Five Members shall form a quorum.

(b.) At the last Meeting of the Assembly, the officers of the Society shall be elected for the ensuing year. The new Fellows to be elected on the Council shall be the first Officers elected at the Annual Assembly; and all other Officers of the Society required for the ensuing year shall then be elected from among the Members of the Council.

(c.) At the Annual Assembly, any Member may propose a new law. The proposition must be in writing, and seconded; it must be read from the chair, and affixed during two Meetings in a conspicuous part of the room, before it can be discussed; and three-fourths of the Members present must be in favour of the proposition before it can pass into law.

(*d.*) No Member shall bring forward a motion involving a material change in, or repeal of, any of the existing laws, without the consent of a majority of two-thirds of the Members present; the proposition shall then be reduced to writing, and seconded; it shall be read from the chair, and affixed in some conspicuous part of the room for two successive Meetings; and cannot pass into law without a majority of four-fifths of the Members present.

(*e.*) On rejection of such motion, no resolution affecting the same law, or of a like tenor, can be brought forward during the same Assembly.

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#### OFFENCES AND PENALTIES.

XVII. If any Member has cause of complaint against another, he shall be entitled to claim the protection of the Society by first stating his case to the President. The President, if he deem the matter a fit subject for inquiry, shall, with two Members of the Society (the person complaining and the person complained of each choosing one), investigate the grounds of the accusation, and determine whether the matter can be settled by an amicable adjustment or whether it shall be referred to the Council; who, in conjunction with the aforesaid parties, shall decide—whether the question in dispute can be adjusted,—whether the offending party shall be admonished by the President,—or whether, finally, it shall be brought under the consideration of a full Extraordinary Meeting of the Society, as conduct deserving a public reprimand in the presence of the whole Society, or expulsion of the offending Member.

XVIII. Any Member who shall intentionally infringe the Laws and Regulations of the Society, or shall by speaking, writing, printing, or otherwise, do anything to the detriment or dishonour of the Society, shall be liable to expulsion under the obligation signed by him on admission.

XIX. Any person who shall announce by placard on any public place, or shall publish in any advertisement or circular letter, his

mode of practice or place of abode, or shall sell, or cause to be sold, any secret remedy or nostrum, or shall publish any pamphlet or book in which cases of cure are detailed and the remedies concealed, is not admissible as a Member; and, moreover, if any Member shall commit any of the above offences against the Society, he shall be liable to expulsion.

XX Any Member assuming a professional title to which he has no right, or to which he is not entitled by the customs or usages of the profession, if continuing to do so after being admonished by the President, shall be liable to expulsion.

XXI Whenever any Member, by the infringement of the foregoing laws or by any other act, shall in the opinion of the President and Council, have rendered himself liable to expulsion, the Secretary shall notify the same to the offending party; an Extraordinary Meeting of the Society shall be convened for the purpose of taking the matter into consideration, at which Meeting the accused party shall have an opportunity of explaining. The question shall be decided by a majority of the Members present, the votes being taken by Ballot.

XXII Expulsion deprives a Member of all the privileges of the Society, and his name shall be struck off the list of Members. The cause of expulsion shall be entered upon the Minutes, and a copy of the Minutes shall be forwarded to the Member expelled, and to the Members generally.

XXIII A Member omitting to discharge his debts to the Society before the close of the Annual Assembly, shall be liable to have his name stricken from the list of Members.



### THE PRESIDENT AND VICE-PRESIDENTS.

XXIV The President, or in his absence one of the Vice-Presidents, shall preside at all Meetings, and conduct the business of the Society according to the forms prescribed.

(a.) The President of the Meeting shall announce from the chair the subject of the evening's discussion, signify any vacancy occurring in the Office-bearers of the Society, and report progress in case of adjournment of any meetings.

(b.) On all occasions of voting, the President of the Meeting shall receive from the Secretary the report of the Ballot, and communicate the result to the Society.

(c.) The President of the Meeting shall have a casting vote in addition to his vote as a Member.

(d.) The President shall keep possession of the Seal of the Society, and affix it to the Diplomas and acts of the Society.

(e.) The President shall countersign the petition for Diplomas, in testimony that the Member or Fellow petitioning has fulfilled the necessary conditions.

(f.) The President is *ex-officio* Chairman of all Committees, but with the option of declining attendance; whereupon one of the Vice-Presidents shall preside.

---

### THE COUNCIL.

XXV. The Council shall consist of the President, two Vice-Presidents, the Treasurer, and all previous holders of these offices, together with three Fellows, to be elected annually, and to be eligible for re-election. Three Members of Council shall form a quorum. The Honorary Secretary shall *ex-officio* attend all Meetings of Council.

(a.) They shall be called together for the purpose of considering such other matters connected with the Society as the President shall deem necessary.

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### TREASURER.

XXVI. All moneys shall be paid into the hands of the Treasurer, and the appropriation of the funds of the Society shall be subject to the decision of the Annual Meeting.

(*a.*) The Treasurer shall take charge of and pay to the Bankers all the funds of the Society, and shall prepare a financial statement to be laid before the Annual Assembly.

(*b.*) The Treasurer shall keep a cash-book of all his receipts and payments.

---

### HONORARY SECRETARY.

XXVII. The Honorary Secretary shall keep a book, in which every Member attending the Meetings of the Society shall enter his name.

(*a.*) He shall also keep a book of incidental expenses, for the reimbursement of which he shall receive an order from the Treasurer.

(*b.*) He shall keep a record of all Transactions and Minutes of Private Business, and read them at the next Meeting, when they shall be laid before the President of the Meeting for signature. He shall also keep a Record of the following points in connection with Public Business: 1, Names of Visitors and their Introducers. 2, The title of the Paper or Papers which may be read, together with the names of those who take part in the Discussions, and the remarks of the several speakers.

(*c.*) He shall inscribe in a book provided for that purpose, all new Laws and Regulations passed at the Annual Assembly before the subsequent Annual Meeting.

(*d.*) In case of Voting he shall distribute the balls, bear round the ballot-box, attended by a Member as a Teller, and report upon the Ballot to the President of the Meeting.

(*e.*) He shall send to all Members of the Society timely notice of all Meetings, Ordinary and Extraordinary, and of the Annual Assembly.

(*f.*) When sending out the Notice of the First Meeting of each Session, he shall remind each Member that his Annual Subscription has become due, and also regarding any arrears.

(*g.*) He shall send to each Candidate for admission into Member-

ship, a letter containing extracts from Laws ix., xviii., xix., xx., and xxi., and informing him that on admission he will be required to sign a Declaration that he will abide by the Laws of the Society.

(*h.*) On admission of a new Member he shall see that he subscribes the obligation regarding the keeping of the Laws of the Society, and that he is provided with a copy of the said Laws.

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### PAPERS.

XXVIII. New Members, each one in his turn, will be expected to prepare a Paper, to be read before the Society, the title of which shall be announced at the Meeting previous to that at which it is to be read.

XXIX. All Papers read before the Society become thenceforth the property of the Society, and shall be deposited in the hands of the Hon. Secretary.

The Author of a Paper read before the Society, wishing to publish it himself, must obtain the sanction of the President and Editing Committee.

(*a.*) No Member shall publish, or furnish any materials for publishing, any transactions of the Society, without the authority of the President and Editing Committee.

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### DIPLOMAS.

XXX. The Diplomas of the British Homœopathic Society shall be divided into—Diploma of Member, Corresponding Member, Honorary Member, Fellow, and President.

(*a.*) Any Member or Fellow wishing for a diploma shall petition the Society in writing, through the President.

(*b.*) The qualifications for obtaining a Diploma of Member are as follows :—The petitioner shall have written one or more disser-

tations, and two or more original communications, and shall have discharged all his debts to the Society.

(c.) No petition shall be taken into consideration by the Society, unless countersigned by the President, and until it has been placed in a conspicuous part of the Society's room for two Meetings.

(d.) On delivery of a Diploma of Member, the Member receiving it shall pay the sum of one guinea.

(e.) A fellow wishing to obtain his Diploma must have fulfilled all the conditions required, and must petition the Society through the President.

(f.) On delivery of a Diploma of Fellow, the Fellow so receiving it shall pay a fee of one guinea.

(g.) Honorary Members shall not be required to pay any fee for a Diploma.

(h.) The President shall be authorized to grant a Diploma on a simple majority of the Society by ballot.

(i.) On delivery of a Diploma of President, the President so receiving it shall pay the sum of one guinea.









**BYE-LAWS.****ORDINARY MEETINGS.**

I. The Business of the Society shall be divided into Private and Public.

II. The Hour of Meeting for private business shall be seven o'clock p.m., and the time shall not be prolonged beyond eight, except by a vote of the majority of the Members present.

The Order shall be as follows :—

1. The Minutes of the private business of the preceding Meeting read and confirmed.
2. Notice of new motions.
3. New Petitions for admission read.
4. Candidates for admission balloted for.
5. Miscellaneous business.
6. New Members called in, and the laws signed.
7. Motions brought forward at former Meetings discussed.

III. Each Member is entitled to introduce a Visitor [during the public business] to the Ordinary Meetings of the Society, on delivering his name in writing to the President of the Meeting, who shall have the power to invite him, if a Medical Man, to take part in the discussion.

IV. A book shall be kept by the Secretary, in which Members introducing Visitors shall see that they sign their names previous to admission.

V. Public business shall commence at eight o'clock p.m., and shall not be prolonged beyond half-past ten, except by a vote of the majority of the Members present.

The Order shall be as follows :—

1. Visitors announced.







